Mental-Illness-Related Stigma in Health Care in South India: Mixed-Methods Study

Thenral Munisami[1], Rajesh Kannan Namasivayam[2], Arunkumar Annamalai[3]

ABSTRACT

Background: Stigma related to mental illness is a reality among health care providers. This study is an attempt to understand the attitudes of doctors from different specialties toward mental illness and the stigma related to it.

Methods: We used a concurrent nested mixed-methods approach to understand and identify the various factors of mental-illness-related stigma in medical practitioners. Between November 2018 and March 2019, 100 medical practitioners from South India were administered a self-reporting OMS-HC (Opening Minds Scale for Health Care Providers), followed by in-depth interviews among 25 of the 100 participants selected using purposive sampling. Quantitative surveys were analyzed using SPSSv23. In-depth interviews were transcribed as extended notes, translated, and initially explored using focused coding and the constant comparative method.

Results: Though findings from quantitative analysis show low to moderate stigma (Mean = 53.52, SD = 7.61), the qualitative study revealed unintended and covert negative attitude toward mental illness.

Conclusion: As stigma occurs at various levels—structural, institutional, interpersonal, and personal—anti-stigma measures also need to be systematically designed. Qualitative studies give more insight regarding the nature of stigma in medical practitioners toward mental illness

Keywords: Mental health, stigma, health care, mixed-methods, South India

Key Messages: Stigma reduction initiatives targeting the healthcare professionals need to be structured covering cognitive, emotional and behavioral aspects. It should be continuous for sustained changes and contact based collaborative program to be a corrective learning experience.

Access to mental health treatment is affected by several barriers, of which mental-illness-related stigma is identified as paramount.[1] It can be in the form of stereotyping, loss of status, separation, labeling, discrimination using power, or all of the above in various forms and combinations.[2] The stigma related to mental illness among health care providers is a reality in the existing health care system, which is less studied and affects the general health-seeking behavior of the patients as well.[3] This stigma not only affects the patients seeking mental-health-related help but also affects the mental health help seeking behavior of the health care providers.[4] This creates an overall negative impact on health care settings.[5]

Mental-health-related stigma is a serious public health issue[6] and affects the quality of life of the patient.[7] Undertreatment is another issue related to this stigma.[8] Social marginalization is also prevalent in clinical settings.[9] In the medical community, health care professionals face mental health stigma (when affected) and also stigmatize others within the community (when another medical professional is affected).[10] These covert negative attitudes may be due to the lack of knowledge among doctors during their medical school training.[11,12]

Few studies had addressed stigma related to mental illness among medical practitioners. Especially, studies among Indian medical practitioners are lacking. This suggests a need to systematically and accurately measure the attitudes of the medical practitioners. To understand the true nature of this stigma, it is necessary to do an exploratory study to identify various factors of mental-illness-related stigma in medical practitioners.

In this study, we used a concurrent nested mixed-methods approach to

[1]Shri Sathya Sai Medical College and Research Institute, Ammapettai, Kanchipuram, Tamil Nadu, India. [2]Government Institute of Psychiatric Medicine, Research and Rehabilitation, Government Theni Medical College & Hospital, Theni, Tamil Nadu, India. [3]LAMED, Center for Interdisciplinary Research on Language Acquisition and Allied Sciences, Chennai, Tamil Nadu, India.

HOW TO CITE THIS ARTICLE: Munisami T, Namasivayam RK, Annamalai A. Mental-illness-related stigma in health care in South India: Mixed-methods study. *Indian J Psychol Med.* 2021;43(1):58–64.

Address for correspondence: Thenral Munisami, 179, First Floor, 14th Cross Street, Defence Officer's Colony, Ekkattuthangal, Chennai, Tamil Nadu 600032, India.
E-mail: drthenralmd@gmail.com

Submitted: 9 Oct. 2019
Accepted: 8 Apr. 2020
Published Online: 20 Jul. 2020

ACCESS THIS ARTICLE ONLINE
Website: journals.sagepub.com/home/szj
DOI: 10.1177/0253717620932244

understand and identify the various factors of mental-illness-related stigma in medical practitioners. The study was designed to understand the attitudes of doctors from different specialties toward mental illness and to deconstruct and analyze the various components of stigma related to it.

Materials and Methods

This was a mixed-methods study. It was approved by the Institutional Ethical Committee. The quantitative component used random sampling, while the qualitative component used purposive sampling. Between November 2018 and March 2019, 100 medical practitioners, across various specialties, working at different health care levels in South India were randomly chosen using the lottery method. The methodology for choosing the participants is as follows.

Five states of South India and their respective capitals were chosen, namely

1. Tamil Nadu, Chennai
2. Andhra Pradesh, Vijayawada
3. Karnataka, Bangalore
4. Kerala, Trivandrum
5. Telangana, Hyderabad

Premier tertiary care centers from these cities were chosen. Five doctors from each of the following specialties were randomly chosen to be contacted for the study: pediatrics, obstetrics, general surgery, general medicine, dermatology, anesthesiology, ENT, and ophthalmology. Five general practitioners belonging to the same geographic location too were randomly chosen using online directories. Overall, 225 doctors were contacted through phone initially and explained about the study, and their email addresses were obtained. A questionnaire about sociodemographic details (age, gender, specialization, and years of practice) and OMS-HC (Opening Minds Scale for Health Care Providers) was emailed to them.

The OMS-HC is a 20-item self-report questionnaire on a 5-point scale, organized under three major sub-headings: Attitudes of health care providers toward people with mental illness; disclosure/help-seeking; and social distance. Seven items (3, 8, 9, 10, 11, 15, and 19) are reverse coded. The minimum score is 20, and the maximum score is 100. Higher scores correlate with higher stigma. The scale has Cronbach's α of 0.77.[13]

The participants were followed up for their responses. The responses were obtained as a separate Word document attached in the mail. Reminders were given after a couple of weeks. No personal identifiers were collected from the respondents.

Out of the 225 doctors, 67 did not respond to the email. Out of the 158 responses received, only 100 cleared the checks for completeness and consistency. Out of these 100 doctors with complete responses, 25 were purposively chosen for in-depth interviewing. The choice of doctors was done based on representativeness from the five cities and also the specialties that were approached for the quantitative survey. After procuring permission, AK met them in person at their places of work and interviewed them. The findings were taken as field notes. The author who conducted the interview in person (AK) is a trained qualitative researcher with over ten years of experience in qualitative research. The following interview guide was used for the in-depth interviewing:

1. As a doctor, what are the challenges you face in dealing with mentally ill patients? (In diagnosing, treating, explaining, referring, and other issues.)
2. In case of your own mental health issues, what aspects would you consider in seeking help? (Modality of treatment, place, timing, trials, disclosure.)
3. How do you deal with your family members'/relatives' mental health issues? (Issues addressed in questions 1 and 2.)
4. As an administrator, what are the aspects you would consider in the placement of a person whose mental illness has improved? (Nature of job, disclosure, timings.)
5. How interested are you in communicating with a psychiatrist and how often do you interact with the psychiatrist in your workplace in discussing about patients? (Referral, follow-ups, doubts and clarifications, liaison issues.)

Quantitative survey was analyzed using SPSSv23. The in-depth interviews were transcribed as extended notes, translated, and initially explored using focused coding and constant comparative method.[14,15] A few emergent codes and categories were identified from the text and added to the existing codes gained from observational studies. Axial coding was done to develop connections between the categories derived from all the data. Themes were identified by looking for similarities, differences, and relationships between categories.[16]

Results

Participant Characteristics

Table 1 shows the sociodemographic characteristics of the participants. **Table 2**

TABLE 1.

Sociodemographic Characteristics of the Participants

Sociodemographic Characteristics		Quantitative (N = 100)	Qualitative
Age		Mean: 35.12 years (SD = 2.37)	Mean: 34.57 years (SD = 1.18)
Gender	Males	*n* = 40	*n* = 10
	Females	*n* = 60	*n* = 15
Specialization	General practitioners	29	5
	Pediatricians	13	3
	Obstetricians	16	3
	General surgeons	12	2
	Physicians	11	3
	Dermatologist	5	4
	Anesthesiologist	4	2
	ENT specialist	5	2
	Ophthalmologist	5	1
Number of years of practice		Mean: 10.19 years (SD = 2.13)	Mean: 11.54 years (SD = 2.94)

shows the responses of the participants on the OMS-HC. The overall score for mental-illness-related stigma in medical practitioners in South India show low to moderate stigma (OMS-HC score Mean = 53.52, SD = 7.614).

Findings from the Qualitative Research

The qualitative analysis using grounded theory approach revealed various nodes that were organized into themes, and relevant illustrative quotes were selected. **Table 3** shows the findings from qualitative research. They can be broadly classified as personal and interpersonal factors.

Personal Factors

Lack of awareness about mental illness and the resultant unconscious biases are the major reasons why doctors express stigma-related behavior toward a patient. This lack of awareness, coupled with a lack of adequate training and skills, leads to a failure to recognize and diagnose mental health problems. Even if identified, doctors felt that it was difficult to explain, treat, and refer patients to a psychiatrist when the patients themselves did not feel a need to do so. All this affects the patient–provider interactions and the quality of the care.

The acceptance of mental illness in significant others is debatable and differs from doctor to doctor though treating the illness has always been emphasized. When the doctors themselves are affected, they prefer nonjudgmental psychiatrists and preferred disclosure to mental health professionals who are mostly unknown to them. However, they felt no discomfort in taking treatment for their mental illness. When it comes to the workplace culture, the doctors respected the privacy of the patients. They invariably stated that they prefer nondisclosure policies and felt that mentally ill patients have the right to pursue their vocation, provided the illness does not interfere with productivity.

Interpersonal Factors

Doctors, when faced with challenges in identifying/diagnosing mental health issues, felt that liaising with mental health experts is an issue to be addressed. Also, there are difficulties in referrals,

TABLE 2.

Responses to the Opening Minds Scale for Health Care Providers (OMS-HC)

	Questions	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1	I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.	11	24	22	35	8
2	If a person with a mental illness complain of physical symptoms (e.g., nausea, back pain, or headache), I would likely attribute this to their mental illness.	12	44	15	25	4
3	If a colleague with whom I work told me they had a managed mental illness, I would be just as willing to work with him/her.	1	13	13	51	22
4	If I were under treatment for a mental illness, I would not disclose this to any of my colleagues.	4	20	22	34	20
5	I would be more inclined to seek help for a mental illness if my treating health care provider was not associated with my workplace.	8	9	13	50	20
6	I would see myself as weak if I had a mental illness and could not fix it myself.	12	19	19	36	14
7	I would be reluctant to seek help if I had a mental illness.	28	42	7	18	5
8	Employers should hire a person with a managed mental illness if he/she is the best person for the job.	2	3	8	48	39
9	I would still go to a physician if I knew that the physician had been treated for mental illness.	2	20	20	41	17
10	If I had a mental illness, I would tell my friends.	10	16	28	33	13
11	It is the responsibility of health care providers to inspire hope in people with mental illness.	2	3	2	28	65
12	Despite my professional beliefs, I have negative reactions toward people who have a mental illness.	43	36	12	7	2
13	There is little I can do to help people with mental illness.	16	27	13	33	11
14	More than half of people with mental illness do not try hard enough to get better.	5	14	23	43	15
15	People with mental illness seldom pose a risk to the public.	8	33	26	26	7
16	The best treatment for mental illness is medication.	19	24	23	20	14
17	I would not want a person with a mental illness, even if it were appropriately managed, to work with children.	14	34	18	30	4
18	Health care providers do not need to be advocates for people with mental illness.	18	29	27	24	2
19	I would not mind if a person with mental illness lived next door to me.	1	11	10	48	30
20	I struggle to feel compassion for a person with mental illness.	18	38	15	13	16

follow-ups, doubts, and clarifications, which affect holistic patient care.

Discussion

Stigma is a combination of several independent and interrelated factors.[2] Studies have reported a commixture of emotional, behavioral, and cognitive components leading to a cascade of labeling, othering, devaluation, and discrimination.[17] The process of stigmatization and its consequences happen in tandem at various levels: personal, interpersonal, and structural.[18] Stigma fosters fear, apprehension, and distorted views of mental illness and psychiatry.[19]

Though OMS-HC indicated low to moderate stigma and a positive attitude and approach to mental illness among doctors, the interviews revealed many unintentional discriminatory behaviors, which they were unaware of. This reflected a tendency to "see the illness ahead of the person" and could contribute to dismissive behaviors such as addressing mentally ill persons as "difficult" and "manipulative." Also, they held pessimistic views about the course of illness, treatment duration, and treatment outcome, which may affect the mental health seeking behavior of the doctors. This resonates with previous studies that mention mental-illness-related stigma in health care as a barrier to access and care.[20]

In the present study, the challenges doctors face in dealing with mentally ill patients fell under "what and how to say and do" categories of problems. Though many had little or no difficulty in identifying psychiatric issues in their patients, they felt that they are ill-equipped to persuade the patient for a psychiatric referral. Similar studies have shown that there is a long-standing difference of opinion among the nonpsychiatric doctors about the appropriateness of psychiatric referrals.[21] The doctors, during the in-depth interviews, were more concerned about the side-effects of psychotropics and the duration of treatment. Studies from Swedish primary care also reported similar findings of skepticism related to medications.[22] Some practitioners, in our study, reported that they start a few patients on benzodiazepines as sedatives and anti-anxiety agents, albeit for a short term, without consulting

TABLE 3.

Findings from Qualitative Research

Themes	Nodes	Frequency	Findings	Illustrative Quotes
Challenges faced in dealing with mentally ill patients	Diagnosing	15	Most of the participants reported difficulty in diagnosing mental health problems	"Taking a history and making a provisional diagnosis is very challenging when it comes to mental illness … specially when the symptoms and signs are not clear" (General practitioner, 12 years' experience)
	Treating, explaining, and referral	10	Some of them stated that it was difficult to explain to the patients about the mental illness, treat them, or refer to a psychiatrist, when the patients themselves do not feel a need to do so.	"Explaining the need to meet a psychiatrist is very difficult… They become very defensive when we ask them to visit a psychiatrist… They keep asking why they should meet them (mental health expert)…" (Physician, ten years' experience)
Mental health help-seeking behavior	The expectation from the doctor	13	Most of them expected the psychiatrist to be nonjudgmental	"When I face any mental health issue… I would like to visit a psychiatrist only if they are nonjudgmental… Otherwise, I might think twice before taking any professional help…" (Obstetrician, eight years' experience)
	Modality of treatment	21	Most of them stated that they did not have any issues with taking medications.	"If I have any mental illness… I will not hesitate to take medications… (Dermatologist, nine years' experience) "If taking medicines is the only option, I will take them" (General surgeon, 11 years' experience)
	Disclosure	11	Some of them said that they would prefer to disclose their mental health issues to someone unknown to them.	"I would prefer to keep my mental illness private… I would reveal my mental illness to any doctor who is unknown to me or my social circle…" (General practitioner, 14 years' experience)
Dealing with mental health issues among significant others	Taking expert help	20	Bringing insight to the patient was of prime importance to most of the participants.	"When my friends or relatives suffer from any mental issues, I will explain the nature of the illness and encourage them to take psychiatric opinion…" (Pediatrician, 10.5 years' experience)

Themes	Nodes	Frequency	Findings	Illustrative Quotes
	Acceptance	6	Some of them reported difficulties in accepting mental illness in significant others.	"Accepting mental illness in spouse or kids is not easy... It takes time... And also, the process of seeking professional help is not easy... I would wonder how the people around us would respond, etc..." (General practitioner, eight years' experience)
Being an administrator	Recruiting people	23	Most of them stated that they would not reject a person because of mental illness.	"I don't think I would ever reject any suitable candidate just because he/she has mental illness..." (General practitioner, Hospital Administrative Head, nine years' experience)
	Disclosure	25	All of them stated that they would not disclose without the consent of the patient.	"Revealing the news to the patient's relatives would require the consent of the patient... Without consent, it is unethical..." (General surgeon, 11 years' experience)
Interaction with psychiatrist	Referral, follow-ups, doubts and clarifications	22	Most of the respondents stated that there are difficulties in giving referrals, doing follow-ups, clearing doubts, and getting clarifications regarding the mental illness	"Calling up a psychiatrist to clarify doubts or refer the patients to them is not easy... Most of the times, there is not much communication between the mental health experts and us, especially in private practice..." (Anesthesiologist, 12 years' experience)
	Liaison issues	4	A few of them reported issues in liaising with mental health experts	"Working in collaboration with a mental health professional in treating a patient is still a distant reality... The system is just not there to enable smooth liaison..." (Physician, 14 years' experience)

a psychiatrist. The reasons cited were difficulty in convincing the patients to consult a psychiatrist, the perceived stigma of mental illness, and poor communication and rapport the doctors had with the psychiatrist. Similar problems of lack of rapport between nonpsychiatric doctors and psychiatrists have been reported in the literature, and this has been known to affect the delivery of quality care.[23]

On the other hand, when dealing with psychiatric patients referred to them, the nonpsychiatric doctors find difficulty in eliciting the history, delineating the symptoms, and discussing the treatment with the patient. The majority accept social distancing and attribute it to the nature of the mental illness. Many expected the psychiatrist to play an active role in sensitizing the fellow doctors and to participate actively in general case conferences and academic meets. Academic literature cites similar suggestions from nonpsychiatric doctors who stated the need for sensitization by psychiatrists.[24]

Consultation-Liaison Psychiatry (C-L Psychiatry) is almost nonexistent in India. Studies show that referral rates from other doctors remain very low, and many private super-specialty hospitals and tertiary care centers function without a psychiatry department.[25] Psychiatry has been alienated, ostracized, and sidelined from the mainstream medicine and has been rightly called the "Cinderella" of medicine.[26] It has always been a direct consultation by the patient or relatives when the reasons are obvious and, at times, by doctors when the behavioral disturbances are unmanageable. Many a time, referrals are made only when they are sought for.[27,28]

Previous studies showed that in the case of their (doctors) illness, perceived stigma was higher than self-stigma, and also they were not sure about adherence to medication.[29] When it comes to the matter of mental illness among their significant others, doctors were more convinced of the need for treatment in the elderly but found it difficult to persuade them for treatment.[30] On the contrary, for their own children, they were not very convinced for taking any psychiatric consultation for stress-related issues and were highly skeptical about starting psychotropics.[31] Even in this present study, in-depth interviews reflected this skeptical attitude of nonpsychiatric doctors toward psychiatric medications.

Doctors in the study felt that the spectrum of mental illness is vast and could not be categorized under an umbrella term "psychiatric disorders." In-depth interviews revealed that they saw common psychiatric illnesses differently from serious mental health disorders. Also, the attitudes of the respondents toward mental illness varied widely between manageable mental illnesses that are common and severe psychiatric illnesses that required hospitalization.

The in-depth interviews revealed that doctors had a better understanding of psychotic and neurotic illnesses than substance use and personality disorders. They were not much convinced about the need for referral and the reliability of persons with substance use disorders in case of employment. They were not convinced about referring a patient for psychiatric treatment (even when there were symptoms suggestive of underlying mental illness), an attitude that is commonly encountered in regular clinical practice.[27,28]

Alienating, segregating, and ostracizing psychiatry continues, and though public awareness about mental health has improved, health care professionals need to "unlearn" many erroneous concepts about psychiatric issues. But for a few conditions, it has been reported that they hold a nihilistic attitude about recovery from the illness.[32]

As stigma occurs at various levels (structural, institutional, interpersonal, and personal), anti-stigma measures also need to target the same. The strategies to be implemented should be integrated both vertically and horizontally.[33]

The structural level includes insurance coverage, budget allocation, legislation, and policies, especially encouraging mental health-seeking behavior among health care providers. Institutional, interpersonal, and personal level are closely knit, and "catching them young," and training medical students, interns, postgraduates, and resident doctors with more emphasis on treating mental illness within the same ontological realm as other illnesses is a key step in achieving "conceptual parity" and integration of psychiatry into mainstream medicine.[33]

Sensitizing the nonpsychiatrists about the magnitude of mental health issues, the heterogeneity of the presenting complaints, the impact of psychiatric treatment on the overall improvement and well-being of the patient, and also the increased gratification for themselves for being "holistic" is an important strategy in combating stigma. Positive role models can bring about a change in organizational cultures.[33]

Stigma reduction programs should be an ongoing and continuous process focusing on pre-service and in-service training of all cadres of health professionals. De-stigmatizing mental illness should be done through an emphasis on incorporating elements designed to increase knowledge, develop skills, and change the attitude toward mental illness. The programs should target the unintentional, unconscious bias toward mental illness and be a truly myth-bursting and transformative learning experience.[33]

The study has the following limitations: lower response rate from the respondents, which affects the generalizability of the findings. The concurrent mixed-method design was chosen to offset the weakness due to <50% responses in the quantitative survey and single interviewer bias in qualitative research. The study was self-funded, which affected the scale of research. Hence, a limited number of respondents were chosen, and the study was limited to South India.

Future research focusing on rigorous evaluation and standardization of anti-stigma measures and testing the designed intervention methods for effectiveness could guide us in the right direction.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

References

1. Abbey S, Charbonneau M, Tranulis C, et al. Stigma and discrimination. Can J Psychiatry 2011 Oct; 56(10): 1–9.
2. Link BG and Phelan JC. Conceptualizing stigma. Annu Rev Sociol 2001 Aug 28; 27(1): 363–385.
3. Henderson C, Noblett J, Parke H, et al. Mental health-related stigma in health care and mental health-care settings. Lancet Psychiatry 2014 Nov; 1(6): 467–482.
4. Ross CA and Goldner EM. Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature. J Psychiatr Ment Health Nurs 2009 Aug; 16(6): 558–567.
5. Wallace JE. Mental health and stigma in the medical profession. Health (London) 2012 Jan 25; 16(1): 3–18.
6. Corrigan P. How stigma interferes with mental health care. Am Psychol 2004 Oct; 59(7): 614–625.
7. Smith M. Stigma. Adv Psychiatr Treat 2002 Sep 2; 8(5): 317–323.
8. Oliver MI, Pearson N, Coe N, et al. Help-seeking behaviour in men and women with common mental health problems: cross-sectional study. Br J Psychiatry 2005 Apr 2; 186(4): 297–301.
9. Thornicroft G. Stigma and discrimination limit access to mental health care. Epidemiol Psichiatr Soc 2008; 17(1): 14–19.
10. Sayce L. Stigma, discrimination and social exclusion: what's in a word? J Ment Heal 1998 Jan 6; 7(4): 331–343.
11. Kallivayalil R. The importance of psychiatry in undergraduate medical education in India. Indian J Psychiatry 2012 Jul; 54(3): 208. http://www.ncbi.nlm.nih.gov/pubmed/23226842. Cited October 28, 2019.
12. Chawla JM, Balhara YPS, Sagar R, et al. Undergraduate medical students' attitude toward psychiatry: a cross-sectional study. Indian J Psychiatry 2012 Jan; 54(1): 37–40.
13. Modgill G, Patten SB, Knaak S, et al. Opening Minds Stigma Scale for Health Care providers (OMS-HC): examination of psychometric properties and responsiveness. BMC Psychiatry 2014 Dec 23; 14(1): 120. http://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-14-120. Cited October 29, 2019.
14. Charmaz K. *Constructing grounded theory: a practical guide through qualitative analysis*. London, UK: SAGE Publications, 2006: 223 p.
15. Glaser BG, Strauss AL, and Strauss AL. *The discovery of grounded theory*. UK: Routledge, 2017. https://www.taylorfrancis.com/books/9781351522168. Cited October 28, 2019.
16. Gibson WJ and Brown A. *Working with qualitative data*. London, UK: SAGE, 2009: 222 p.
17. Goffman E. *Stigma: notes on the management of spoiled identity*. New York: Simon & Schuster, 1963: 147 p.
18. Livingston JD. Mental Illness-Related Structural Stigma | Mental Health Commission of Canada, 2013. https://www.mentalhealthcommission.ca/English/media/3477. Cited October 30, 2019.
19. Ungar T, Knaak S, and Szeto AC. Theoretical and practical considerations for combating mental illness stigma in health care. Community Ment Health J 2016 Apr 15; 52(3): 262–271.
20. Knaak S, Mantler E, and Szeto A. Mental illness-related stigma in healthcare: barriers to access and care and evidence-based solutions. Healthc Manage Forum 2017 Mar; 30(2): 111–116.
21. Hull J. Psychiatric referrals in general practice. Arch Gen Psychiatry 1979 Apr 1; 36(4): 406. http://archpsyc.jamanetwork.com/article.aspx?doi=10.1001/archpsyc.1979.01780040048005. Cited October 30, 2019.
22. Svensson SA, Hedenrud TM, and Wallerstedt SM. Attitudes and behaviour towards psychotropic drug prescribing in Swedish primary care: a questionnaire study. BMC Fam Pract 2019 Dec 5; 20(1): 4. https://bmcfampract.biomedcentral.com/articles/10.1186/s12875-018-0885-4. Cited October 30, 2019.
23. Shrivastava A, Johnston M, and Bureau Y. Stigma of mental illness-1: clinical reflections. Mens Sana Monogr 2012 Jan; 10(1): 70–84.

24. Ahmedani BK. Mental health stigma: society, individuals, and the profession. J Soc Work Values Ethics 2011; 8(2): 41–416.
25. Grover S. State of consultation-liaison psychiatry in India: current status and vision for future. Indian J Psychiatry 2011 Jul; 53(3): 202. http://www.ncbi.nlm.nih.gov/pubmed/22135437. Cited October 28, 2019.
26. Arena E. *Oxford handbook of psychiatry*. 3rd ed.pdf. https://www.academia.edu/35843898/Oxford_Handbook_of_Psychiatry_3rd_Ed.pdf. Cited October 30, 2019.
27. Keertish N, Sathyanarayana MT, Kumar BGH, et al. Pattern of psychiatric referrals in a tertiary care teaching hospital in southern India. J Clin Diagn Res 2013 Aug; 7(8): 1689–1691.
28. Grover S, Sahoo S, Aggarwal S, et al. Reasons for referral and diagnostic concordance between physicians/surgeons and the consultation-liaison psychiatry team: an exploratory study from a tertiary care hospital in India. Indian J Psychiatry 2017; 59(2): 170. http://www.ncbi.nlm.nih.gov/pubmed/28827863. Cited October 30, 2019.
29. Kamaradova D, Latalova K, Prasko J, et al. Connection between self-stigma, adherence to treatment, and discontinuation of medication. Patient Prefer Adherence 2016; 10: 1289–1298.
30. Kua EH. Psychiatric referrals of elderly patients in a general hospital. Ann Acad Med Singapore 1987 Jan; 16(1): 115–117.
31. Choudhry FR, Mani V, Ming LC, et al. Beliefs and perception about mental health issues: a meta-synthesis. Neuropsychiatr Dis Treat 2016; 12: 2807–2818.
32. Drake RE and Whitley R. Recovery and severe mental illness: description and analysis. Can J Psychiatry 2014 May; 59(5): 236–242.
33. Committee on the Science of Changing Behavioral Health Social Norms; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; National Academies of Sciences, Engineering, and Medicine. Approaches to reducing stigma. In: *Ending discrimination against people with mental and substance use disorders*. Washington, DC: National Academies Press, 2016 Aug 3. https://www.ncbi.nlm.nih.gov/books/NBK384914/. Cited October 30, 2019.