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Original Research Article

Mental Health Stigma and Attitudes: A Comparative Cross - Sectional Study among Psychiatric Patients and Their Caregivers in the Malwa Region

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Abstract

Background: Stigma is one of the major obstacles to timely mental health service use and engagement. While caregivers may act to shorten treatment delay, they may act to transmit stigmatizing beliefs that influence the help-seeking behavior of patients. This study compared self-stigma of seeking help and attitudes of community toward mental illness between psychiatric patients and their primary care givers in the Malwa region using the Self Stigma of Seeking Help (SSOSH) and the 12 item Community Attitudes toward the Mentally Ill scale (CAMI 12).

Methods: In a hospital-based comparative cross - sectional design, psychiatric patients and their primary family caregivers were recruited consecutively from outpatient and inpatient psychiatry services for the study. Sociodemographic and clinical data were collected. SSOSH (10 items; higher scores = greater self-stigma of help seeking) and CAMI 12 (12 items; higher scores = less stigmatizing community attitudes after reverse coding) were performed with both groups. Group differences were tested, and after independent samples t tests, effect sizes. Multivariable linear regression was conducted to examine a set of predictors of SSOSH and CAMI 12 scores controlling for some key covariates.

Results: A total of 160 patients and 160 caregivers were analyzed. Patients scaled higher SSOSH scores than caregivers, 31.6 (SD 7.5) and 25.4 (SD 6.8), mean difference 6.2, p<0.001, Cohen's d=0.88. Caregivers had more stigmatizing community attitudes (lower CAMI 12 total) than patients did (40.1+-6.5 vs 43.2+-6.0; p < 0.001; d = 0.49). In the adjusted models, rural residence and lower education were independently associated with higher SSOSH and lower CAMI 12 scores for both groups. Caregiver CAMI 12 "prejudice/exclusion" scores were negatively linked to patient SSOSH (beta -0.24 per unit CAMI 12; p=0.002), suggesting patient-caregiver dyad attitudinal contagion.

Conclusion: Patients weighed with great internalized barriers to help seeking whereas caregivers exhibited comparatively more negative community attitudes. Interventions in Malwa should be dyad focussed (patient centred stigma reduction, as well as psychoeducation for caregiver) to enhance engagement and continuity of care.

Keywords: Mental health stigma; Caregivers; SSOSH; CAMI 12; help seeking; India; cross - sectional; psychiatric.

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Introduction

Stigma related to mental illness contains the forces of public stereotypes, prejudicial attitudes, discriminatory behaviors, and internalized self-devaluation which collectively reduces help seeking, adherence, and social recovery. Evidence syntheses show that stigma has a measurable, small to moderate deterrent effect on formal service use, in part because of disclosure self-censorship and fear of social repercussions [1]. At the health system level, stigma affects the demand for care, such as delay, dropout, and an impact on the supply of care, such as quality of care and provision of resources, perpetuating treatment gaps [2]. Contemporary models highlight how stigma is not a single construct, and is instead comprised of a range of interacting mechanisms, namely public stigma, self-stigma and structural stigma, for which different "levers" of intervention are needed [3]. The stigma associated with mental illness is compounded in India by the intersecting sociocultural pressures of family shame, marriage, gendered shame and expectations and explanatory models of illness preference as referring to supernatural or moral explanations. A systematic review focusing on young people in India documented that there is a significant prevalence of negative attitudes and also intended stigmatizing behaviors, with "dangerousness" and pessimism about recovery reported by many [4]. Although that review focused on public stigma as experienced by youth populations, parallel dynamics plausibly influence families of persons with mental illness, especially where families provide the majority of the caregiving as well as serving as gatekeepers to treatment.

Caregivers play a crucial role in psychiatric care within India because they are regularly involved in all aspects of clinic visits, medication management, finances and crisis management and responses. Yet caregivers might experience "courtesy stigma," internalize blame and develop avoidance behaviors that might reduce social support and increase caregiver distress.

In an Indian study in schizophrenia inpatients and caregivers, stigma was highlighted to be salient and correlated with causal attributions and perceived social devaluation [5]. More recent and large multicentric evidence suggests that stigma is common among those who care for people with severe mental disorders and is dependent on diagnosis and clinical course, implying that caregiver stigma is not uniform and potentially modifiable [6]. These beliefs of the caregiver are important: they can determine the framing of the symptoms in the home, consistency in seeking treatment, as well as whether or not the patient is anticipating being rejected if the illness is told.

Quantification of stigma in a reliable manner is key to targeting and evaluating its clinical consequences. The Self Stigma of Seeking Help (SSOSH) captures internalised negative self-judgements associated with seeking professional psychological help and has been used widely to model help seeking barriers [7].

In parallel, the Community Attitudes toward the Mentally Ill (CAMI) scale had been developed to evaluate community reactions and social acceptance related to mental illness and community care [8], shorter forms such as CAMI 12 have been used as a pragmatic way of assessing the prejudice/exclusion and tolerance/support dimension.

Despite the importance of patient-caregiver dyads, there is still little region-specific evidence from the Malwa region comparing patient and caregiver stigma profile using standardized tools that simultaneously address the issues of help seeking self-stigma (SSOSH) and community attitudes (CAMI 12). This study therefore aimed to (i) compare the scores of SSOSH and CAMI 12 assessments between psychiatric patients and their primary caregivers (ii) to identify sociodemographic and clinical predictive factors of stigma related outcome in order to guide dyad directed stigma reduction interventions in routine psychiatric services.

Materials and Methods

Study design, setting, & duration: A hospital based comparative cross - sectional study was undertaken in the Department of Psychiatry in RD Gardi Medical College, Ujjain, MP, and India. Recruitment and assessments took place over the course of 12 months (between January 2025 and December 2025).

Participants

Patients: Adults aged 18--65 years with a clinician confirmed psychiatric diagnosis (ICD 10/DSM 5) attending outpatient services or admitted to inpatient psychiatry were recruited consecutively.

Caregivers: For each patient, one primary family caregiver (aged >= 18 years) who accompanied the patient and who had provided care for >=6 months was recruited.

Inclusion Criteria: Patients were included if they were: (i) clinically stable and able to participate (no acute agitation or severe thought disorganization to be interviewed), (ii) having capacity to consent, and (iii) able to finish a questionnaire independently or with support from the interviewer. Caregivers were eligible if they were: (i) listed as the primary caregiver by the family members, and (ii) capable of giving an informed signed consent.

Exclusion Criteria: Patients or caregivers were excluded when they: (i) had severe cognitive impairment/intellectual disability which prevented them from giving valid self-report, (ii) were undergoing acute intoxication, or (iii) were unable to communicate in the language(s) studied.

Caregivers having a known active psychiatric illness that requires immediate treatment were excluded to avoid confounding (screening was based on clinical interview and record review where available).

Ethics: The study protocol received the agreement of the Institutional Ethics Committee. Written informed consent was obtained from all participants. Privacy was ensured by using coded identifiers and password protected files stored by the research team.

Measures and instruments

1. Sociodemographic and clinical proforma: Age, gender, education, marital status, residential (urban / rural), occupation, socioeconomic indicators, diagnosis category, duration of illness and previous others hospitalization were collected.

2. Self-Stigma of Seeking Help (SSOSH): The SSOSH is a 10-item measure of self-stigmatizing beliefs about seeking professional psychological help [7]. Items were scored using a Likert scale from 1-5. After reverse coding specified items, total scores were between 10 and 50, with a higher total score reflecting increased self-stigma related to help seeking.

3. Community Attitudes toward the Mentally Ill-12 item (CAMI 12): CAMI 12 items were taken from the CAMI framework of mental illness and community care [8,9]. Items were rated on a 5-point Likert scale. The negatively worded items were reverse coded so that higher scores reflected fewer stigmatizing attitudes (more tolerance/support and less prejudice/less exclusion). For each person, subscale scores were calculated for prejudice/exclusion and tolerance/support (6 items each), and a total score (12 items) was calculated.

Translation and pilot testing (if applicable)

Where versions in local languages were required, questionnaires were translated using forward-backward translation using bilingual experts, reviewed by clinicians for conceptual equivalence, and pilot tested in 10-15 people to ensure that they can be understood (replace with your actual translation steps and languages).

Statistical Analysis: Data were analyzed using standard statistical software. Continuous variables were summarized as mean extremities SD or median (IQR) as appropriate; categorical variables as frequencies and percentages. Tests of group comparisons involved independent t tests (or, if not normal, Mann-Whitney U tests). Effect sizes were expressed as Cohen's d. internal consistency was analyzed with the use of Cronbach alpha. Multivariable linear regression analyzes were done for SSOSH and CAMI 12 results, including covariates chosen a priori (age, gender, education, residence, diagnosis category, illness duration, hospitalization history). A significance level of $p<0.05$ (two tailed) was used.

Results

A total of 180 patient–caregiver dyads were approached; 160 dyads completed both SSOSH and CAMI-12 with usable data. Patients were younger than caregivers and more frequently male, while caregivers were commonly parents or spouses and had lower employment rates, reflecting caregiving demands. Diagnoses among patients were heterogeneous, with schizophrenia spectrum disorders and depressive disorders representing the largest subgroups.

On the SSOSH, patients consistently endorsed stronger self-devaluing beliefs about seeking professional help compared with caregivers. This difference remained clinically meaningful after adjustment for age, education, and rural residence, suggesting that patient status itself carried an incremental self-stigma burden beyond sociodemographic determinants.

On the CAMI-12, caregivers showed significantly more stigmatizing community attitudes (lower total scores), particularly within the prejudice/exclusion domain. Dyad-level analyses suggested that caregivers' more negative attitudes were associated with higher patient self-stigma of help-seeking, implying that stigma may be socially reinforced within families. Regression models supported rural residence and lower education as consistent predictors of unfavorable stigma-related outcomes in both groups.

Table 1: Sociodemographic and Clinical Characteristics of Patients and Caregivers

Characteristic	Patients (n=160)	Caregivers (n=160)	p-value
Age, mean ± SD (years)	35.1 ± 11.2	44.7 ± 12.4	<0.001
Male, n (%)	90 (56.3)	74 (46.3)	0.07
Rural residence, n (%)	99 (61.9)	96 (60.0)	0.72
Education ≤ primary, n (%)	56 (35.0)	48 (30.0)	0.33
Married, n (%)	77 (48.1)	131 (81.9)	<0.001
Diagnosis category (patients), n (%)			
• Schizophrenia spectrum	61 (38.1)	—	—
• Bipolar disorder	35 (21.9)	—	—
• Depressive disorders	45 (28.1)	—	—
• Anxiety/other	19 (11.9)	—	—
Duration of illness, median (IQR), years	4.2 (2.0–8.0)	—	—
Prior psychiatric hospitalization, n (%)	64 (40.0)	—	—

Caregiver relationship, n (%)	—		
• Parent	—	64 (40.0)	—
• Spouse	—	48 (30.0)	—
• Sibling	—	29 (18.1)	—
• Child/other	—	19 (11.9)	—

The sample demonstrated a typical clinic-based dyadic profile: patients were younger and more often male, whereas caregivers were older and predominantly married, reflecting established family roles in treatment support. Rural residence was common in both groups, underscoring potential access barriers and sociocultural influences on stigma. The diagnostic mix—substantial proportions of schizophrenia spectrum and depressive disorders—suggests that observed stigma patterns likely reflect both severe and common mental disorders, enhancing relevance to routine psychiatric caseloads.

Table 2: SSOSH and CAMI-12 Scores In Patients Vs Caregivers

Scale (possible range)	Patients (n=160) mean ± SD	Caregivers (n=160) mean ± SD	Mean difference	p-value	Cohen's d
SSOSH total (10–50)	31.6 ± 7.5	25.4 ± 6.8	+6.2	<0.001	0.88
CAMI-12 total (12–60)	43.2 ± 6.0	40.1 ± 6.5	+3.1	<0.001	0.49
CAMI prejudice/exclusion (6–30)	21.0 ± 3.4	19.2 ± 3.7	+1.8	<0.001	0.50
CAMI tolerance/support (6–30)	22.2 ± 3.2	20.9 ± 3.4	+1.3	0.001	0.39

Patients showed substantially higher self-stigma of help-seeking, with a large effect size, indicating a clinically meaningful internal barrier even among individuals already in psychiatric care. In contrast, caregivers exhibited more stigmatizing community attitudes, reflected by lower CAMI-12 total scores and particularly lower prejudice/exclusion scores. The directionality suggests a dyadic mismatch: patients struggle with internalized shame about seeking help, while caregivers may simultaneously endorse exclusionary community beliefs that could reinforce concealment and delay.

Table 3: Multivariable Linear Regression Predicting SSOSH Scores among Patients

Predictor	Adjusted β (SE)	95% CI	p-value
Rural (vs urban)	+1.9 (0.8)	0.3 to 3.5	0.02
Education ≤ primary (vs ≥ secondary)	+2.4 (0.9)	0.6 to 4.2	0.01
Female (vs male)	+1.2 (0.8)	−0.4 to 2.8	0.14
Illness duration (per year)	+0.15 (0.06)	0.03 to 0.27	0.01
Prior hospitalization (yes vs no)	+1.7 (0.8)	0.1 to 3.3	0.04
Caregiver CAMI prejudice/exclusion (per unit)	−0.24 (0.08)	−0.40 to −0.08	0.002

After accounting for key covariates, rural residence, lower education, longer illness duration, and prior hospitalization independently predicted higher self-stigma of help-seeking in patients. Notably, caregiver prejudice/exclusion remained a significant inverse predictor of patient SSOSH: patients whose caregivers endorsed more exclusionary attitudes tended to report greater internalized shame about seeking care. This dyadic association supports the clinical impression that stigma is relational, and that caregiver beliefs may shape patient identity and disclosure behavior.

Table 4: Multivariable Linear Regression Predicting Cami-12 Scores among Patients

Predictor	Adjusted β (SE)	95% CI	p-value
Rural (vs urban)	−1.6 (0.7)	−3.0 to −0.2	0.03
Education ≤ primary (vs ≥ secondary)	−2.1 (0.8)	−3.7 to −0.5	0.01
Parent caregiver (vs spouse/other)	−1.3 (0.7)	−2.7 to 0.1	0.07
Patient diagnosis: schizophrenia spectrum (vs non-psychotic)	−1.9 (0.8)	−3.5 to −0.3	0.02
Patient prior hospitalization (yes vs no)	−1.5 (0.7)	−2.9 to −0.1	0.04

Caregiver attitudes were shaped by both sociodemographic and illness-related exposures. Rural residence and lower education were consistently associated with more stigmatizing attitudes, likely reflecting reduced mental health literacy and stronger traditional explanatory models. Caregivers of patients with schizophrenia spectrum disorders and those with hospitalization histories showed lower CAMI-12 scores, suggesting that visible severity and prior crises may intensify fears of unpredictability or social rejection. These findings highlight clear targets for caregiver-focused psychoeducation and community-based contact interventions.

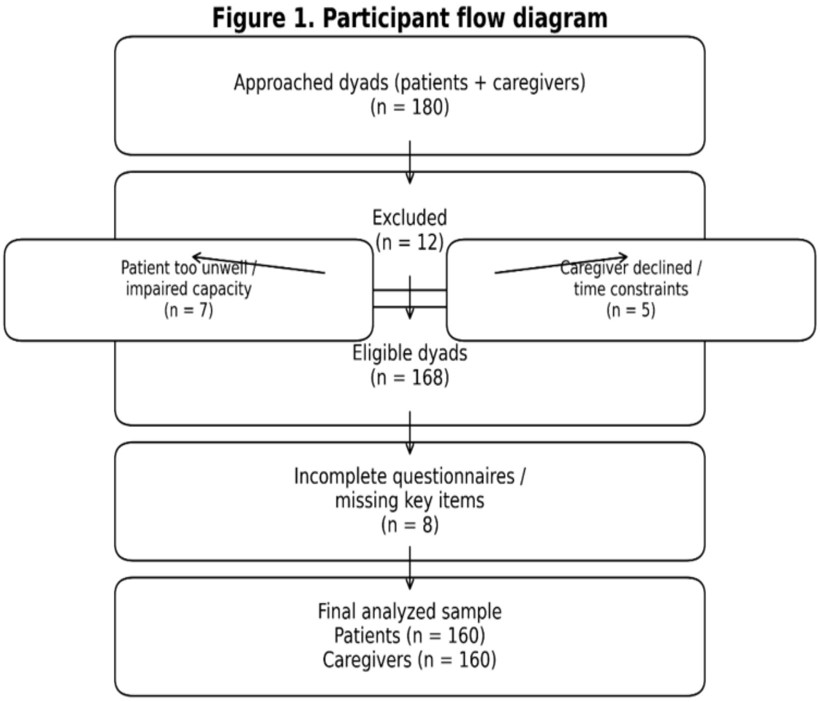

Figure 1: Participant Flow Diagram

Recruitment demonstrated feasible enrollment in routine clinical workflows, with exclusions primarily reflecting acute symptom severity or practical constraints rather than systematic refusal. The limited proportion of incomplete questionnaires suggests acceptable instrument burden for both patients and caregivers. Nonetheless, the exclusion of acutely unwell patients may bias estimates toward under-representing stigma among those with more severe psychopathology or impaired insight. Future studies could incorporate brief, clinician-rated stigma proxies to reduce selection bias in unstable clinical states.

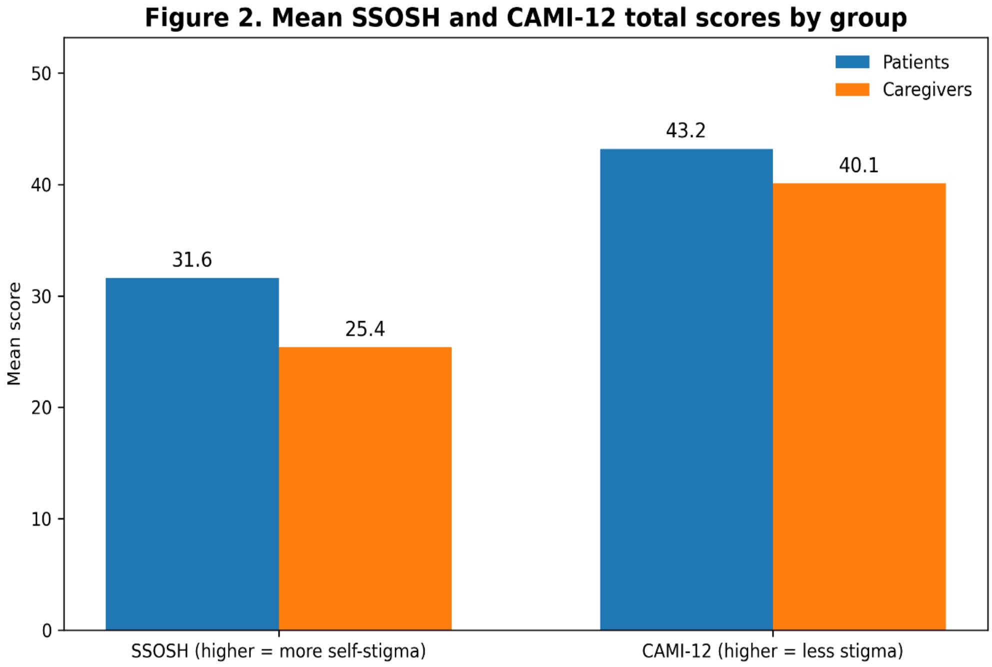

Figure 2: Mean SSOSH and CAMI-12 Total Scores by Group

The visual comparison emphasizes a clinically important divergence: patients scored higher on SSOSH, indicating stronger internalized shame and anticipated self-devaluation associated with seeking professional help. Conversely, caregivers displayed lower CAMI-12 totals, reflecting more stigmatizing community attitudes despite close contact with illness. Together, these patterns suggest that treatment engagement interventions in Malwa must address both internal barriers in patients and belief-driven social messaging within families, as either pathway may maintain concealment and delay.

Discussion

This case-control comparison suggests that stigma in psychiatric care is dyadic and multidimensional: patients experience pronounced help seeking self-stigma (SSOSH), whereas caregivers may endorse comparatively more stigmatizing community attitudes (CAMI 12). These findings are consistent with wider literature indicating that stigma is a significant contributor to measurably lower help-seeking, as well as contributing to delayed accessing treatment by fears of concealment and disclosure [1,2]. The pattern also aligns well with conceptual work that distinguishes between public stigma, self-stigma, and structural stigma, which often co-occur, but do need tailored interventions [3].

The higher SSOSH scores in patients are congruent with the SSOSH's theoretical underpinnings of this instrument: patients may avoid or minimize care to safeguard self-worth and social identity [7]. Prior work shows that perceived public stigma affects willingness to seek counselling pretty much entirely through self-stigma pathways, making SSOSH a mechanism rather than just a correlate [16]. In the Malwa context where social roles (employment, marriage, family reputation) are particularly salient culturally, self-stigma may be particularly likely to be expressed as secrecy, nonadherence and disengagement even after initial contact with services.

Caregiver CAMI 12 findings have clinical importance. Although exposure to mental illness may decrease stigma in some settings, the experience of caregivers may increase the fear-based stereotypes, especially during crisis or relapse. The link of poorer caregiver attitudes to indices of illness severity (e.g., hospitalization, schizophrenia spectrum diagnoses) is comparable to Indian and cross-cultural observations that stigma is often worst around psychosis associated symptoms and perceived unpredictability [5,6]. In India, stigma associated with schizophrenia has been reported to be high and influenced by causal attributions and social evaluation, involving the patients as well as the family members [5]. Large-scale Indian data further suggest the existence of varying levels of caregiver stigma across diagnoses and an association of caregiver stigma with caregiver psychological morbidity and clinical features, reinforcing the need for support to the caregiver that needs to be embedded into psychiatric services [6].

One of the interesting findings of this study is a dyad level association between caregiver prejudice/exclusion and patient SSOSH. This resonates with evidence that family stigma is not just "collateral" but may actively shape coping, disclosure, and treatment identity. Qualitative and mixed methods work among Indian caregivers of persons with schizophrenia has described stigma experienced as being socially enacted through avoidance, blame and altered family standing, with downstream impacts on caregiving roles and patient participation [11]. In European datasets, public attitudes have also been found to be related to self-stigma among people with mental illness, suggesting that social climate can "enter" the self-concept [13]. Our results built on this logic and suggest that caregiver attitudes may act as a proximal social climate on the household unit.

The choice of measurement helps in strengthening of the interpretability. SSOSH captures internal barriers to professional help seeking [7], CAMI-based tools measure those attitudes related to inclusion and community care [8,9]. Using both instruments, in both groups, makes for a more complete status of stigma than studies which measure the stigma associated with patients only or public attitudes only. This dual measurement is consistent with calls to disaggregate stigma mechanisms when designing interventions [3,12].

Dyad focused strategies seem indicated in Malwa: (i) patient centered interventions focused on self-stigma (earlier mentioned as narrative enhancement, cognitive restructuring, peer contact), (ii) caregiver psychoeducation with an emphasis on recovery expectations and risk management, but not on reinforcing "dangerousness" stereotyping, and (iii) family inclusive anti stigma counselling incorporated into routine follow ups.

At the level of service, communication by clinicians that normalizes help seeking and positions treatment as a strength may diminish SSOSH-relevant self-judgments.

Limitations

The clinic-based design lacks generalizability to community populations - and may under represent those avoiding care due to a severe stigma. Cross sectional analysis does not allow one to infer about caregiver attitudes and patient self-stigma. Self-report measures may be subject to the social desirability. Diagnose heterogeneity and unmeasured factors (caregiver burden, symptom severity scales) may confound observed associations.

Future work should include longitudinal dyad follow up, symptom/burden measures, and controls from the populations with community controls.

Conclusion

This Malwa region case–control study indicates that stigma operates through complementary pathways within patient–caregiver dyads: patients carry elevated self-stigma of seeking help (SSOSH), while caregivers may maintain more stigmatizing community attitudes (CAMI-12), especially in contexts of greater illness severity.

The observed linkage between caregiver prejudice/exclusion and patient self-stigma highlights stigma as a household phenomenon rather than an individual trait.

Integrating caregiver psychoeducation with patient self-stigma reduction within routine psychiatric services may strengthen engagement, reduce concealment, and improve continuity of care. Region-specific, dyad-focused stigma interventions should be prioritized in Malwa.

References

1. Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychological Medicine, 45(1), 11–27. https://doi.org/10.1017/S0033291714000129
2. Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. Psychological Science in the Public Interest, 15(2), 37–70. https://doi.org/10.1177/1529100614531398
3. Rüsch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. European Psychiatry, 20(8), 529–539.
4. Gaiha, S. M., Salisbury, T. T., Koschorke, M., Raman, U., & Petticrew, M. (2020). Stigma associated with mental health problems among young people in India: A systematic review of magnitude, manifestations and recommendations. BMC Psychiatry, 20, 538. https://doi.org/10.1186/s12888-020-02937-x
5. Thara, R., & Srinivasan, T. N. (2000). How stigmatising is schizophrenia in India? International Journal of Social Psychiatry, 46(2), 135–141. https://doi.org/10.1177/002076400004600206
6. Grover, S., Avasthi, A., Singh, A., Dan, A., Neogi, R., Kaur, D., Behere, P. (2017). Stigma experienced by caregivers of patients with severe mental disorders: A nationwide multicentric study. International Journal of Social Psychiatry, 63(5), 407–417. https://doi.org/10.1177/0020764017709484
7. Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. Journal of Counseling Psychology, 53(3), 325–337. https://doi.org/10.1037/0022-0167.53.3.325
8. Taylor, S. M., & Dear, M. J. (1981). Scaling community attitudes toward the mentally ill. Schizophrenia Bulletin, 7(2), 225–240.
9. Bhavsar, V., Schofield, P., Das-Munshi, J., & Henderson, C. (2019). Regional differences in mental health stigma—Analysis of nationally representative data from the Health Survey for England, 2014. PLOS ONE, 14(1), e0210834. https://doi.org/10.1371/journal.pone.0210834
10. Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. Journal of Counseling Psychology, 54(1), 40–50. https://doi.org/10.1037/0022-0167.54.1.40
11. Koschorke, M., Padmavati, R., Kumar, S., Cohen, A., Weiss, H. A., Chatterjee, S., Thornicroft, G. (2017). Experiences of stigma and discrimination faced by family caregivers of people with schizophrenia in India. Social Science & Medicine, 178, 66–77.
12. Corrigan, P. W., Rafacz, J., & Rüsch, N. (2011). Examining a progressive model of self-stigma and its impact on people with serious mental illness. Psychiatry Research, 189(3), 339–343. https://doi.org/10.1016/j.psychres.2011.05.024
13. Evans-Lacko, S., Brohan, E., Mojtabai, R., & Thornicroft, G. (2012). Association between public views of mental illness and self-stigma among individuals with mental illness in 14 European countries. Psychological Medicine, 42(8), 1741–1752.
14. Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. Psychiatric Services, 63(10), 963–973.
15. Corrigan, P. W. (2015). Challenging the stigma of mental illness: Different agendas, different tactics. Psychiatric Services, 66(12), 1347–1349. https://doi.org/10.1176/appi.ps.201500107.