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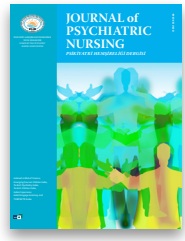

Systematic Review

Unveiling the predisposing factors of stigma towards individuals with mental disorders: A scoping review

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Abstract

Objectives: The issue of stigma related to mental disorders has increasingly become a global concern, despite significant improvements in mental health treatment and services. However, reductions in stigma associated with mental disorders have not kept pace with these advancements. Stigma refers to a negative label assigned to individuals, which may lead to their isolation from other social groups. This study aims to identify the predisposing factors that influence stigma toward individuals with mental disorders.

Methods: A scoping review approach was used to identify various factors influencing the emergence of stigma, from both the perspective of individuals experiencing stigma and their social environments.

Results: Based on the analysis of published studies, several key factors were identified, including demographic characteristics, disease-related factors, culture, education level, and family support, all of which play significant roles in either exacerbating or reducing stigma.

Conclusion: The findings of this study provide deeper insight into the factors that should be addressed to reduce stigma related to mental disorders.

Keywords: Mental disorders; predisposing factors; scoping review; stigma

Mental health issues are an increasing global concern, with significant improvements in treatment and healthcare services. However, progress in reducing the stigma associated with mental disorders has not kept pace.[1] Stigma refers to a negative or discrediting label placed on individuals, causing them to be separated from other members of their group. Social stigma toward mental disorders remains prevalent worldwide.[2] Individuals experiencing mental health issues are often viewed as deviant and are subjected to low social regard. Society tends to hold negative perceptions of those with mental disorders, with some segments justifying the marginalization and isolation of individuals with mental health issues.[3] In addition, stigma is also experienced by families with members who have mental disorders, as stigma can increase the burden on families due to the shame associated with having a family member with a mental illness.[4]

The emergence of stigma is caused by various factors, such as personal beliefs, lack of knowledge, misinformation, and limited personal experience.[5] Additionally, Abi Doumit suggests that stigma can also arise from misinformation, cultural taboos, and deeply rooted beliefs regarding mental instability.[4] As a result of stigmatization, individuals with mental disorders may experience declines in self-esteem and self-efficacy, emotional distress such as anxiety or anger, and reluctance to seek help.[6–8]

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Individuals with mental disorders often face greater stigma and discrimination from surrounding society compared with those experiencing medical illnesses.[9] The prevalence of mental disorders is higher among young people. In OECD countries, approximately one in four individuals aged 15–24 years experiences a mental disorder, placing them at greater risk of dropping out of school and reducing their opportunities to secure stable employment.[10] According to data from the World Health Organization (WHO), in 2019 there were 264 million people experiencing depression, 45 million people with bipolar disorder, 50 million people affected by dementia, and 20 million individuals with schizophrenia.[9]

Stigma and discrimination against individuals with mental disorders can create significant problems for those diagnosed with mental illness.[11] These issues may lead to real-life disadvantages, including poor access to mental and physical healthcare, difficulties in obtaining or maintaining employment, challenges in securing accommodation, and reduced life expectancy. Additionally, stigma and negative treatment may cause individuals with mental disorders to experience relapse upon reintegration into society, as they may not receive adequate roles and social support from the community.[3]

Studies among Asian American and European populations underscore that gender, language, cultural attitudes, and mental health literacy play significant roles in how stigma develops and is experienced.[12,13] However, many current interventions and studies have not adequately explored which of these factors are most impactful, particularly among individuals with vulnerabilities in self-concept. This reflects a critical gap in the existing literature, where generalized strategies fail to address the nuanced, person-centered dimensions of stigma.

Therefore, a scoping review is necessary to explore the predisposing factors that influence stigma in individuals with mental disorders. The aim of this scoping review is to gain a deeper understanding of the predisposing factors related to stigma in individuals with mental disorders.

What is presently known on this subject?

- Stigma and discrimination against individuals with mental disorders can create significant problems for those diagnosed with mental illness.

What does this article add to the existing knowledge?

- This scoping review helps identify various factors that can influence the emergence of stigma, both from the perspective of individuals experiencing stigma and from their social environment.

What are the implications for practice?

- This research contributes to clinical practice by enabling practitioners to better understand the stigma frequently experienced by patients with mental disorders as a potential cause of inconsistent patient care.
- In the field of education, it provides information on the factors that contribute to stigma, as well as the negative impact of stigma on individuals with mental disorders.

Materials and Method

Research Question Identification

The research question for this scoping review is to determine the predisposing factors that influence stigma in mental health patients. The PCC mnemonic (Population, Concept, Context) was used to formulate the research question.[14]

Study Design

We conducted a scoping review in accordance with the PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews) standards.[14] The protocol for this scoping review has been registered with the Open Science Framework (https://osf.io/hfrxa) (Fig. 1).

Search Strategy

The databases used to search for articles in this scoping review included Scopus, PubMed, ProQuest, and Google Scholar. The analyzed articles were scientific publications published between 2021 and 2025 and available in Indonesian or English. The search strategy employed a combination of subject terms and free-text keywords. Data collection began in August 2024.

Inclusion Criteria

Respondents had to be over 18 years old, with no changes in treatment in the past month, and the research setting had to be community-based.

Exclusion Criteria

Studies were excluded if the samples did not include individuals with mental health disorders or if the research was conducted in hospital settings.

P = Population

The population included in this scoping review comprised patients with mental health disorders. This included observational studies describing their experiences of stigma since being diagnosed with a mental health disorder.

C = Concept

The main concept in this scoping review is self-concept and the dominant factors contributing to self-concept issues. The theoretical framework for self-concept was based on Stuart's theory, which explains that self-concept arises from several dimensions, including body image, self-esteem, ideal self, role performance, and personal identity.[15]

C = Context

This scoping review focused on the predisposing factors of stigma in individuals with mental disorders.

Data Extraction

After the literature search, references were imported into Rayyan to remove duplicates and to independently evaluate

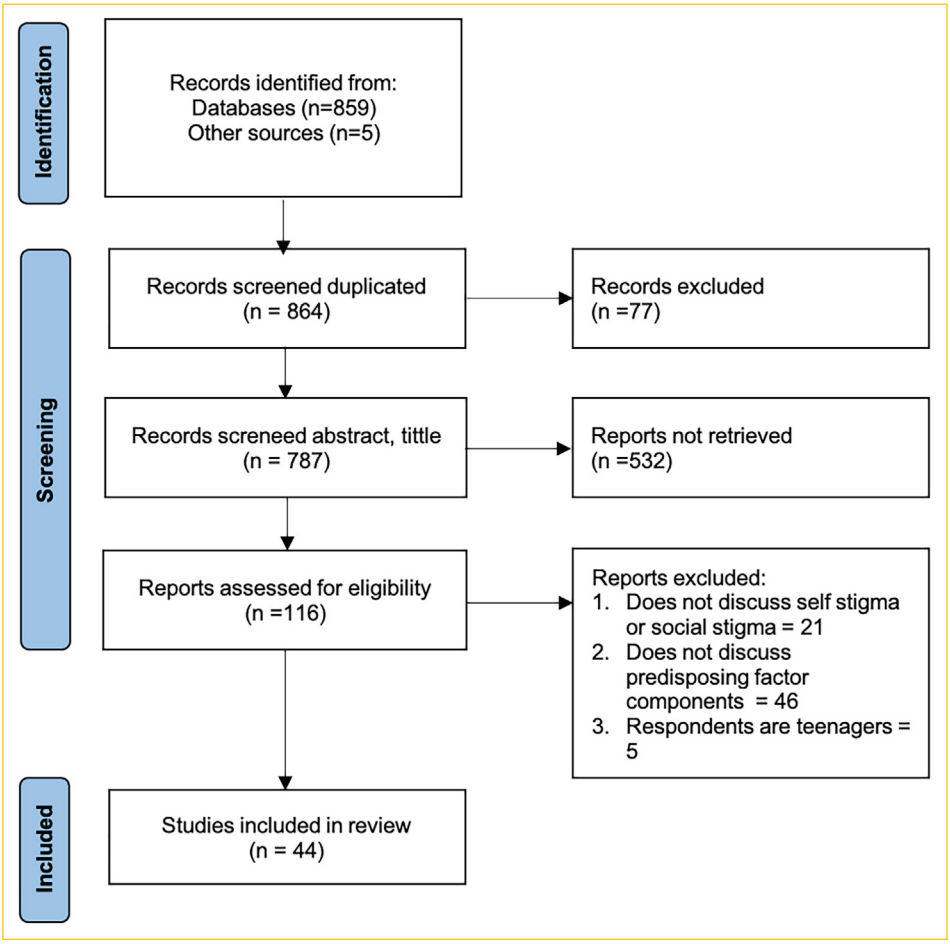

Figure 1. Prisma scoping review.

studies based on titles and abstracts as the initial screening step. Two researchers conducted the screening, and a third researcher was consulted in cases of disagreement. The extracted information included country, year, author, study type, inclusion criteria, and predisposing factors of stigma. The final PRISMA-ScR flow diagram will illustrate the study selection process.

Quality Appraisal

To assess the quality of the included studies, we employed the critical appraisal approach developed by the Joanna Briggs Institute (JBI).[16] The assessment was conducted using JBI Critical Appraisal tools designed to evaluate the methodological quality of studies and determine the extent to which they addressed potential bias in their design, conduct, and analysis. Each criterion was rated as "Yes," "No," "Unclear," or "Not Applicable." Criteria rated "Yes" were assigned a score of 1, whereas "No" or "Unclear" were assigned a score of 0. Total scores were calculated to determine the overall quality of each study.

The JBI Critical Appraisal tools have undergone rigorous evaluation and approval by the JBI Scientific Committee through an extensive peer-review process. Studies were classified as high quality if they achieved a score exceeding 75%, based on relevance to the research topic and adherence to JBI criteria.[16] Two independent reviewers assessed the articles separately to ensure objective and unbiased evaluation. Any discrepancies in scoring were discussed and resolved with a third reviewer to reach consensus. This process ensured that only studies meeting the predetermined quality criteria were included, thereby minimizing bias and enhancing the credibility and reliability of the findings.

Statistical Analysis

After the literature search and selection process, all included articles underwent comprehensive examination and analysis by the entire author team. This process began with a detailed review of each study to extract and summarize essential insights related to the predisposing factors of stigma in patients with mental disorders.

The authors then conducted in-depth discussions to synthesize the extracted data. Key themes and patterns were identified, and a concise summary for each article was developed to capture critical insights. To facilitate synthesis, factors contributing to stigma—including sociodemographic characteristics, employment status, disease characteristics, resistance

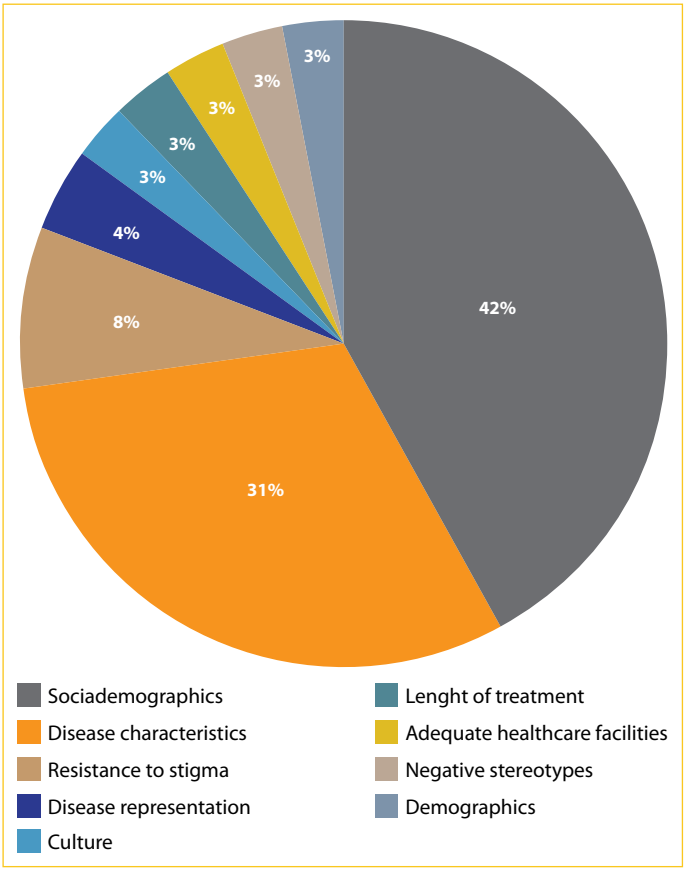

Figure 2. The scope of predisposing factors of stigma in mental disorders.

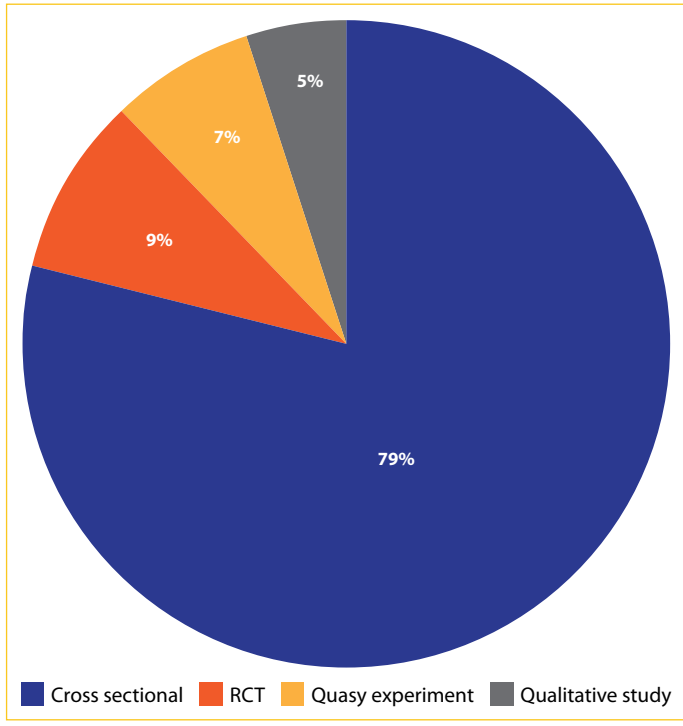

Figure 3. Selected research articles.

to stigma, cultural influences, length of hospitalization, family support, and the availability of healthcare facilities—were systematically categorized.

Each category was then further explored to provide a comprehensive understanding of how these factors contribute to stigma. To ensure rigor and consistency, all steps of the analysis were independently verified by multiple authors. Discrepancies were resolved through discussion, and consensus was reached to ensure the reliability of the findings. This systematic approach ensured that the review was thorough, transparent, and adhered to high scientific standards.

Results

Based on Figure 2, the journal search on the theme of predisposing factors of stigma in individuals with mental disorders identified a total of 44 articles. These articles discuss several factors, including disease representation, disease characteristics, demographics, negative stereotypes, adequacy of healthcare facilities, length of treatment, culture, resistance to stigma, sociodemographic factors, and family support.

Based on Figure 3, the selected research articles predominantly employed cross-sectional study designs. In addition to these, other studies used different methodologies, such as quasi-experimental designs, randomized controlled trials (RCTs), and qualitative approaches.

The selected articles were then subjected to critical appraisal using the JBI tools to assess their quality. The results of the critical appraisal for the studies included in this review are presented in Appendix 1. Furthermore, the scoping review process was evaluated using the PRISMA-ScR checklist, the results of which are provided in Appendix 2-4.

Based on Table 1, the reviewed research articles summarize various predisposing factors contributing to stigma in the context of mental health and chronic illness, drawing on studies conducted in different countries. Overall, these factors can be categorized into several main groups: sociodemographic factors, disease characteristics, psychosocial and environmental factors, culture and stereotypes, and other specific factors.

Discussion

Stigma associated with mental health conditions is a complex phenomenon influenced by various sociodemographic factors. Age is one critical determinant; studies show that older individuals tend to hold more conservative views on mental disorders, often reinforcing social stigma. In contrast, younger generations exhibit greater openness toward mental health issues, although they still experience stigma.[17] This generational difference underscores the need for targeted educational interventions to address misunderstandings about mental health across age groups.

Table 1. Predisposing factors for stigma

No	Author/year	Country	Predisposing factors
1	Lu et al., 2024[19]	China	Higher illness representation and illness understanding, emotional representation. Rural area/ insufficient availability of health facilities, a negative stereotypical image, unemployed, the more hospitalizations insuffi cient disease management at home results in repeated relapses or diffi culty in controlling the disease, the longer the total length of treatment.
2	Shi et al., 2024[27]	China	Social/ public stigma, stigma strees appraisal, cooping orientation, psychological capital, socio-demographic , disease characteristics of the participants, educational level, stigma resistensi.
3	Mahfoud et al., 2023[31]	Lebanon	Socio-demographic, disease characteristics of the participants, educational level, body weight
4	Shah et al., 2022[25]	USA	Stage self stigma, culture .
5	Marcussen et al., 2021[37]	USA	Sosiodemography, stigma resisten, welbeing.
6	Au et al., 2019[21]	China	Socio-demographic, disease characteristics of the participants.
7	Ouali et al., 2020[29]	Tunisia	Socio-demographic, disease characteristics of the participants.
8	Catalano et al., 2021[41]	USA	Socio-demographic, disease characteristics of the participants.
9	Lysaker et al., 2007[8]	USA	Socio-demographic, disease characteristics of the participants.
10	Shimotsu et al. 2014[40]	Japan	Socio-demographic, disease characteristics of the participants.
11	Maharjan et al., 2019[9]	Nepal	Socio-demographic, disease characteristics of the participants.
12	Bos et al., 2009[7]	Nederland	Socio-demographic, disease characteristics of the participants.
13	Lysaker et al., 2012[38]	USA	Socio-demographic, disease characteristics of the participants.
14	Hamidi et al., 2023[3]	Iran	Age, gender, employment, status, total monthly income, educational level, and marital, status. Medical records were also reviewed to confirm the disease's diagnosis, duration, and hospitalization number.
15	Picco et al., 2016[4]	Singapure	Age, gender, employment status, total monthly income, educational level, and marital status. Medical records were also reviewed to confirm the disease's diagnosis, duration, and hospitalization number.
16	Pal et al., 2017[5]	India	Age, gender, employment status, total monthly income, educational level, and marital status.Medical records were also reviewed to confirm the disease's diagnosis, duration, and hospitalization number, duration of treatment, family history, age of onset.
17	West et al., 2015[10]	USA	Socio-demographic, disease characteristics of the participants, charge criminal.
18	Picco et al., 2017[11]	Singapure,	Socio-demographic, disease characteristics of the participants.
19	Oliveira et al., 2015[12]	Portugal	Socio-demographic, disease characteristics of the participants.
20	Billian et al., 2024[13]	Switzerland	Socio-demographic, disease characteristics of the participants.
21	Lysakera et al., 2008[14]	USA	Socio-demographic, disease characteristics of the participants.
22	Roe et al., 2014[39]	Israel	Socio-demographic, disease characteristics of the participants.
23	Goepfert et al., 2019[42]	Germany	Socio-demographic, disease characteristics of the participants, negative event relating to depression).
24	Rüsch et al., 2006[1]	Germany	Socio-demographic, disease characteristics of the participants, Anxiety dan fobia social.
25	Li et al., 2017[15]	China	Socio-demographic, disease characteristics of the participants.
26	Hansson et al., 2017[43]	Sweeden	Socio-demographic, disease characteristics of the participants.
27	Świtaj et al., 2017[32]	Polland,	Socio-demographic, disease characteristics of the participants.
28	Vass et al., 2015[16]	UK	Socio-demographic, disease characteristics of the participants.
29	Lundberg et al., 2009[17]	UK	Socio-demographic, disease characteristics of the participants.
30	Kao et al., 2016[18]	Taiwan	Socio-demographic, disease characteristics of the participants.
31	Morrison et al., 2016[44]	UK	Socio-demographic, disease characteristics of the participants.
32	Howlanda et al., 2016[36]	USA	Demographic variables (age, gender, years of education), comorbidities, and symptom severity (BPRS and MADRS).
33	Ociskova et al., 2015[22]	New Zealand	Relatively young age, primary education level, intensity of depressive symptoms.
34	Karidi et al., 2015[24]	Greece	Family support, Diagnosis, Gender self-stigma is felt more in male patients, Duration of illness.
35	Watson et al., 2007[20]	USA	Time since disease onset, level of disability, socioeconomic status, and utilization of services.
36	Karakas et al., 2016[30]	Turki	Cultural stereotypes.
37	Ow et al., 2015[33]	Singapore	Gender, depression, education.
38	Kim et al., 2015[34]	Korea	Gender, education, occupation.
39	Verhaeghe et al., 2008[26]	Belgium	Rejection from environtment.
40	Young et al., 2016[23]	Hong Kong, China	Gender, diagnosa, marital, education, living arrangment, occupational status, income, periode of illness, number of hospitalization.
41	Segalovich et al., 2013[6]	Israel	Loneliness, societal discrimination.
42	Nagai et al., 2017[2]	Japan	Socio-demographic, disease characteristics of the participants.
43	Oshodi et al., 2014[28]	Nigeria	Gender, age, education.
44	Krajewski et al., 2013[35]	Nederland	Age, occupation, lower social contact.

Gender differences also play an essential role in shaping perceptions of mental illness.[45–47] Men often face pressure to conform to traditional masculinity norms, in which mental health problems are perceived as signs of weakness.[45,48,49] This pressure results in greater stigma toward men who seek help.[50] Conversely, women are frequently labeled as "overly emotional," which complicates their experiences of mental health stigma.[48] These gendered expectations create a context in which both men and women must navigate stigma that affects their willingness to seek treatment and openly express psychological distress.[46,47]

Unemployment is another crucial factor related to stigma. Individuals with severe and common mental disorders are 7 and 3 times more likely to be unemployed, respectively, than individuals without mental disorders.[10] Research indicates that unemployed individuals with schizophrenia are more likely to experience self-stigma and discrimination, as economic instability reinforces negative societal stereotypes.[18,19] The relationship between unemployment and stigma is cyclical; stigma associated with unemployment can hinder access to mental health resources, thereby worsening symptoms and reinforcing feelings of shame and social isolation.[20,21] Marital status also influences the stigma experienced by individuals with mental disorders. Those who are unmarried or living alone often face greater stigma due to the absence of strong social support systems, which are critical for mitigating negative perceptions.

Poverty is a major determinant of mental health, and individuals with low income are more likely to experience poor mental health outcomes. The stigma of poverty can be conceptualized as a broad construct encompassing both the general stigma associated with living in poverty and more specific forms of stigma related to the use of services designed to support low-income populations (e.g., social welfare).[22] Low economic status may also contribute to family conflict, which can, in turn, increase the risk of mental health problems.[24]

Limited knowledge and misconceptions about schizophrenia within society can lead families of patients to feel shame and withdraw from their communities. Consequently, inaccurate societal beliefs and perceptions influence family attitudes toward accepting individuals with schizophrenia.[24] As education level increases, individuals are generally more receptive to information and possess higher levels of health literacy. In contrast, low educational attainment may hinder understanding of mental health concepts, particularly in forming informed opinions and providing support to individuals with mental disorders.[25,26]

The emotional representation of mental illness plays a significant role in reinforcing stigma. Individuals who internalize negative stereotypes related to mental health often experience profound self-stigma, leading to feelings of shame and reduced self-esteem. This internalization may result in symptoms of depression and social withdrawal, further complicating their mental health status.[27] How individuals perceive stigma also influences their coping mechanisms. Those who perceive stigma as a stressor are more likely to adopt maladaptive coping strategies, thereby exacerbating their mental health challenges.[27] In contrast, positive coping strategies, such as seeking social support, may help reduce the negative impact of stigma.

Cultural factors also strongly influence stigma surrounding mental health. In many cultures, mental disorders are frequently associated with mystical beliefs or moral failings, generating fear and prejudice and contributing to stigmatizing attitudes and behaviors toward individuals with mental illness, their families, and mental health professionals.[28] While cultural structures are often interpreted through the symptoms of mental disorders, they can also affect individuals' recovery processes, which involve coping with illness, regaining control over life, and finding meaning.[51] Therefore, a deeper understanding of the impact of stigma across different cultural contexts is crucial to inform culturally sensitive strategies that minimize its consequences and contribute to a more equitable and effective psychiatric care system.[29] These culturally rooted beliefs highlight the need for comprehensive educational initiatives to shift public perceptions of mental health, particularly in regions where stigma is deeply entrenched.[30]

The phenomenon of resistant stigma adds an additional layer of complexity. Resistant stigma refers to deeply ingrained social prejudices that persist despite educational efforts and awareness campaigns. Negative stereotypes about individuals with mental illness, such as perceptions of dangerousness or unreliability, contribute to this form of stigma.[31] Moreover, frequent hospitalizations due to inadequate disease management may reinforce stigma, as families and communities may interpret repeated hospital stays as indicators of instability, thereby strengthening negative stereotypes.[32] Individuals who experience multiple hospitalizations may become trapped in a cycle of stigma that further isolates them from social support.

Access to mental health services is also critical in combating stigma, particularly for individuals living in rural areas. Many rural communities lack adequate mental health facilities, making it difficult for individuals to obtain timely and appropriate care.[19] Limited access may exacerbate stigma, as individuals may not receive accurate diagnoses or effective treatment, leading to misunderstandings and misrepresentations of mental illness.[33] Furthermore, social norms in rural areas are often more conservative, which may contribute to stronger stigmatizing attitudes toward mental disorders.

Public understanding of mental illness is frequently shaped by inaccurate stereotypes, such as the belief that all individuals with mental disorders behave unusually, are dangerous, or are unreliable. Public stigma consists of three components: stereotypes, prejudice, and discrimination.[27] A more accurate and comprehensive understanding of mental illness is necessary to combat stigma effectively. Patients exposed to negative representations of their illness often feel more isolated and experience greater shame.[31] This stigma may be further intensified by the side effects of psychiatric medications, such as weight gain or tremors, which can lead patients to feel judged based on their physical appearance during mental health visits.

Family support plays a crucial role in mitigating stigma. Research indicates that individuals with strong family support are better able to cope with both external and internalized stigma.[34] Families that provide emotional, financial, and practical support can facilitate treatment adherence and protect patients from social isolation. Conversely, a lack of family support may intensify the effects of stigma and make help-seeking more difficult.

In conclusion, the interaction of sociodemographic factors, emotional representations, cultural beliefs, and family dynamics significantly shapes stigma related to mental health. Addressing these multifaceted influences is essential for improving the lives of individuals with mental disorders and fostering a more inclusive society. Comprehensive educational campaigns and support systems should be implemented to challenge stigma and promote mental health awareness across communities. Such efforts can encourage open discussions about mental health, ultimately leading to improved treatment outcomes and a better quality of life for affected individuals.

Limitations

Although this review contributes to a better understanding of stigma among individuals with mental disorders, several limitations must be noted. First, there is a scarcity of studies addressing specific predisposing factors of stigma, with most existing research focusing primarily on general stigma or help-seeking behavior. Furthermore, the literature is heavily concentrated in Western contexts, which limits the generalizability of the findings to non-Western and culturally diverse populations. In addition, many studies rely on cross-sectional designs and self-reported measures, making it difficult to establish causality and potentially introducing bias. The limited attention to intersectionality, such as the combined effects of gender, ethnicity, or socioeconomic status, also oversimplifies the complexity of stigma. Future research should address these gaps by employing more diverse samples and more robust methodological approaches to comprehensively evaluate the multifaceted nature of stigma.

Conclusion

Patients with mental disorders often face both external and internal stigma, which significantly affects their lives. Individuals who experience stigma from both internal and external sources are more likely to discontinue treatment. Moreover, stigma can lead to substantial challenges for those diagnosed with mental illness, resulting in tangible disadvantages in daily life. Several factors have been identified as contributing to the harmful effects of stigma, including discriminatory environments, school dropout, and difficulties in securing employment, even among patients who have consistently received treatment.

Online Appendix Files: https://jag.journalagent.com/phd/abs_files/PHD-63549/PHD-63549_(3)_PHD-63549_Appendix.pdf

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