9-17-2025

Reducing Stigma and Enhancing Outcomes: An Antistigma Education Program for Mental Healthcare Professionals

Chidi Oriaku
Walden University

Walden University

College of Nursing

This is to certify that the doctoral study by

Chidi Oriaku

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Margaret Harvey, Committee Chairperson, Nursing Faculty
Dr. Diane Whitehead, Committee Member, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2025

Executive Summary: Staff Education Project

Reducing Stigma and Enhancing Outcomes: An Antistigma Education Program for Mental Healthcare Professionals

by

Chidi Oriaku

MSN, Walden University 2022

MHSA, Strayer University 2015

RN, BSN, Mountain State University 2010,

BSC, Computer Information System, Strayer University, 1995

Executive Summary Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2025

Summary

This Doctor of Nursing Practice (DNP) project was a staff education project that addressed the stigmatization of patients with mental illness (PMI) within psychiatric contexts. The project site healthcare organization's mental health professionals had a high rate of stigmatization of PMI. Stigma is linked to poor medication adherence rates, delays in accessing healthcare, lower healthcare utilization among PMI, psychiatric morbidity and mortality, and poor quality of life. Despite recognizing this problem, the healthcare organization had no targeted antistigma interventions. I developed an antistigma education to improve outcomes. The practice-focused question was: In mental health staff, will an educational program on antistigma, compared to no education program, increase staff knowledge? I conducted this DNP project to determine whether implementing an antistigma education program would improve staff knowledge and awareness to lower stigma towards PMI. A total of 16 mental health staff participated and completed pre- and posttest knowledge questionnaires and a self-rated Likert-type program evaluation. Data were analyzed via percentages. Postimplementation, participants' average knowledge score increased to 80.625% from the 48.75% recorded preimplementation. About 81.25% of participants agreed that the training could help staff lower the stigma towards PMI. Participants gained knowledge on mental health stigma, its impact on outcomes, and how to combat stigma. Further recommendations include contact-based, educational interventions and culturally sensitive practice interventions. The staff education project is expected to make a positive social impact by improving care quality, decreasing health inequalities, and developing a psychiatric healthcare system that is inclusive, efficient, and meets the needs of PMI.

Background

Mental healthcare staff are sources of stigma and can exhibit negative beliefs, attitudes, and stereotypes towards PMI (Wong et al., 2024). An identified problem at the project site healthcare organization was the high rate of stigma regarding PMI on psychotropic medications. At the evidence-based practice (EBP) site, employees rely on self-reflection towards stigma and cultural competence. Despite recognizing stigma within the workplace and implementing cultural competence and patient-centered care training, stigma is still prevalent. With limited opportunities for antistigma awareness and education programs within the facility, PMI will suffer poor outcomes. Failing to address the issue can exacerbate disparities and inequalities that PMIs are already subjected to, and resultant adverse outcomes will include low levels of medication adherence, coping challenges, poor functioning, compromised social relationships, and psychiatric morbidity and mortality due to suicidality (see Chukwuma et al., 2024; Gupta et al., 2024).

Therefore, the purpose of the DNP project was to determine if implementing an educational program on antistigma will increase staff knowledge related to stigma towards patients with psychiatric disorders taking psychotropic medications and improve staff awareness to lower stigma and increase care quality, ultimately resulting in better treatment outcomes for individuals diagnosed with psychiatric disorders taking medication. An antistigma intervention was implemented to ensure patients continually seek treatment and receive high-quality mental healthcare that improves their outcomes and quality of life. My overall aim with the project was to enhance the quality of care provided at the project site, improve patients' quality of life and mental health clinical outcomes, and lower economic costs.

Evidence supported the gap in practice, high rates of stigma, and an antistigma educational intervention targeting mental healthcare staff. According to the Johns Hopkins evidence-based tools for critical appraisal of research articles, four high-quality, Level I studies were included in contributing to evidence that supports antistigma staff education project: One randomized controlled trial, a cluster randomized controlled trial, a systematic review, and a meta-analysis. Rodríguez-Rivas et al. (2024) reported that virtual reality software achieved reductions in overall stigma levels, particularly avoidance, dangerousness-fear, and lack of solidarity. Khenti et al.'s (2023) antistigma intervention improved stigma scale outcomes. Wong et al. (2024) reported that contact-based and face-to-face interventions effectively decreased attitudes towards mental illness and PMI. However, McCullock and Scrivano (2023) reported that interventions had limited longitudinal effects.

Four Level II studies were included: Three quasi-experimental studies and a systematic review. Saguem et al.'s (2023) 4-hour educational intervention yielded moderate effects, with positive effects maintained immediately for 2 months. Latifian et al.'s (2023) psychoeducation effectively decreased internalized stigma and increased positive attitudes. Moreover, Hopp et al. (2023) showed that stigmatization was decreased more significantly with physical contact than instruction only. Tóth et al. (2023) indicated that face-to-face, mixed-methods, and online interventions all achieved significant reductions in attitudes.

A total of six Level III good-quality studies were included: Three cross-sectional studies, a cohort study, and two systematic reviews. Hemingway et al. (2024) revealed that residents exhibited attitudes towards PMI. Kılıç-Demir and Kızılpınar (2024) reported that general and forensic psychiatric nurses perceived PMI as threatening and dangerous, while Hao et al. (2023) revealed that caregivers

perceived PMIs as dangerous and were unwilling to let PMIs marry into their families. Chukwuma et al. (2024) reported that stigmatization resulted in poor medication adherence, delays in accessing healthcare, adverse psychiatric health outcomes, poor quality of life, disempowerment, lower self-efficacy, and complicated care delivery. Van Liew et al. (2023) recorded longitudinal improvements due to antistigma education, such as fewer negative stereotypes, less stigma, and lower anxiety associated with treating PMI. In the review by Bannatyne et al. (2023), only three studies showed reductions in self-stigma.

Additionally, five good-quality Level V studies provided recommendations to address the stigmatization of individuals with substance use disorder and other psychiatric conditions. Gupta et al. (2024) recommended increasing awareness, antistigma initiatives, and enhancing care access. Shi et al. (2023) suggested contact, education, protest, and psychotherapeutic approaches, while Ahad et al. (2023) recommended contact-based interventions, educational interventions, and culturally sensitive practice interventions. Chen et al. (2024) suggested online education, face-to-face education, direct contact, and combined interventions. Cazalis et al. (2023) recommended teaching individuals what addiction entails and substance-use disorder stigma-focused training.

Staff Education Project Development

I began this staff education project by identifying key stakeholders; assessing organizational readiness; conducting a strengths, weaknesses, opportunities, and threats analysis; and obtaining permission and approval from the project site healthcare organization and Walden University to conduct the project. The staff education was developed based on the analysis, design, development, implementation and evaluation framework (see Crompton et al., 2023): I followed the steps of

analysis (of learning environment, content, learner characteristics, and constraints); design (of course content, data collection tools, and implementation plan); development of specific, measurable, achievable, relevant, and time-bound goals; implementation and monitoring changes to the implementation plan; and evaluation of the DNP project to determine its effectiveness. I then identified a gap and developed a practice-focused question, using the question development tool. This was followed by the review of individual articles that informed the project, which were later collated into an evidence synthesis tool in which organization-specific recommendations were created. I developed a translation and action plan, and then, the EBP project was implemented.

I raised awareness about the project at the project site, recruiting mental healthcare professionals who were willing to participate in the study. Next, participants consented to take part in the project by completing the demographic survey (see Appendix A) and a pretest knowledge questionnaire (see Appendix B). After a 75-minute PowerPoint presentation (see Appendix C), participants completed the posttest knowledge questionnaire and program evaluation (see Appendix D).

The demographic data collected from participants included educational status and years of experience. Data collection entailed pre- and posttest knowledge scores that were compared to determine the efficacy of antistigma education. I provided participants with pre- and posttest knowledge questionnaires that they completed in ink and pen using the same unique identifiers for both tests. This took place in the project site healthcare organization’s conference room, which was also the site for the antistigma educational intervention. Participants completed a program evaluation using a 5-point Likert system that assessed their satisfaction with the teaching and

whether they perceived that it could help other mental health staff to improve knowledge and awareness of stigma towards PMI and improve patient outcomes.

I completed data collection, storage, and analysis. The data were transferred into a Microsoft Excel sheet stored on a password-protected computer. Paper copies were later destroyed, and data were analyzed using the same computer. No unauthorized personnel handled the data.

I assessed the efficacy of the antistigma staff education by comparing the participants' pre- and posttest knowledge scores. Data analysis encompassed percentages for participants' knowledge. Participants' satisfaction was also determined based on their self-reported level of agreement that the program was vital to improving knowledge among mental healthcare staff.

Results

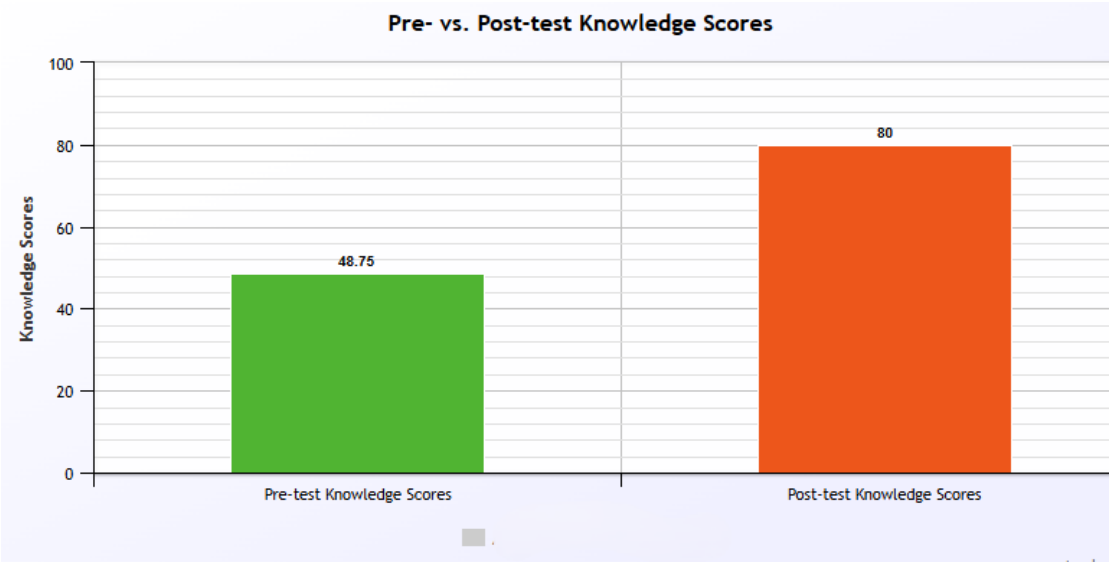
A total of 16 healthcare professionals attended the staff education program and completed pre- and posttest evaluations. The represented professional roles included mental health nurses (6.25%), social workers (12.5%), pharmacists (12.5%), occupational therapists (18.75%), psychologists (18.75%), and psychiatric and mental health nurse practitioners (31.25%). The highest educational qualification was predominantly a bachelor's degree (68.75%), followed by a master's degree (25%) and a doctorate/Ph.D. (6.25%). Regarding years of service at the EBP site, 12.5% had worked for 1–3 years, 43.75% had worked for 4–6 years, 25% had worked for 7–10 years, and 18.75% had worked for over 10 years.

Postimplementation, the participants' average knowledge score was 80.625%, indicating an increase in knowledge compared to their average preimplementation score of 48.75%. Figure 1 indicates the change in average knowledge scores

expressed as percentages. Moreover, 81.25% of participants strongly agreed that the staff education project improved awareness and can lower the stigma towards PMI.

Figure 1

Pre- vs. Posttest Average Knowledge Scores regarding the anti-stigma education (Percentage)



The staff education project had a significant impact on the project site healthcare organization by improving staff knowledge related to the occurrence of stigma in psychiatric contexts and its negative implications on the quality of care. Participants gained knowledge related to common mental health disorders, stigmatization of PMI, causes and expressions of stigma, the effect of stigmatization on outcomes, and how to combat stigma in mental health settings. The intervention will promote access to psychiatric care that will improve mental health and quality of life outcomes (see Hao et al., 2023).

A few limitations of the project were identified. The staff education project had a small sample (N = 16). The small sample size was not entirely representative of the population of mental health settings. Moreover, the study relied on convenience sampling; therefore, the results have limited generalizability to other contexts and

other populations of healthcare providers. The generalizability was also affected by participant characteristics in terms of professional roles and other demographic variables. Additionally, the self-developed knowledge questionnaire was not validated. In the staff education project, I did not assess any long-term changes related to knowledge or changes sustained after 3 months or changes. Confounding factors, such as stress or limited exposures, among participants were not accounted for in the analysis. Assessing a clinician's behavior is also essential in determining changes in stigmatization attitudes.

Regardless, the project is significant beyond the EBP site. Statistics have revealed that 1 in every 5 U.S. adults and adolescents (i.e., those 13–17 years old) are affected by mental illnesses or debilitating mental illnesses (Centers for Disease Control and Prevention, 2023). Self-stigma results in PMI withdrawing from opportunities or responsibility, increased suicidality or poor compliance with psychotropic medications, discrimination, social exclusion, and hinders healthcare utilization or treatment-seeking behavior (Gupta et al., 2024). Implementing an antistigma education program for mental healthcare staff will improve staff knowledge and awareness to lower stigmatization towards individuals with psychiatric disorders taking psychotropic medications, ultimately leading to improved patient outcomes.

Conclusions

Participants gained knowledge related to common mental health disorders, stigmatization of PMI, causes and expressions of stigma, the effect of stigmatization on outcomes, and how to combat stigma in mental health settings. The intervention will promote access to psychiatric care that will improve mental health and quality of life outcomes.

Further recommendations at the project site include contact-based interventions that can shift negative attitudes; educational interventions to increase awareness and knowledge of stigma and decrease stereotypes; psychotherapeutic approaches; and culturally sensitive practice interventions, such as cultural competence training to overcome stigma and meet the needs of diverse populations. Stigma-focused training to improve the attitudes of staff to decrease stigma must be tailored to staff needs related to format, components, length, delivery fit-for-purpose, and psychometrically sound instruments. Other approaches, such as mass media campaigns, workshops, and online courses, are also recommended as scalable interventions.

The staff education project had a positive social impact. When mental health staff have incorrect beliefs and poor attitudes towards PMI, patients will perceive the healthcare organization as a less friendly site and will not readily open up to mental health providers due to fear of being judged. With limited opportunities for antistigma awareness and education programs within psychiatric contexts, the adverse impacts will be poor outcomes. This staff education project addressed diversity, inclusion, and equity by enhancing knowledge on mental health stigma, raising awareness that aids in decreasing stigmatization of PMI, decreasing disparities and inequalities towards PMI, and improving outcomes among a vulnerable and underserved population of PMI. Overall, the project contributes to the development of a psychiatric healthcare system that is inclusive, efficient, and meets the needs of its patients.

References

Ahad, A., Sanchez-Gonzalez, M., & Junquera, P. (2023). Understanding and addressing mental health stigma across cultures for improving psychiatric care: A narrative review. *Cureus, 15*(5), e39549.

Bannatyne, A., Jones, C., Craig, B., Jones, D., & Forrest, K. (2023). A systematic review of mental health interventions to reduce self-stigma in medical students and doctors. *Frontiers in Medicine, 10*, 1204274. https://doi.org/10.3389/fmed.2023.1204274

Cazalis, A., Lambert, L., & Auriacombe, M. (2023). Stigmatization of people with addiction by health professionals: Current knowledge. A scoping review. *Drug and Alcohol Dependence Reports, 9*, 100196. https://doi.org/10.1016/j.dadr.2023.100196

Centers for Disease Control and Prevention. (2023, April). *Mental health data and statistics.* National Center for Injury Prevention and Control https://www.cdc.gov/mentalhealth/data_publications/index.htm

Chen, X., Wang, S., Liao, X., Li, Y., Leung, S., & Bressington, D. (2024). Interventions to decrease health students' stigma toward schizophrenia: A scoping review. *International Journal of Nursing Studies, 158*, 104837. https://doi.org/10.1016/j.ijnurstu.2024.104837

Chukwuma, O., Ezeani, E., Fatoye, E., Benjamin, J., Okobi, O., Nwume, C., & Egberuare, E. (2024). A systematic review of the effect of stigmatization on psychiatric illness outcomes. *Cureus, 16*(6), e62642. https://doi.org/10.7759/cureus.62642

Crompton, H., Jones, M. V., Sendi, Y., Aizaz, M., Nako, K., Randall, R., & Weisel, E. (2024). Examining technology use within the ADDIE framework to

develop professional training. *European Journal of Training and Development, 48*(3–4), 422–454. https://doi.org/10.1108/EJTD-12-2022-0137

Gupta, S., Kumar, A., Kathiresan, P. P., Pal, A., & Singh, V. (2024). Mental health stigma and its relationship with mental health professionals - A narrative review and practice implications. *Indian Journal of Psychiatry*, *66*(4), 336–346. https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_412_23

Hao, Y., Wu, Q., Wang, X., Ma, Y., Wang, Y., Peng, P., Wang, X., Yang, Q., Liu, Y., Li, M., He, L., Wang, Q., Zhou, Y., Liu, T., & Chen, S. (2023). Stigmatizing attitudes toward mental illness among caregivers of patients with mental disorders in China. *Frontiers in Public Health, 11*, 1071954. https://doi.org/10.3389/fpubh.2023.1071954

Hemingway, J., Kunz, J., Draney, D., Martin, D., & Sukpraprut-Braaten, S. (2024). Evaluating stigmatization toward mental illnesses among resident physicians. *Cureus, 16*(6), e61648. https://doi.org/10.7759/cureus.61648

Hopp, A., Dechering, S., Wilm, S., Pressentin, M., Müller, T., Richter, P., Schäfer, R., Franz, M., & Karger, A. (2023). The influence of patient-centered teaching on medical students' stigmatization of the mentally ill. *GMS Journal for Medical Education*, *40*(4), Doc46. https://doi.org/10.3205/zma001628

Khenti, A., Bobbili, S., Lentinello, E., Sapag, J., van der Maas, M., Sanches, M., & Corrigan, P. (2023). A cluster randomized controlled trial exploring stigmatization and recovery-based perspectives on mental illness and substance use problems among primary healthcare providers in Toronto, Ontario. *International Journal of Mental Health and Addiction*, 1-18. https://doi.org/10.1007/s11469-023-01136-5

Kılıç-Demir, B., & Kızılpınar, S. (2024). Stigmatization of patients with mental disorders: A comparative study of nurses in forensic psychiatry and inpatient settings. *Frontiers in Psychiatry*, *15*, 1440917. https://doi.org/10.3389/fpsyt.2024.1440917

Latifian, M., Raheb, G., Abdi, K., Alikhani, R., & Shariful Islam, S. (2023). The effectiveness of psychoeducation in improving attitudes towards psychological disorders and internalized stigma in the family members of bipolar patients: A quasi-experimental study. *Psych Journal*, *12*(2), 272–279. https://doi.org/10.1002/pchj.621

McCullock, S., & Scrivano, R. (2023). The effectiveness of mental illness stigma-reduction interventions: A systematic meta-review of meta-analyses. *Clinical Psychology Review*, *100*, 102242. https://doi.org/10.1016/j.cpr.2022.102242

Rodríguez-Rivas, M., Cangas, A., Martin, A., Romo, J., Pérez, J., Valdebenito, S., Cariola, L., Onetto, J., Hernández, B., Ceric, F., Cea, P., & Corrigan, P. (2024). Reducing stigma toward people with serious mental illness through a virtual reality intervention: A randomized controlled trial. *Games for Health Journal*, *13*(1), 57–64. https://doi.org/10.1089/g4h.2023.0118

Saguem, B., Ouanes, S., Rhouma, A., & Nakhli, J. (2023). Effectiveness of an educational program for reducing mental illness stigma targeting family medicine trainees in Tunisia: A quasi-experimental study. *Applied Psychology. Health and Well-Being*, *15*(2), 686–704. https://doi.org/10.1111/aphw.12405

Shi, X., Li, L., & Fan, Z. (2023). Psychiatrists' occupational stigma conceptualization, measurement, and intervention: A literature review. *World Journal of Psychiatry*, *13*(6), 298–318. https://doi.org/10.5498/wjp.v13.i6.298

Tóth, M., Ihionvien, S., Leduc, C., Aust, B., Amann, B., Cresswell-Smith, J., Cresswell-Smith, J., Reich, H., Cully, G., Sanches, S., Fanaj, N., Qirjako, G., Tsantila, F., Ross, V., Mathieu, S., Pashoja, A., Arensman, E., Purebl, G., & MENTUPP Consortium (2023). Evidence for the effectiveness of interventions to reduce mental health-related stigma in the workplace: A systematic review. *BMJ Open*, *13*(2), e067126. https://doi.org/10.1136/bmjopen-2022-067126

Van Liew, J., Jie, C., Tucker, J., & Streyffeler, L. (2023). Reducing stigma and increasing competence working with mental illness: Adaptation of a contact-based program for osteopathic medical students to a virtual, active learning format. *Medical Education Online*, *28*(1), 2151069. https://doi.org/10.1080/10872981.2022.2151069

Wong, J., Chua, J., Chan, P., & Shorey, S. (2024). Effectiveness of educational interventions in reducing the stigma of healthcare professionals and healthcare students towards mental illness: A systematic review and meta-analysis. *Journal of Advanced Nursing*, *80*(10), 4074-4088. https://doi.org/10.1111/jan.16127

Appendix A: Demographic Survey

Unique Identifier: _____ **Date: _____**

Instruction: *Kindly circle the right answer that relates to your demographic data.*

1. Role Description: What is your current job role?

- PMHNP
- Social Workers.
- Mental Health Nurses.
- Occupational Therapists.
- Psychiatrists.
- Psychologists.
- Mental Health Pharmacists.
- Other (please specify): _____

2. Years of Service: How long have you worked at this organization?

- 1-3 years
- 4-6 years
- 7-10 years
- 10 years

3. Education Level: What is your highest level of education?

- Associate's Degree
- Bachelor's Degree
- Master's Degree
- Doctorate/Ph.D.
- Other (please specify): _____

Appendix B: Pretest Knowledge Questionnaire

Instruction: *Kindly circle the correct answer.*

1. Which of the following commonly stigmatized psychiatric disorders is the most prevalent in the USA?

a) Schizophrenia
b) PTSD
c) Personality disorders
d) Depressive disorders
e) Bipolar disorder

2. Which of the following statements are TRUE?

a) SSRIs are not routinely used for the treatment of anxiety disorders and PTSD.
b) Lithium monotherapy is used as a maintenance treatment for PTSD.
c) Interpersonal psychotherapy and cognitive-behavioral therapy are considered first-line psychotherapies for depressive disorders.
d) A mood stabilizer and/or a second-generation antipsychotic with an adjunct benzodiazepine are routinely prescribed for anxiety disorders.
e) Maintenance phases of depressive disorders are treated with SGA depot preparations for compliance and relapse prevention.

3. Quality of life for a patient with a psychiatric disorder can determine;

a) The need for drug treatment.
b) Resilience.
c) Vulnerability.
d) Whether the patient's illness is diminishing
e) Whether well-being aspects are improving.

4. Which of the following is NOT a cause of stigmatization?

a) Adequate knowledge.

b) Previous negative experience.

c) Cultural factors.

d) Biological causal beliefs.

e) Continuum beliefs regarding mental illnesses.

5. Which of the following is an example of internalized stigma?

a) Community showing anger or pity towards an individual with dissociative disorder.

b) A patient with schizophrenia is aware of others' stereotypes towards him/her.

c) Alienation of a person with posttraumatic stress disorder from the society.

d) A person taking antipsychotics is deprived of employment and housing.

e) Biased views towards an individual with bipolar disorder as aggressive and dangerous.

6. Which of the following is NOT a part of the process of stigma?

a) Labeling and marking of patients.

b) Negative reaction/behavior.

c) Shunning, rejection, and avoidance.

d) Separation and isolation due to psychiatric illness.

e) Maintenance of previous status or position.

7. All the following mental health professionals' behaviors characterize how stigma is manifested in psychiatric settings, EXCEPT?

a) Contravening patients' rights.

b) Poor-quality treatment.

c) Informed consent is required for a competent patient after full disclosure of the care plan.

d) Lack of confidentiality, such as disclosing a patient's diagnosis.

e) Patient discrimination.

8. Which one of the following is NOT an outcome linked to higher stigmatization towards psychiatric patients?

a) Psychiatric comorbidity.

b) Lost hope of recovery for affected patients.

c) Increased death ideation and suicide cases.

d) Higher odds of patients seeking treatment.

e) Higher internalized stigma and altered perception of self-worth.

9. The following approaches are essential in addressing mental health stigma in psychiatric contexts, EXCEPT?

a) Sensitization of patient rights, confidentiality, and quality care without discrimination

b) Regular counseling for caregivers/family members not to speak about PMI's dehumanization or discrimination.

c) Meaningful collaborations with service users.

d) Discourage the culture of stigmatization of PMI.

e) Create an enabling and friendly environment.

10. Which one of the following characterizes a stigma-free healthcare organization?

a) Indicates that the stigma of patients with mental illnesses is acceptable.

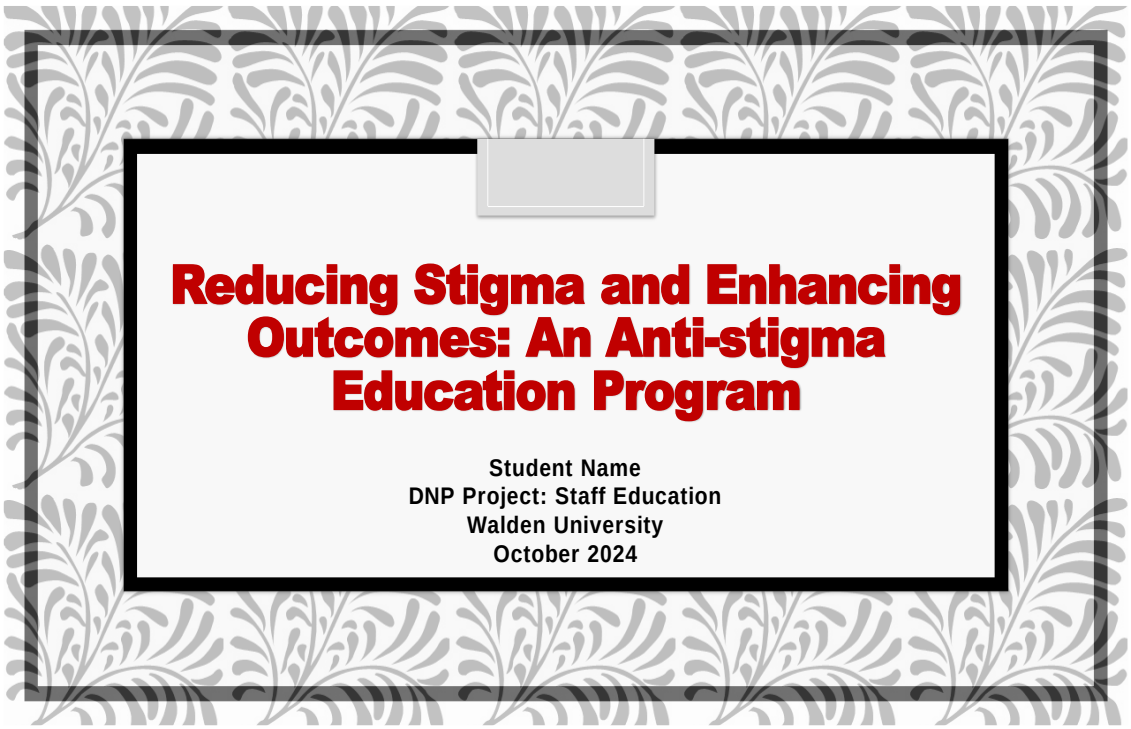
b) Confers preferential treatment of patients with physical illness to PMI.

c) Limited sensitization and communication of the rights of patients.

d) Implements and enforces anti-stigma policies.

e) Discourages patients to report discrimination or stigmatization.

Appendix C: PowerPoint Presentation



Presentation Outline

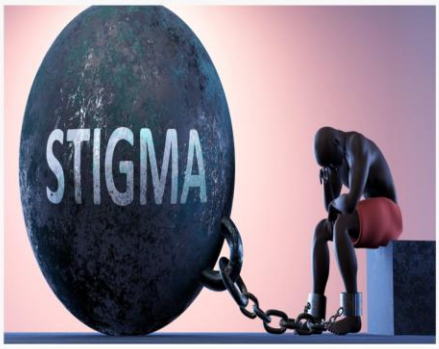
1. SMART Learning Goals
2. Gap and Problem Overview
3. Evidence Summary
4. Common Mental Health Disorders
5. Stigmatization of Patients with Mental Illnesses (PMI).
6. Definitions, Prevalence, Causes and Expressions of Stigma
7. Effect of Stigmatization on Mental Health Outcomes
8. Combatting Stigma in Mental Health Settings.

SMART Learning Goals

1. Define mental health stigma.
2. Create a list of mental health disorders and psychotropic agents used in their management.
3. Develop a list of four causes of stigma.
4. Illustrate four cases of stigma manifestations in the healthcare environment.
5. List three negative implications of stigmatization on mental health care and the management outcomes.
6. Illustrate the methods that can be used to mitigate and overcome stigma.

Problem Statement and Objective

- **Problem:** Patients diagnosed with psychiatric conditions and are taking medications face stigma in their care environment. Out of lack of interventions, stigmatization of PMI persists among MHPs.
- **Objective:** To create awareness and knowledge on combating stigma towards patients diagnosed with psychiatric conditions taking psychotropic medications.



Evidence Summary

- Wong et al. (2024): Educational interventions resulted in positive attitudinal improvements.
- Khenti et al. (2023): Anti-stigma intervention improved staff's attitudes towards MHSUP.
- Saguem et al. (2023): A 4-hour educational intervention yielded moderate effects on stigma.
- McCullock and Scrivano (2023): Education interventions and contact-promotion lowered stigma.
- Hopp et al. (2023): Direct contact and reflective experiences decreased stigmatization attitudes.
- Rodríguez-Rivas et al. (2024): An effective, novel, and scalable intervention lowered stigmatized perceptions of psychotic conditions.
- Latifian et al. (2023): Psychoeducation decreased internalized stigma among family members of patients with BD.
- Tóth et al. (2023): Face-to-face, mixed methods and online interventions had similar efficacy in stigma reduction.

Mental Health Disorders

- **Anxiety disorders**
- **Depression**
- **Schizophrenia**
- **Bipolar disorder**
- **PTSD**
- **Personality disorders.**

Anxiety Disorders

- Prevalence >30%.
- **Types:** Social anxiety disorders is the most common. **Others:** Panic disorder, GAD, separation anxiety disorder, specific phobia, selective mutism, and agoraphobia.
- **Signs and Symptoms:** Distracted sleep patterns, fatigue, restlessness, irritability, concentrating difficulty, fatigue, emotional distress, trembling/shaking, sweating, shortness of breath, paresthesias, palpitations, nausea, abdominal distress and derealization or depersonalization.
- **Treatments:** SSRIs, TCAs, benzodiazepines, Buspirone, and beta-blockers (propranolol and atenolol).
- **Psychotherapy:** CBT and exposure therapy.

Depression

- **Prevalence:** 9% of adults had ≥1 major depressive episode.
- **DSM-5 Criteria:** Depressed mood, anhedonia, insomnia, energy loss, appetite and weight changes, suicidal ideation.
- ≥5 Symptoms must present within 14 days, and ≥1 symptom must be anhedonia or depressed mood (APA, 2022).
- **Self-Report Screening Instruments:** PHQ-9, HAM-D, and BDI-II.
- **Pharmacotherapy:** SNRIs/SSRIs (first-line agents).
- Others: TCAs, atypical antidepressants, MAOIs, and NMDA-receptor antagonists.
- **Psychotherapy:**
  - Interpersonal psychotherapy (IPT)
  - Problem-solving therapy (PST), and Cognitive-behavioral therapy (CBT).

Schizophrenia

- **Prevalence:** 2%.
- **Positive symptoms:** Delusions, hallucinations, and thought disorders.
- **Negative symptoms:** Lack of motivation, anhedonia, speech disorganization.
- **DSM-5 Criteria:** ≥2 symptoms of disorganized speech, disorganized behavior, hallucinations, delusions, and negative symptoms, causing occupational and social dysfunction (APA, 2022).
- Symptoms ≥ 6 months.
- Acute psychosis treatment: SGA and benzodiazepines for behavioral disturbances.
- **Maintenance Phase:** Depot preparations for compliance, and relapse prevention.
- **Nonpharmacological treatments:** CBT, drama/art therapies, and electroconvulsive therapy.
- Pts suffer significant disability reduction in life expectancy.
- Possibility of increased suicide risk.

Bipolar Disorders

- **Prevalence:** 2.4%
- Bipolar disorder (BD): Alternating episodes of mania with depression.
- **DSM-5:**

1. BD-1: ≥1 manic episode followed by an MDD or hypomanic episode.
2. BD-II: ≥1 past or current hypomanic episode and MDD symptoms without any manic episodes (APA, 2022).

- **Manic/hypomanic episodes:** Mood stabilizer (Valproate or Lithium) and SGA with adjunctive benzodiazepines
- **Acute bipolar depression:** Quetiapine, lurasidone, and olanzapine. Combinations include Lurasidone + lithium/valproate, olanzapine + fluoxetine, lithium or valproate+ lamotrigine.
- **Maintenance Treatment:** Lithium monotherapy.

Posttraumatic Stress Disorder

- PTSD affects up to 10% of the population.
- **DSM-5 Diagnostic Criteria: S**tressor/causation, traumatic event, avoidance, ≥2 symptoms of mood/cognition alterations, and hyperarousal, symptoms lasting over 1 month with associated significant clinical distress and impaired functioning (American Psychiatric Association, 2022).
- Psychotherapies: Prolonged exposure, cognitive processing therapy, trauma-focused CBT, and eye movement desensitization and reprocessing.
- Psychotherapies are more effective than medications.
- **Pharmacotherapy:** SNRIs/SSRIs, guanfacine, clonidine, trazodone, and prazosin.

Definitions of Stigma

- **Stigma:** False belief, negative attitude and improper conduct towards a certain category of persons
- **Stereotypes:** Biased views towards PMI such as unfit around people, aggressive, dangerous.
- **Prejudice:** Community agreement with beliefs accompanied by negative emotional reactions such as fear, pity, or anger.
- **Discrimination:** Apparent by failure to cater for housing needs, alienation from the society and deprived employment of individuals with mental illnesses.
- **Internalized or self-stigma:** A patient is aware of others stereotypes towards him/her.
- **Mental health stigma:** Discrimination, prejudice, and negative stereotypes directed towards PMI (Ahad et al, 2023).

Stigma (Cont.)

Process of Stigma

- Labeling and marking of PMI
- Negative reaction/behavior.
- Shunning, rejection, and avoidance.
- Separation from other individuals and the community due to their psychiatric illness.
- Loss of status, positions, and dignity.
- Isolation due to mental health status.

Manifestations in Psychiatry

- Contravening patients' rights.
- No informed consent.
- Poor-quality treatment.
- Lack of confidentiality.
- Patient discrimination.
- Disclosure of patients diagnosis.
- Denial of care.

Prevalence of Stigma

- Hao et al. (2023) indicated a high level of stigma and desire for social distancing among caregivers of PMI.
- Hemingway et al. (2024): Residents exhibited attitudes towards PMI with multiple inpatient admissions to the psychiatric units.
- Kılıç-Demir & Kızılpınar (2024): General nurses with first-relative degree with PMI had higher odds of perceiving PMI as threatening and having negative perceptions.
- Gupta et al. (2024): Internalized stigma/self-stigma, is common among PMI due to internalized negative stereotypes of mental disorders as experienced by others.
- Cazalis, Lambert & Auriacombe (2023): 20-51% of healthcare professionals had negative beliefs or attitudes towards individuals with SUD.

Causes of Stigma

- Fear
- Misconceptions
- Deficient knowledge
- Lack of treatment
- Previous negative experience.
- Social identity.
- Cultural factors.
- Biological causal beliefs
- Religion and culture backgrounds.
- Continuum beliefs regarding mental illnesses.

- Hopp et al. (2023): Previous experience with PMI, female gender, and interest in psychosomatics or psychiatry determined stigma levels.

Expressions of Stigma

- Perceptions of PMI as violent/unpredictable violent behavior.
- Bipolar Disorder and Schizophrenia: Viewed as dangerous and having a weakness
- Having a 'weaknesses'
- Aggressiveness.
- Low value for affected PMI.
- Patient's cannot be cured.
- PMI are evil.

Effect on Mental Health Outcomes

- Lower odds of patients seeking treatment.
- Increased self-stigma: Negative perception of self-worth.
- Low self-esteem.
- Lost hope of recovery for affected patients.
- Poor social life and relationships,
- Poor functioning
- Psychiatric comorbidity.
- Increased death ideation and suicide cases.
- Poor quality of life, results in
- Adverse clinical, occupational and economic outcomes.

Addressing Stigma

- Discourage the culture of stigmatization of PMI.
- Train health workers to fight stigma.
- Discuss issues of stigma.
- Sensitization on patient rights; Confidentiality and quality care without discrimination.
- Demystify false beliefs. Sharing accurate information.
- Regular counselling.
- Create an enabling and friendly environment.
- Meaningful collaborations with service users.
- Education on therapy and medication
- Self awareness.
- Assertiveness in preventing stigma.

Person-Centered Care

Stigma-Free Healthcare Organization

- Compassion, respect and access to PMI.
- Equal care of PMI to other patients
- Sensitization and communication of patients rights.
- Encourage patients to report discrimination or stigmatization
- Screening of mental disorders should regularly.

Sustainability

Understand	• Highlight the negative impacts of stigma.
Accept	• Accept that stigma of PMI is unacceptable.
Plan	• Establish an inclusive working team against stigma
Assess	• Continuously assess stigmatization of PMI.
Enforce	• Implement, and enforce anti-stigma policies.
Train	• Conduct regular training anti-stigma training
Embed	• Working culture against stigma.

References

Ahad, A., Sanchez-Gonzalez, M., & Junquera, P. (2023). Understanding and addressing mental health stigma across cultures for improving psychiatric care: A narrative review. *Cureus, 15*(5), e39549. https://doi.org/10.7759/cureus.39549

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders (5th ed., text rev.).* https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425787

Bannatyne, A., Jones, C., Craig, B., Jones, D., & Forrest, K. (2023). A systematic review of mental health interventions to reduce self-stigma in medical students and doctors. *Frontiers in Medicine, 10*, 1204274. https://doi.org/10.3389/fmed.2023.1204274

Cazalis, A., Lambert, L., & Auriacombe, M. (2023). Stigmatization of people with addiction by health professionals: Current knowledge. A scoping review. *Drug and Alcohol Dependence Reports, 9*, 100196. https://doi.org/10.1016/j.dadr.2023.100196

Chen, X., Wang, S., Liao, X., Li, Y., Leung, S., & Bressington, D. (2024). Interventions to decrease health students' stigma toward schizophrenia: A scoping review. *International Journal of Nursing Studies, 158*, 104837. https://doi.org/10.1016/j.ijnurstu.2024.104837

Chukwuma, O., Ezeani, E., Fatoye, E., Benjamin, J., Okobi, O., Nwume, C., & Egberuare, E. (2024). A systematic review of the effect of stigmatization on psychiatric illness outcomes. *Cureus, 16*(6), e62642. https://doi.org/10.7759/cureus.62642

Gupta, S., Kumar, A., Kathiresan, P. P., Pal, A., & Singh, V. (2024). Mental health stigma and its relationship with mental health professionals - A narrative review and practice implications. *Indian Journal of Psychiatry, 66*(4), 336–346. https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_412_23

Hao, Y., Wu, Q., Wang, X., Ma, Y., Wang, Y., Peng, P., Wang, X., Yang, Q., Liu, Y., Li, M., He, L., Wang, Q., Zhou, Y., Liu, T., & Chen, S. (2023). Stigmatizing attitudes toward mental illness among caregivers of patients with mental disorders in China. *Frontiers in Public Health, 11*, 1071954. https://doi.org/10.3389/fpubh.2023.1071954

Hemingway, J., Kunz, J., Draney, D., Martin, D., & Sukpraprut-Braaten, S. (2024). Evaluating stigmatization toward mental illnesses among resident physicians. *Cureus, 16*(6), e61648. https://doi.org/10.7759/cureus.61648

Hopp, A., Dechering, S., Wilm, S., Pressentin, M., Müller, T., Richter, P., Schäfer, R., Franz, M., & Karger, A. (2023). The influence of patient-centered teaching on medical students' stigmatization of the mentally ill. *GMS Journal for Medical Education, 40*(4), Doc46. https://doi.org/10.3205/zma001628

Khenti, A., Bobbili, S., Lentinello, E., Sapag, J., van der Maas, M., Sanches, M., & Corrigan, P. (2023). A cluster randomized controlled trial exploring stigmatization and recovery-based perspectives on mental illness and substance use problems among primary healthcare providers in Toronto, Ontario. *International Journal of Mental Health and Addiction*, 1-18. https://doi.org/10.1007/s11469-023-01136-5

Appendix D: Posttest Knowledge Questionnaire and Program Evaluation

Instruction: *Kindly circle the correct answer.*

1. Which of the following commonly stigmatized psychiatric disorders is the most prevalent in the USA?

a) Schizophrenia
b) PTSD
c) Personality disorders
d) Depressive disorders
e) Bipolar disorder

2. Which of the following statements are TRUE?

a) SSRIs are not routinely used for the treatment of anxiety disorders and PTSD.
b) Lithium monotherapy is used as a maintenance treatment for PTSD.
c) Interpersonal psychotherapy and cognitive-behavioral therapy are considered first-line psychotherapies for depressive disorders.
d) A mood stabilizer and/or a second-generation antipsychotic with an adjunct benzodiazepine are routinely prescribed for anxiety disorders.
e) Maintenance phases of depressive disorders are treated with SGA depot preparations for compliance and relapse prevention.

3. Quality of life for a patient with a psychiatric disorder can determine;

a) The need for drug treatment.
b) Resilience.
c) Vulnerability.
d) Whether the patient's illness is diminishing
e) Whether well-being aspects are improving.

4. Which of the following is NOT a cause of stigmatization?

a) Adequate knowledge.

b) Previous negative experience.

c) Cultural factors.

d) Biological causal beliefs.

e) Continuum beliefs regarding mental illnesses.

5. Which of the following is an example of internalized stigma?

a) Community showing anger or pity towards an individual with dissociative disorder.

b) A patient with schizophrenia is aware of others' stereotypes towards him/her.

c) Alienation of a person with posttraumatic stress disorder from the society.

d) A person taking antipsychotics is deprived of employment and housing.

e) Biased views towards an individual with bipolar disorder as aggressive and dangerous.

6. Which of the following is NOT a part of the process of stigma?

a) Labeling and marking of patients.

b) Negative reaction/behavior.

c) Shunning, rejection, and avoidance.

d) Separation and isolation due to psychiatric illness.

e) Maintenance of previous status or position.

7. All the following mental health professionals' behaviors characterize how stigma is manifested in psychiatric settings, EXCEPT?

a) Contravening patients' rights.

b) Poor-quality treatment.

c) Informed consent is required for a competent patient after full disclosure of the care plan.

d) Lack of confidentiality, such as disclosing a patient's diagnosis.

e) Patient discrimination.

8. Which one of the following is NOT an outcome linked to higher stigmatization towards psychiatric patients?

a) Psychiatric comorbidity.

b) Lost hope of recovery for affected patients.

c) Increased death ideation and suicide cases.

d) Higher odds of patients seeking treatment.

e) Higher internalized stigma and altered perception of self-worth.

9. The following approaches are essential in addressing mental health stigma in psychiatric contexts, EXCEPT?

a) Sensitization of patient rights, confidentiality, and quality care without discrimination

b) Regular counseling for caregivers/family members not to speak about PMI's dehumanization or discrimination.

c) Meaningful collaborations with service users.

d) Discourage the culture of stigmatization of PMI.

e) Create an enabling and friendly environment.

10. Which one of the following characterizes a stigma-free healthcare organization?

a) Indicates that the stigma of patients with mental illnesses is acceptable.

b) Confers preferential treatment of patients with physical illness to PMI.

c) Limited sensitization and communication of the rights of patients.

d) Implements and enforces anti-stigma policies.

e) Discourages patients to report discrimination or stigmatization.

Program Evaluation

Instructions: *Rate your level of agreement on a scale of 1 to 5, with 1 indicating strong disagreement and 5 strong agreement. A score of 2 indicates disagreement, 3 is neutral, and 4 is agree. Higher scores indicate a higher level of agreement with the question.*

Question: Does the information provided in this training help mental healthcare professionals improve awareness and lower stigma toward patients with mental illness?

1. Strongly Disagree
2. Disagree
3. Neutral
4. Agree
5. Strongly Agree