Stigma: The Perspective of Workers on Community Mental Health Services— Brazil

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Abstract

In this study, we have surveyed how professionals from multidisciplinary teams at psychosocial care centers (CAPS), in the city of São Paulo, understand the concept of mental illness stigma. The aim of the survey was to characterize the actions developed by the team to overcome stigma and, thus, contribute to develop strategies that incorporate overcoming stigma in the territory. Our objective is to get acquainted to the concepts about stigma shared by the participants. This survey was based on the theory of stigma by Erving Goffman; data were collected through semi-structured interviews with mental health professionals belonging to the CAPS teams. Results indicate that social exclusion is understood as a synonym to stigma, and that proximity of CAPS to society in the territory facilitates social inclusion and the overcoming of the mental illness stigma.

Keywords

stigma, qualitative analysis, mental health and illness, deinstitutionalization, health care professionals

Introduction

Until the 1950s, psychiatric treatment in Brazil was limited to isolation of people with mental illness in large psychiatric hospitals. However, early in the 1970s, a movement inspired by Italian deinstitutionalization, understood as deconstruction, aimed at the removal of psychiatric institutions and the revitalization of mental illness care (S. Barros & Egry, 2001). The psychiatric reform replaced the belief that mental health issues could only be treated at psychiatric hospitals. The movement proposed the onset of alternative outpatient services capable of expansion respecting the rights of people with mental illnesses, pursuing their social and family reintegration (D. D. Barros, 1994) and the consequent overcoming of the mental illness stigma.

In this context, in 1987, the city of São Paulo introduced the first community psychosocial care centers (CAPS), ruled by the Administrative Rule 336/GM of February 19, 2002, and incorporated the CAPS to the SUS (Brazilian Unified Health System). This service recognized the complexity and the large scope of work at the territory, replacing rather than supplementing the psychiatric hospital.

The CAPS are open, community-based health services that provide daily care. As mental health services, the CAPS serve people with severe and persistent mental disorders, such as psychoses and serious neuroses, aimed at easing and treating crises so these people can recover their autonomy

and be reinserted in the everyday activities. This new model of care was based on the concept of citizenship and integral care that, according to Yanos, Roe, Markus, and Lysaker (2008), are elements that increase the chances of overcoming the mental illness stigma. Through interventions on the territory where they live, the CAPS provided the possibility of designing new practices that comprise the required care and psychosocial rehabilitation aimed at the social inclusion of people suffering from mental illness (Brazil, 2004).

According to the Ministry of Health, there are nearly 2,096 CAPS in Brazil (2015), of which 56 are located in the municipality of São Paulo (City Hall data, São Paulo, 2015). The modalities of CAPS can vary according to the needs of each territory: CAPS I—for municipalities with 20,000 to 70,000 inhabitants; CAPS II—for populations ranging from 70,000 to 200,000 inhabitants; CAPS III—more than 200,000 inhabitants (this is the only one 24/7); CAPSi—provides services to children and adolescents of up to 17 years old; and the CAPSad—that assists alcohol and other drugs users,

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whose use is secondary to the clinical mental disorder (Brazil, 2004).

When mental health service interventions become therapeutic actions for users, all involved actors benefit (Dalmolin, 2006). Leão and Barros (2011) affirm that one advantage may be the improvement in social representations about mental illness. For that, the authors focus on the need to overcome stigma and prejudice. According to Leão and Barros (2011), territory is a cultural reference point where exchange takes place, and where there is the possibility of building new social relations comprising the learning of co-existence with difference, contributing to overcome the stigma.

Stigma

Stigma is defined as an undesired difference: a pejorative attribute that implies intolerance, and that when related to mental illness generates fear of the unknown, exclusion, and a set of false beliefs born from the lack of knowledge and understanding about mental disorders. According to Thornicroft (2006), besides being related to insufficient or inadequate knowledge (stereotypes), the stigma leads to prejudice, discrimination, and social withdrawal of the stigmatized person, and entails the social exclusion of the individual. Therefore, it produces self-stigma and low self-esteem in patients, contributing to deterioration in the quality of life of individuals suffering from mental illness (Salles & Barros, 2013; Thornicroft, 2006) and to the maintenance of the asylum model.

In general, people are not familiar with mental disorders and this is one of the reasons for prejudice and stigma. Moreover, many times, they react negatively toward people with mental illnesses, considering them "dangerous, unfit and unpredictable" (Corrigan, 2005; Klin & Lemish, 2008; Salles & Barros, 2013). This view about mentally diseased individuals has been historically disseminated by the culture of asylums, laws formulated by different societies, and the promotion of feelings of "fear, distrust and aversion" by people with mental disorder to this day.

The need to understand how stigma influences the life of individuals is justified by the observation that stigma leads to self-denigration and to exclusion from social relationships, adding to difficulties in family and professional relationships (Moreira & Melo, 2008).

Stigma can be reduced through actions on empowerment/citizenship of the users and partnerships in the community where they are inserted. Pinho, Hernández, and Kantorski (2010) show that CAPS team work in the community increased the participation of people with mental illness in the society through inter-sectoral and social actions, which is a basic premise to produce new socio-cultural practices and changes.

As articulators, the mental health teams have the power to create strategies to overcome the stigma, as these are in direct contact with the territory and its resources (Corrigan, Watson, & Miller, 2006; Gray, Robinson, Seddon, & Roberts, 2010; Holttum, 2011; Marttila, Johansson, Whitehead, & Burström, 2010).

Media interventions are also important to disseminate the knowledge about stigma, which can be accompanied by promotion of contact/relations between patient and society through social gatherings promoted by the services, changing the cultural perception on mental illness and deconstructing stigma (Corrigan et al., 2006; Feldman & Crandall, 2007). Strategies to change stigmatizing attitudes have been developed in some countries (the United States, England, Portugal, etc.) and can be divided into the following:

1. education (information about mental illnesses and mentally diseased people), which is not long lasting and does not necessarily change attitudes;
2. contact (through direct interaction with individuals suffering from mental illness); and
3. protest (attempting to suppress stigmatizing attitudes, mainly in the media), where the latter is less efficient (Corrigan et al., 2006; Perese, 2007; Thornicroft, 2006).

More recently, strategies that favor the empowerment and recovery of people with mental illness have been envisaged to promote their effective participation in the therapeutic planning and evaluation of mental health services (Corrigan, Larson, & Rüsch, 2009; Corrigan et al., 2006; Thornicroft, 2006; Yanos et al., 2008; Yanos, Roe, & Lysaker, 2010). Therefore, it is understood that overcoming stigma increases the contractual power of people with mental illness (Kinoshita, 2001).

To be effective, strategies should rely on a skilled team with well-founded knowledge about psychiatric reform, deinstitutionalization, psychosocial rehabilitation, mental health and collective health, social exclusion and inclusion, and the mental illness stigma. The study by Sadavoy, Meier, and Ong (2004) reaffirms the need to train professionals on the topics that guide their practices.

Because the identification of the human resources needs is a requirement for their proper training, this study aimed at the identification of the perception of professionals from CAPS in regard to the concept of the mental illness stigma.

Method

This study is part of a survey targeted to identify the understandings and actions to overcome the stigma of mental health shared by workers from three CAPS adults in the municipality of São Paulo—Brazil, employing a qualitative approach as the research methodology. This survey was approved by the Committees of Ethics in Research With Human Beings of the School of Nursing of the University of São Paulo (protocol 114178/12), according to the Resolution

196/96 in force by the time of the study. The names of participants and institutions were replaced by alphabet characters to keep anonymity.

This is a qualitative survey to understand the conceptions of professionals about stigma, as this has hindered the social inclusion of individuals with mental illness. Therefore, the qualitative approach was selected as it is the method that best fits into the study of relationships, representations, beliefs, perceptions, and opinions; products of the perceptions of individuals on how they live and build artifacts to themselves. In addition, this approach is more suitable for investigations of delimited and focused groups and segments, as well as for analysis of discourses and documents (Minayo, 2010). As it tries to describe facts or phenomena, in an attempt to explore and deepen the study in the limits of a specific reality (Triviños, 1987), this is a descriptive survey.

The Erving Goffman theory served as theoretical frame that supported the elaboration of the survey on social stigma. According to that theory, stigma is "a stereotype that discredit the person characterized by it" (Goffman, 1963), that is, the caricature of a person. The frame selected is coherent with the object of the study, because it supports the understanding of the concepts reported by professionals.

The concept of psychosocial rehabilitation was the category of analysis used to understand the object of study. The analytical categories are those that historically comprise the primordial social relations, and are delimiting elements to understand the object in its generic nature (Minayo, 2010). Considering that the CAPS bear the mission to promote the psychosocial rehabilitation of users, the concept should sustain the destigmatizing actions performed by the CAPS multidisciplinary teams on behalf of people with mental illnesses in the territory.

Pitta (2001), emphasizing the notion of equality, defines psychosocial rehabilitation as follows:

> ethic of solidarity that enables individuals with limitations to everyday chores resulting from severe and persistent mental disorders, to increase the capacity of engendering affective, social and economic contracts that facilitate the best level of autonomy to live in community. (p. 9)

According to Saraceno (2001), mental health professionals should be attentive to the development of citizenship of individuals with mental illness, as well as the restitution of their power of contract regarding housing, social network, and work with social value, which are the guiding axes to the psychosocial rehabilitation process. It can expand the negotiation rooms to perform social exchanges for those excluded by the system, thus reducing the stigma of mental illness. This way, the multidisciplinary teams of territory substitute services—the CAPS—are devices aimed at the psychosocial rehabilitation, which could foster actions to overcome the stigma of mental illness in their territory of work, to include people with mental illness in the society, as the stigma of mental illness is a barrier for that.

Procedures

By the time of the study, the population of the city of São Paulo, capital of the state of São Paulo, Brazil, was 11,320,000 inhabitants. The city was divided into five health districts, each of them in charge of coordinating different health services, including the CAPS. The West Zone of São Paulo is an administrative zone established by the city hall, and comprises three counties. According to the health information estimates (TABNET), the population in that area was 1,033,719 inhabitants.

This study will approach only the CAPS adults, as these are institutions working with adults suffering from severe and persistent mental disorders—characteristics historically related to the stigma of mental illness. Therefore, the criteria to select services (CAPS adult) was limited to community-based services that provided care to adult population with severe mental disorders, part of the public health network of the West Zone of São Paulo, where nurses were part of the teams. There are other types of CAPS that are meant only for alcohol and drug users or only for children with mental issues, but are not approached in this research.

The CAPS adults in the West Zone were selected for data collection because these services have been in the field of education, research, and extension of the School of Nursing of the University of São Paulo for over a decade, facilitating the dialogue and access to the professionals. There were four CAPS adults in the selected area: one Type-I CAPS adult (opening hours—8:00 a.m. to 5:00 p.m.), two Type-II CAPS adults (opening hours—7:00 a.m. to 7:00 p.m.), and one Type-III CAPS adult (24 hours services). However, only the two Type-II CAPS adults and the Type-III CAPS adults cooperated with the data collection in the field, because their professionals expressed interest in being part of the sampling.

The criteria for selection of professionals were all associate degree and college degree professionals who were part of a multidisciplinary team of the service, and who were available to answer the questionnaire throughout data collection. The subjects who refused to participate or have not responded to the questionnaire during data collection due to medical leave, extended strikes, absence, or personal reasons have been excluded from the survey.

All associate degree and college degree health professionals (79 workers) working at the CAPS adults were considered potential subjects, but only 27 cooperated with the study. The remaining (52 professionals) have not cooperated due to schedule incompatibility, refusal to be interviewed, or were on vacation by the time of data collection.

With a total of 27 interviewed professionals (34.2%), 20 belonged to the CAPS III Adult A, two to the CAPS II Adult B, and five to the CAPS II Adult C. Among the interviewed individuals, 19 were female and eight were male. The average age of professionals was 48.2 years, and they worked for the institution for 9.5 years on average. Regarding education,

16 professionals held college degree (10 women and six men): two physicians, five nurses, six occupational therapists, three psychologists, and two social assistants, whereas 13 nursing assistants (11 women and two men) held associate degree.

Data were collected through interview with close-ended questions about the socio-demographic identification and characterization of subjects, and four open-end questions related to the object of the survey. The following questions were asked to learn about their perception on the concept of stigma:

1. What does stigma mean to you?
2. How do you see the person with mental health issues? Describe.
3. What would (or did) you do against a stigmatizing situation suffered by a person with mental health issues? Give an example.
4. What actions addressing stigma are carried out in the territory by the multidisciplinary team of CAPS? Discuss the possibilities and the difficulties found by the multidisciplinary team and you to implement strategies to overcome the stigma of mental illness in the territory.

The interview brought data through the interviewee point of view, thus being somewhat limited in regard to the study of broader social relationships. However, it is useful to get information about what the individual "knows, believes or expects, feels or wants, intends to do, does or did, as well as about their explanations or reasons for any of the precedent items" (Gil, 2004, p. 115) in line with the objective of the qualitative survey.

Interviews were obtained from November to December 2012. All interviews were conducted by the first author, and were obtained in adequate rooms in the health services installations, minimizing noise and interference from users and other workers. These were recorded and the content was further transcribed. Subjects were identified with the letter "E" followed by ascending numbers (1 to 27). Each interview lasted 20 minutes on average. The analysis stage has three purposes: "establish the understanding about data collected; confirm or not the research premises and/or respond to the questions asked; and, expand knowledge about the subject surveyed, linking it to the cultural context to which it is part" (Minayo, 2010, p. 69).

The analysis was performed considering the thematic content analysis technique. According to Minayo (2010), the thematic content analysis aims at revealing the meaning cores that make up communications whose presence or frequency means something to the targeted analytical objective, using it in a more interpretative way. Still according to the author, the thematic analysis verifies the frequency of the units of significance of the discourse or, in opposition, performs a qualitative verification on the presence of given

topics denoting the reference values and the behavior standards found in the discourse (Minayo, 2010).

This is a three-stage technique: pre-analysis, exploration of material, and handling and interpretation of the results achieved. This technique divides the text in units and categories to the further analytical regrouping, that is, first it makes the inventory/isolation of elements and then performs the classification/organization of messages based on the elements divided. After the interviews, the material was transcribed, and then, texts were skim read to selection of statements. Skim reading is one of the stages of the analysis process in qualitative research, and is characterized as the first contact with the documents to be analyzed, letting impressions and instructions flow into the reader. Later, new and successive readings were performed to analyze in depth the topics emerging from the text in each statement, which were then separated and grouped in thematic phrases of workers.

Findings

The analysis of the thematic content identified the following empirical category: the Process of Stigma and Social Exclusion. This category is in line with Pescosolido (2013), according to whom, despite the advance in the decrease of psychiatric hospital beds, with an increasing number of mentally diseased individuals living in society, the inheritance of years of exclusion and stigma against these individuals remain and have established in the society a negative and hopeless view of people suffering from mental illnesses.

The stigma of mental illness is linked to social exclusion, either during treatment in substitutive services or after discharge, emphasizing the need for change in the imagery of the society in relation to the stigma of mental illness (Pattyn, Verhaeghe, Sercu, & Bracke, 2013).

Therefore, the interviews were classified in "perceptions on the stigma of mental illness" and "consequences of the stigma of mental illness."

Perceptions on the Stigma of Mental Illness

Through the analysis of the content and discourses, phrases on the topic of perceptions on the stigma were highlighted and we decided to present these separately, for ease of understanding.

The analysis of the discourses of the interviewees disclosed phrases that point out the socially built perception of stigma of mental illness that is incorporated into the culture of the society. It shows the disapproval and disqualification of individuals with mental illness due to the obscuration of the personal traits and images, putting emphasis exclusively on the stereotype.

> To me, stigma has to do with a given image used in culture by the population at large . . .

Something socially established, determined by a group of individuals, which runs against to what is normal.

I see it as a characteristic that blurs all the others, a unique characteristic that defines the individual.

The excerpts of the discourses show that perceptions on stigma refer to the concept of devaluation of an individual. That devaluation emanates from the society to isolate the individual that bears traits, which are not accepted by the society. According to Corrigan et al. (2009), the devaluation of individuals with mental illness is one of the most frequent consequences in the society.

. . . the stigma that mental health patients bear has the sense of devalue, never of valuation.

It is a position that a group poses to a person to devaluate her . . .

The following thematic phrases reaffirm that perceptions of stigma are related to a label that shows the products with no distinction, that is, refers to a person whose stereotype is in the spotlight and, thus, reduces their mobility in the society and family, isolating them.

. . . this is quite common today, this issue of stigma is a label, a ghost . . .

. . . a label which you can't see what is in it . . .

. . . condition attributed to a person and that puts an end to the person's possibility of freedom, of changing their position, their context, their situation . . .

The perception on stigma of mental illness highlighted the characteristics of an institutionalized life that could generate "signs" on users who have passed through several asylums. Those signs (medication, psychiatric hospitalization, signals, and symptoms of mental illness) would invalidate patients in their everyday lives because of the stereotype built by the society—the stigma (Goffman, 1963).

. . . people who have run a path of hospitalization in asylums bear signs not only on their faces, but also in their way of behaving; so you go with a girl like that to the bakery, she is ordering something and the guy who is serving her looks at me and asks "she wants that . . .," I guess this is a quite simple situation of invalidating the "crazy" and of stigmatization.

According to the following excerpt, this sign is established by the time the consumer gets a medical diagnosis. Thus, it is understood that when one gets the medical diagnosis, the illness and its stereotypes will be highlighted, disregarding the subject and all his attributes. The sign of "mental illness" means being out of the standard of normality, classifying the person as different and generating the stigma.

I see it as a sign of a diagnosis . . .

Those signs, which are consciously established by the society, make mentally diseased people vulnerable. The vulnerability of individuals suffering from mental illness is related to stigma that generated, among others, the belief that the individual is unfit for work, thus hindering the establishment of social links, as the individual is deprived from social exchanges.

. . . A vulnerability consensually agreed on by the collective consciousness . . .

Consequence of the Stigma of Mental Illness

The perceptions are related to a sign that shows that a given individual is different. Thus, it is a caricature used by the society to discriminate or as exclusion criteria of an individual who does not fit into the rules of the society.

It is when a person ends up being marked by some image, symbol, something significant, everyone sees the person like that . . .

. . . it is a sign that depreciates the person holding it.

Interviewees understand the concept of stigma as synonym of the concept of social exclusion, demonstrating ignorance of both concepts. The person with mental disease is perceived as being aside from society, which is somehow related to the stigma of mental illness. Interviewees share a common understanding that stigma builds barriers that hinder the social inclusion of individuals with mental illness, as can be inferred from the following thematic phrases:

Well, stigma is everything that damages the life of an individual, which could exclude him from living in society . . .

. . . Stigma is marginalization . . . Stigma is related to exclusion, to the exclusion of insane people from society, they are excluded from the social.

The following excerpt of discourse shows that professionals perceive the fear that people with no mental illness feel in regard to the mentally diseased is frequent in their everyday lives, as this fear is typically related to a potential dangerousness of the person with mental health issues, thus the population resorts to defense mechanisms such as discrimination and exclusion.

There is a case of a seriously diseased patient in the process of treatment and life. When she tried to get a job and said he would not have to pay for her transportation, because she had the special bus pass, he gave up contracting her . . .

. . . when [people with no mental illness] don't know, they participate, get together, but when they learn [the person] comes from psychiatry, they become afraid and go away.

It was observed that the perceptions of these professionals are close to Erving Goffman's concept of stigma; however, 100% of the respondents reported to be unfamiliar to the theory of Goffman and of any other contemporary author. This evidences the need for schools and universities to approach this topic in their curricula.

Discussion

The discourses of the interviewed professionals show that the understanding about the stigmatization process, just like the mental health–illness process, is a product of the historical-cultural context. The discourses of the research subjects have also shown that the perception of stigma is related to a symbolic "sign" associated to the illness. In this case, it would be a culturally disseminated caricature, showing dangerousness and incapacity as the main features of people with mental health issues in the society. Despite being irrational ideas or erroneous social perceptions, these are reinforced by culture and inherited, thus contributing to stigma (Leff & Warner, 2006; Sadler, 2009).

Participants understand that stigma is an identity that devaluates the individual through adjectives that never bear the sense of valuation. Hence, all those who are somehow assisted, regardless whether they are "mad," poor, Black, or in homeless situation, are stigmatized and doomed to an undervalued social status that fosters their social disqualification (Salles & Barros, 2013). According to Paugam (2007), these people "remain in society by participating in its last strata" (p. 70), and due to stigma and discrimination, people with mental health issues have their self-esteem deeply affected (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). This perception can be observed in the discourse of the respondents to this study, which brings the need to hide the mental illness, as if their suffering was a social evil. According to Corrigan, Kosyluk, and Rüsch (2013), the stigma of mental illness weakens social, family, and labor relations, thus leading to the social exclusion of the individual. However, the negative impact of stigma is not limited to discrimination by others; some people with mental health issues also endorse stigmatizing attitudes. These individuals seem to believe that socially endorsed stigmas are correct and they cannot live an independent life (Corrigan, 2004; Corrigan & Watson, 2004; Corrigan et al., 2006; Link & Phelan, 2001; Thornicroft, 2006).

Other thematic phrases disclosed the conception of label to conceptualize the stigma of mental illness. Greatley and Ford (2003) believe that the exclusion process starts when people labeled as severe mentally ill experience discrimination, being denied from opportunities and rights ensured to other people. The society's reaction in face of these individuals produces changes in their behavior and self-image.

According to one interviewee, the characteristics of people with mental illnesses who were hospitalized in asylums are the causes of stigma and invalidation of the subject. Hospitalization in a mental asylum adds devalue to the person with mental health issues (Valentini, 2001). When hospitalized for long periods, persons with mental health issues unlearn the basic rules of social life and, when discharged, bear an unfavorable status, that is, are stigmatized (Salles & Barros, 2009).

Professionals have also referred to psychiatric diagnosis as an establisher of stigmatizing features. According to Thornicroft (2006), the individual diagnosed as mentally diseased expects to be discriminated, as the images of mental illness in the Western culture brought by psychiatric diagnosis make clear that mental illness should be avoided or denied, as a person with mental illness is hardly seen as a person who has value and a future that deserves to be lived (Sayce, 2000).

The survey also found that vulnerability is related to the perception of stigma. According to Castel (1991), social vulnerability gathers labor precariousness and weak support. Therefore, the individuals with mental illness build a "vulnerable collective" and go through different modalities of exclusion (Martí, 2006). Huxley and Thornicroft (2003) show that people with mental illness are 4 times more prone to have no close friends than the average population, and more than one third report having nobody to help them during crisis.

Professionals conceived that stigma generates harassment against people with mental illnesses established by a majority group, that is, by a social panorama. According to professionals, that group disseminates a depreciative image about a trace of the identity of an individual with mental illness, conversing it into a defining criterion that generates exclusion. Stigma results from a cognitive process and from the perceived threats and risks that organize the social knowledge and determine self-perceptions (Corrigan, 2004).

Therefore, the cognitive and behavioral components of stigmatization should be targeted by specific actions to overcome the stigma of mental illness. Consequently, to integrate people with mental health issues in the society, we must deal with the cultural heritage that sets the perception that people with mental illnesses must be feared and excluded, changing the over-generalization established and building new opportunities to understand mental illness (Salles & Barros, 2013). According to Repper and Perkins (2003), understanding and empathy are critical elements to build relationships favorable to effective assistance.

In some excerpts of discourses, social exclusion is synonym to stigma. Thornicroft, Brohan, Rose, Sartorius, and Leese (2009) infer that stigma fosters social exclusion but not social exclusion per se, as pointed out by the professionals in the findings of this survey, thus pointing out a lack of knowledge about the concept of stigma per se or of social exclusion/inclusion.

Professionals have reaffirmed that stigma damages the life in society of mentally diseased individuals, as it limits their circulation in the territory and their possibilities,

causing suffering and generating marginalization. Studies by Corrigan (2005) and Corrigan, Kosyluk, and Rüsch (2013) affirm that the stigma of the illness entails harmful effects on individuals with mental illness and on those who internalize the stigma (Ritsher & Phelan, 2004), increasing isolation and, hence, social exclusion. Thus, one could say that stigma is a barrier to social inclusion (Gray et al., 2010; Gulliver, Griffiths, & Christensen, 2010).

According to Escorel (1999), the term "exclusion" is related to expressions such as banning, reclusion, and expelling, with focus on segregating practices architected by the stigmatizing differences found on the everyday life. Huxley and Thornicroft (2003) understand the social exclusion and inclusion process as a matter of social identification and participation. However, the relation of reciprocity between the individual and the society includes sense of belonging, integration, and fulfillment of needs.

Sayce (2000) adds that social inclusion of the person with mental health issues goes beyond leaving the institution and being accepted as a "normal" person; it means including the experience of mental illness as part of the social environment, valuing individuals with mental illness, and recognizing their contributions. Thus, the social inclusion and exclusion process is understood as a multidimensional and dialectic process around the main axes of material condition, labor, social support network, citizenship, and the possibility of leading their own lives (Salles & Barros, 2013; Vianna & Barros, 2002).

Participants revealed some discomfort due to the lack of clarity about the term *stigma* and how to deal with this phenomenon. This is an evidence of the need to provide deep theoretical training to those professionals on the whole process of building the psychiatric reform, its principles and guidelines, as well as about the incoherence of the hospital-centered care model and the historical stigma on mental illness that creates barriers for the social inclusion that these professionals try to promote every day. According to S. Barros and Bichaff (2008), this reflection should disclose the limits and perspectives brought by the reform to the context of mental care services in Brazil.

This way, the theoretical collaboration provided by studies and evaluations on the psychiatric reform and the efforts by the subjects committed to changing mental health in Brazil lead to understanding and acceptance of subjects and, thus, to improve the understanding about the stigma building process, and to recommend strategies to deconstruct it. The fear related to persons with mental health issues is one of the consequences of the stigma in the imagery of the society. Several stereotypes and beliefs about mental illness can influence on attitudes such as the unpredictable, violent, and dangerous character of mentally diseased individuals (Angermeyer, Beck, Dietrich, & Holzinger, 2004; Corrigan, Edwards, Green, Diwan, & Penn, 2001). Due to the perception of dangerousness of people with mental illnesses, some authors consider fear and exclusion or segregation as the most typical characteristics (Corrigan, 2004; Corrigan & Watson, 2004).

Corrigan et al. (2001) have shown that people who believe that persons with mental health issues are dangerous are more inclined to fear and reject them. Likewise, Sadow and Ryder (2008) emphasize the stereotype of dangerousness as a factor to avoid the person with mental illness and to keep social distance. In this way, the perceptions on dangerousness associated to individuals with mental illness can reduce their rights and opportunities (Corrigan et al., 2006) and easily disseminate in the society the disqualification of the subject, the non-acceptance, and the shrinking of social relations. The belief that people with mental illnesses are dangerous can hinder the provision of resources required to the psychosocial rehabilitation—due to the resistance of the society—hampering the presence of those individuals in the society. The society responds with uneasiness and rejection to the negative public images about mental illness rather than specifically to the individual or the illness. Thus, although people recognize the need of assistance and proximity, the fear and danger associated to individuals with mental illness still hinder a change of attitude, that is, approaching and maintenance of stereotypes.

Limitations and Implications to the Future

One limitation of this study is the population surveyed that comprises only professionals from three community-based CAPS under the same Health Technical Supervision, and results could have been influenced by the organizational circumstances of the same regional coordination and by the socioeconomic profile of the territory. Thus, the perceptions referred to herein can be different from those of other professionals in different contexts. This way, further studies should try to comprise more professionals, areas of the municipality and of other cities, as well as users of these services to get a more comprehensive reality, as Brazil has a large territory and is home to different cultures.

According to Nordt, Rössler, and Lauber (2006), health professionals have perceptions similar to the common sense. However, the analysis on the discourses of workers—subjects of this study—differs from Nordt's statement as this presents perceptions in line with Goffman's (1963) theory on stigma, and identifies the need for overcoming the stigma to effectively promote the social inclusion of individuals with mental illness. Therefore, regardless of how far the knowledge of professionals is from the common sense, their actions for overcoming the stigma and promoting social inclusion still lack theoretical and qualitative support. In our view, the active professionals should undergo continuous training on the stigma of mental illness, psychosocial rehabilitation, and social inclusion to expand their knowledge and improve the quality of the actions promoted by them.

In the field of human resources training, we have noticed the need to build educational guidelines for vocational courses

in high schools and universities focused on the processes of destigmatization and promotion of social inclusion of individuals with mental illness, through expansion of human rights, promotion of acceptance of differences and diversity. The guidelines should also focus on municipal mental health policies to provide theoretical and practical support to mental health care professionals in community services, to prevent the replication of the mental asylum model.

Thus, coping with the stigma of mental illness demands practices aimed at full-time services and inter-sectoral partnerships. The actors involved in the deinstitutionalization process should endeavor to set exchanges to enable better housing conditions, promote discussions on stigma and how to overcome it, and foster initiatives involving insertion in the labor market, besides favoring access to public services such as education and culture, thus building favorable conditions for citizenship that will encourage overcoming the stigma of mental illness.

Authors' Note

Jussara C. Santos has made a substantial contribution to the concept and design, acquisition of data, or analysis and interpretation of data. Sônia Barros and Irma M. M. Santos have drafted the article or revised it critically for important intellectual content.

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