How Stigma and Discrimination are Perceived by Rural or Urban Patients Suffering from Schizophrenia? An Exploratory Cross – Sectional Study from Western India

Bharat Agarwal¹, Sunil Kumar² and G.K. Vankar³

ABSTRACT

Background: Stigma is conceptualized as an attribute which is deeply discrediting and makes the person carrying it different from other and of a less desirable kind. Current study aimed to describe the nature and direction of experienced stigma; and discrimination reported by people with schizophrenia. Methods: One hundred and fifty patients diagnosed with Schizophrenia were selected from the Out Patient service of Psychiatry Department of a medical college general hospital. The experiences of stigma and discrimination were assessed using a semi-structured instrument developed by national working group for India by the world psychiatric association steering committee. Results: Differences were seen between rural and urban respondents. Patients from rural background more often reported these experiences: society treats differently, attribution of supernatural cause as most common source of stigma, social exploitation, not fully accepted in the family, pushed into unacceptable social situation and sexual harassment. Reported narratives provided the direct view of these patients. Conclusions: Stigma experience is pervasive: it deeply affects the social, occupational and emotional wellbeing of patients with schizophrenia and should be included in clinical management. Effective anti-stigma intervention should target on improving attitudes and the condition for social integration in the community, empowering people with schizophrenia to challenge self-stigmatization and discrimination behavior towards them.

Key words: Schizophrenia, Stigma, Discrimination, Experiences, Attitude

INTRODUCTION

Schizophrenia is the most debilitating chronic psychiatric disorder which usually affects adolescents and young adults, disrupting pursuit of their educational and occupational goals. The disorder is associated with significant stigma and discrimination, which further increase the burden on these patients and their families. The essence of stigma is a negative and prejudicial attitude toward someone with a mental illness. Many people with mental illness describe the effect of stigma as severe, and more difficult to deal with as compared to the mental health problem itself. Discrimination occurs when people with mental illness are treated unfairly, or are denied their rights because of their mental illness. Individuals with schizophrenia often face social isolation; discrimination in housing, education and employment opportunities, and other forms of prejudice.[1][2] The stigma often extends to family members and to those who provide health care services to patients with the disorder. Major international studies suggest that schizophrenia has better prognosis in low-income nations and in rural settings.[2][4] The industrialization hypothesis has been advanced to explain this differential outcome which argues that industrial economies and attendant life styles lead to poor support, intolerance, rejection, isolation, segregation and institutionalization of the severely mentally ill.[5][6] The value placed on the autonomous individual in industrialized settings therefore accentuates social extrusion of the chronic mentally ill patient who assumes personal responsibility for the illness. In consequence, prognosis worsens in urban industrialized settings. Studies on stigma and mental illness in the Indian setting have focused both on measurements of stigma and on locally important socio-cultural factors shaping stigma.[6-9] Numerous other studies have addressed public attitudes

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Conflict of Interest: None

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towards mental illness.\textsuperscript{10-12} The nature, determinants, and consequences of stigma vary across culture and region. Hence, there is a need for studies to understand the stigma specific to a particular region to plan intervention. Better understanding and identification of determinants may suggest ways to reduce stigma and help prevent its adverse consequences.

With this background, this study was aimed to study stigma and discrimination perceived by patients with schizophrenia and, its comparison between rural and urban patients.

METHODS

2.1 Material

This was a cross sectional study conducted at psychiatry OPD of Civil hospital Ahmedabad, Gujarat. Clearance from the institutional review board was taken prior to conducting the study. The sample consisted of one hundred fifty patients diagnosed with schizophrenia independently by two psychiatrists as per criteria laid down by diagnostic and statistical manual (DSM IV-TR). Information from the caregivers and the patient case file along with a mental status examination also were used for diagnostic confirmation. The purpose of the study was explained to patients and their caregivers. The consent of the caregiver was also taken. The patients' responses were recorded.

2.2 Inclusion criteria:

1. A patient with a diagnosis of schizophrenia under continuous remission of at least six-month period according to DSM IV-TR criteria.
2. Provision of the consent.

2.3 Exclusion criteria:

1. Those patients with co-morbid axis I /II disorder.
2. The patient having co-existing medical or substance usage disorder other than nicotine.

2.4 Instruments for the study

A semi structured interview developed in an earlier study.\textsuperscript{[13]} This instrument has been used on over 1000 patient in four cities, as a part of the Indian initiative of the world psychiatric program to reduce the stigma and discrimination because of schizophrenia. It consists of two parts: first part of the scale elicits the socio-demographic information of the respondents while second part of the scale measures stigma and discrimination experiences including nature of stigma experiences, attitude of relatives, friends and caregiver, source of stigma, consequences of stigma, patient's view how stigma could be reduced and to what level, comparison of severity of mental illness to other medical illness bringing disability. The verbatim regarding patient's stigma experience in areas like personal, family, social, occupational and in marital life also were recorded.

2.5 Statistical analysis

Both quantitative and qualitative analysis were done using computer. The data from urban and rural areas were compared to find out any difference. Quantitative data was analyzed by t-test and chi-square test. The narratives were read to identify the themes of stigma. For natural and objective analyses, the data were coded manually into constructs that emphasized stigmatizing experiences in various spheres of patient's life.

RESULTS

3.1 Socio-demographic characteristics:

The Table 1 shows socio-demographic characters of the sample (N=150).

As shown in Table 1, majority of the patients were male (64%), Hindu by religion (86.6%), of age range 21-30 years (42%), married (49.3%), educated up to class 10th (69.3%), living in a joint family (52%), unemployed (62%), having income under 1000 rupees per month (68%).

Disease related characteristics: Seventy-nine (52.6%) patients (rural=18, urban=61) were having paranoid subtype of the disorder. One hundred thirty-six (90.6%) patients (rural=36 and urban=100) were having duration of illness more than two years.

Table: 1 Demographic characteristic

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Sample (N=150)</th>
<th>Rural N=39 (26%)</th>
<th>Urban N=111 (74%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hindu (130, 86.6%)</td>
<td>33 (84.6%)</td>
<td>96 (86.5%)</td>
</tr>
<tr>
<td></td>
<td>Muslim (17, 11.3%)</td>
<td>05 (12.8%)</td>
<td>12 (10.8%)</td>
</tr>
<tr>
<td></td>
<td>Others (3, 2%)</td>
<td>01 (2.5%)</td>
<td>03 (2.7%)</td>
</tr>
<tr>
<td>2.</td>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male (96, 64%)</td>
<td>23 (59%)</td>
<td>73 (65.8%)</td>
</tr>
<tr>
<td></td>
<td>Female (54, 36%)</td>
<td>16 (41%)</td>
<td>38 (34.2%)</td>
</tr>
<tr>
<td>3.</td>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>21-30 (63, 42%)</td>
<td>20 (51.2%)</td>
<td>39 (35.1%)</td>
</tr>
<tr>
<td></td>
<td>31-40(42, 28%)</td>
<td>08 (20.5%)</td>
<td>34 (30.6%)</td>
</tr>
<tr>
<td></td>
<td>41-50 (28, 16.6%)</td>
<td>09 (23.0%)</td>
<td>19 (17.2%)</td>
</tr>
<tr>
<td></td>
<td>&gt;50 (7, 11.3%)</td>
<td>02 (5.1%)</td>
<td>15 (13.5%)</td>
</tr>
<tr>
<td>4.</td>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Married (74, 49.3%)</td>
<td>18 (46.1%)</td>
<td>56 (50.4%)</td>
</tr>
<tr>
<td></td>
<td>Unmarried (39, 26%)</td>
<td>09 (23.1%)</td>
<td>30 (27.0%)</td>
</tr>
<tr>
<td></td>
<td>Divorced (19, 12.6%)</td>
<td>03 (7.7%)</td>
<td>16 (14.4%)</td>
</tr>
<tr>
<td></td>
<td>Other (18, 12%)</td>
<td>09 (23.1%)</td>
<td>09 (8.1%)</td>
</tr>
<tr>
<td>5.</td>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Illiterate (18, 12%)</td>
<td>06 (15.4%)</td>
<td>12 (10.8%)</td>
</tr>
<tr>
<td></td>
<td>Up to class X (104, 69.3%)</td>
<td>24 (61.5%)</td>
<td>80 (72.1%)</td>
</tr>
<tr>
<td></td>
<td>Higher (28, 18.6%)</td>
<td>09 (23.0%)</td>
<td>19 (17.2%)</td>
</tr>
<tr>
<td>6.</td>
<td>Family type</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nuclear (68, 45.3%)</td>
<td>14 (35.8%)</td>
<td>54 (48.6%)</td>
</tr>
<tr>
<td></td>
<td>Joint (78, 52%)</td>
<td>24 (61.5%)</td>
<td>54 (48.6%)</td>
</tr>
<tr>
<td></td>
<td>Other (4, 2.6%)</td>
<td>01 (2.5%)</td>
<td>03 (2.7%)</td>
</tr>
<tr>
<td>7.</td>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employed (57, 38%)</td>
<td>08 (20.5%)</td>
<td>49 (44.1%)</td>
</tr>
<tr>
<td></td>
<td>Unemployed (93, 62%)</td>
<td>31 (79.5%)</td>
<td>62 (55.8%)</td>
</tr>
<tr>
<td>8.</td>
<td>Income (rupees per month)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;1000 (102, 68%)</td>
<td>31 (79.5%)</td>
<td>71 (64%)</td>
</tr>
<tr>
<td></td>
<td>&gt;1000 (48, 32%)</td>
<td>08 (20.5%)</td>
<td>40 (36.0%)</td>
</tr>
</tbody>
</table>

Table 2 shows various stigma variables experienced by the patients.

Table: 2 Common stigma experienced by patients

<table>
<thead>
<tr>
<th>Variable</th>
<th>Rural N, (%)</th>
<th>Urban N, (%)</th>
<th>Chi square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Society treats differently</td>
<td>27(69.2%)</td>
<td>60 (54.0%)</td>
<td>X\textsuperscript{2}=2.73, df=1, p=0.09</td>
</tr>
<tr>
<td>Ridiculing by others</td>
<td>29(74.4)</td>
<td>67(60.4)</td>
<td>X\textsuperscript{2}=2.45, df=1, p=0.11</td>
</tr>
<tr>
<td>Offensive comments</td>
<td>30(76.9)</td>
<td>62(55.9)</td>
<td>X\textsuperscript{2}=5.40, df=1, p=0.02</td>
</tr>
<tr>
<td>Hide from relatives</td>
<td>26(66.7)</td>
<td>57(51.3)</td>
<td>X\textsuperscript{2}=2.74, df=1, p=0.09</td>
</tr>
<tr>
<td>Difficulty in getting marriage proposal</td>
<td>09(23.1)</td>
<td>36(32.4)</td>
<td>X\textsuperscript{2}=1.20, df=1, p=0.27</td>
</tr>
</tbody>
</table>

Table 3 shows various consequences of the stigma and discrimination experienced by the patients. Other findings of the study were as mentioned here. The most common reported source of stigma was attribution of supernatural cause in rural patients (41%) while in urban patients it was
not being able to work due to illness (39.6%). Avoidance was the most common attitude of relatives towards patients in both regions (51.2% rural, 41.4% urban).

### Table 3: Consequences of the stigma and discrimination

<table>
<thead>
<tr>
<th>Variable</th>
<th>Rural N (%)</th>
<th>Urban N (%)</th>
<th>Chi square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoid disclosing the mental illness histories in jobs/application</td>
<td>03 (7.69%)</td>
<td>21 (18.92%)</td>
<td>X²=2.71, df=1, p =0.010</td>
</tr>
<tr>
<td>Social exploitation</td>
<td>25 (64.10%)</td>
<td>40 (36.04%)</td>
<td>X²=9.26, df=1, p=0.002</td>
</tr>
<tr>
<td>Not fully accepted in the family</td>
<td>29 (74.36%)</td>
<td>61 (54.95%)</td>
<td>X²=4.53, DF=1, p=0.03</td>
</tr>
<tr>
<td>Pushed into unacceptable social situation</td>
<td>11 (28.2%)</td>
<td>15 (13.5%)</td>
<td>X²=4.35, DF=1, p=0.04</td>
</tr>
<tr>
<td>Sexual harassment</td>
<td>14 (35.9%)</td>
<td>20 (18.0%)</td>
<td>X²=5.26, DF=1, p=0.02</td>
</tr>
<tr>
<td>Living alone</td>
<td>24 (61.5%)</td>
<td>80 (72.1%)</td>
<td>X²=1.5, DF=1, p=0.22</td>
</tr>
</tbody>
</table>

**Friends and relative either stopped visiting at all or visited less frequently in rural patients (43.5%), while 42.3% urban patients reported that friends and relatives stopped visiting at all. In rural area, patients attributed their illness to faulty biological functioning (33.3%) while in urban area patients accepted that they are mentally ill (45.0%). Mental illness was reported as most disabling illness by 71.7% rural and 54.0% urban patients. Forty one percent rural patients while 34.2% urban patients reported that stigma can be partially cured. Involvement in advocacy activities was reported to be an effective strategy to reduce stigma by 64.2% rural and 55.8% urban patients. Most of the patients (94.8% rural and 77.4% urban) reported that concealing or selective disclosure of the illness is not an effective strategy to reduce stigma. Increasing awareness of the mental illnesses was reported to be an effective way to reduce stigma (69.2% rural, 65.7% urban).**

Common stigmatizing verbatim reported by the patients:

I. Common stigmatizing verbatim reported by rural patients:

- "In the society, nobody enquires about me. Nobody loves me. Nobody even looks at me. They call me ‘mad,’ and laugh at me. They don’t even invite me at their home on festivals. Due to my illness, my marriage is not getting fixed.”
- "In my village when houses were repaired, everybody got the letter but they didn’t provide the same for me. Nobody wants to come and meet me. Today I have a broken house to stay pending repair work. I asked for help from my friends and relatives but nobody comes forward. Every time during rain, water comes into my house and I am not able to work due to illness (39.6%). Avoidance was the most common attitude of relatives towards patients in both regions (51.2% rural, 41.4% urban)."

II. Common stigmatizing verbatim reported by urban patients:

- "When I fell ill, everyone in my house kept nagging me all day. They didn’t give me food. They used to beat me and threw me out of house, when I went to my mother’s place, there also people used to nag me. In the beginning, my husband was cooperative, but now he doesn’t talk to me much and does not maintain sexual relationship with me.”
- "Neighbors don’t talk to me. When I go to collect water in the morning, they keep on pushing me, they throw my vessels away. They abuse me and also hit me. My house owner keeps on telling me and my family members to vacant the house.”

**Consequences of Stigma**

I. Experiences related to personal area:

- "I was bright in study prior to the illness, but I quit my study as I failed in 10th. My memory power went down. My writing is also getting bad. I can’t work at my home as I get tremor at my hand. I am unmarried yet, few relative come for my younger sister but when they knew about my illness, they went away.”

II. Experiences related to Occupational area:

- "At my work place, people call me “mad”. My boss gets angry on me every day and says that my head is empty. He always says me that they will sack me. At lunch hour I am not allowed to have lunch while everybody else is going for lunch. I get half the salary others get.”

III. Experiences of stigma and discrimination in Social life:

- "I have one house with 2 BHK in Ahmedabad. When some relatives come to the city, though they stay at my house but nobody of them takes lunch or drinks water at my house. They stay only up to next morning and leave afterwards. Neighbors don’t talk to me. They said me that I am mad. They give me work always without giving me any money, and upon asking, they refuse for the money.”

- "Before illness, I was living in rented house. I was an inspector in IT department. People used to meet me and respect me, but when owner of the house knew about my illness, he asked me to vacate his house. Today I am living in small house alone. People avoid me.”

IV. Experiences related to marital life:

- "Because of illness I am not able to work in my land. My land remains uncultivated. My desire for sex has come to an end. My penis is not erection anymore. Due to this, my wife left me and went to her parents place. Today she has got married to another person.”

- "I was married in great pomp. My mental illness started at my in laws place. Initially they used to beat me a lot, they took me to a faith healer, after that they left me to my mother’s place. My mother tried for many attempts one after another for my marriage. Every time, as my wife knew about my illness, she divorced me.”

V. Experiences of stigma and discrimination in Family:

- "I had to hide my illness because mine and my sister’s marriage were at stake. I got married in far Village, but when knew about my illness, they sent back me to my maternal home. I was pregnant at that time. After delivery, they called me back but when I was breast feeding my baby, my mother in law took my baby away and told, "You are mental and the child will also become mental if you breast feed the baby.”

- "Nobody takes care of me at home even if I am ill and I need medication regarding this. When I told my brother and father about this, so they became angry on me and said you are mad, go wherever you want to, we do not have time for you”

VI. Impact of illness on General Life

a. Hiding of illness:

- "I have to stay in my house all day hiding my illness. Whenever I come at the window, my mother gets angry on me and directs me to go inside. She tells me that if people will know about my illness then nobody will marry me and my sister.”

b. Decrease in Work efficiency and cognitive function:

- "Welding was my profession earlier but today I cannot concentrate on my work properly. I have been injured also because of this.”

c. Visiting of Friends and Relative:

- "Since the starting of my illness, people are scared of me and they don’t come near me. I had to live alone at home.”

d. People’s reaction after knowing their illness:
- “If any one comes from my family, they talk only one thing, to take medicine but nobody talks to me more than this. I have to live alone.”

   e. Most Disabling Illness:
   - “Mental health problems should not occur. It becomes difficult to work. I am feeling better till I take medicine but my memory is decreasing. Nothing is remembered. I have to take pills to sleep in night.”

**DISCUSSION**

The present study was aimed to study stigma and discrimination perceived by patients with schizophrenia and, its comparison between rural and urban patients. Majority of the patients were male, Hindu by religion, of age range 21-30 years, married, educated up to class 10th, living in a joint family, unemployed, having income under 1000 rupees per month. Findings of present study revealed that patients from rural background had more often stigmatizing and discriminating experiences compared to patients from urban background.

In our study, 62% patients were unemployed. Due to unemployment and chronic nature of illness, patients are not able to do their work as efficient as of their same age group in the society, which becomes the main culprit associated to creation of stigma. Stigmatization in the workplace and the related denial of access to job are the most important experiences of social exclusion. These experiences are recognized as the main factors producing and maintaining a high rate of unemployment among those with schizophrenia.

In our study too, 21 (18.9%) urban and 3 (7.6%) rural patients reported avoiding disclosure of mental illness histories in job/applications.

In the present study, patients from rural background more often reported these experiences: society treats differently (p=0.09), ridiculing by others (p=0.11), offensive comments (p=0.02), hiding from relatives (p=0.09), Jadhav S et al also reported that rural Indians show significantly higher stigma scores.[14] Similar to our study an Indian study by Loganathan S et al reported that rural respondents experience more ridicule, shame, and discrimination but they reported that urban respondents feel the need to hide their illness. [15] Fear of rejection may be a need to hide their illness from others particularly in rural areas. In our study, more urban patients reported difficulty in getting married compared to rural patients (p=0.1). Weiss et al[16] studying psychiatric stigma across cultures, pointed out that “in Bangalore the main concerns the sample had, were related to lowering their own chance of entering a good marriage and decreasing the chance of one of their relatives”. Disclosing the diagnosis of schizophrenia becomes stigmatizing due to fear of being ridiculed, discriminated, leading to loss of job or not being able to get a job, and difficulty in getting married for the patient as well as family members. So, family members handle with it by hiding the diagnosis or not disclosing the presence of illness.

In our study, more rural patients reported social exploitation (p=0.002), not fully accepted in the family (p=0.03), pushed into unacceptable social situation (p=0.04), and sexual harassment (p=0.02) as a consequence of stigma and discrimination compared to urban patients. Jadhav et al also found that rural Indians showed a more stigmatizing attitude towards severe mental illness. Their study also showed greater stigma and a punitive attitude amongst rural Indians as compared to urban Indians.

In our study, rural patients reported attribution of supernatural cause as the most common source of stigma. Studies support this finding that in rural areas, the frequent association of mental illness with malevolent spiritual forces induces many families with a member with mental illness to seek help from shamans.[17,18] In rural areas, lack of adequate education regarding mental illnesses leads to such beliefs. Jadhav et al also concluded that urban Indians have a more liberal and tolerant attitude but were also more excluding of those with mental illness at work.[14] In our study too, not being able to work due to illness was the most common reported source of stigma in urban patients (39.6%).

In our study, rural patients reported rejecting attitude of peoples around while urban patients reported nagging and uncooperative attitude of the family members and society. Stigma led to painful experiences related to patient’s personal and occupational area, social life, marital and family life. Fact of hiding the diagnosis of schizophrenia was also reported by the patients. Resulted decrease in cognitive functioning and impaired work efficiency also was reported by the subjects. The extent of the discrimination due to the illness resulted in stopped or less frequent visiting of the friends and relatives to the patients. The people around made either limited or no communication with the patients. Patients reported schizophrenia as the most disabling illness of all the illnesses.

Lack of correct knowledge is the variable associated with more stigma responses. Setting up programs directed towards modifying the attitudes of employers, as well as greater attention to the employment-related training of social workers could constitute useful instruments to improve labor market access for people with schizophrenia. These programs should help convincing employers that people with schizophrenia are highly motivated and can provide important contributions. At the same time, people with schizophrenia might need specific support in re-entering the labor market, such as Individual Placement and Support (ISP) Programs[19, 20]. Better integration in the labor market has been shown to improve clinical outcome[21-23] and reduce the risk of hospitalization.[24]

Stigma and negative public attitudes for a patient with schizophrenia is widely prevalent both in rural as well as urban areas. Therefore, while patients continue to consider stigma as a central obstacle to their integration into the community, they themselves contribute to this process by accepting public stereotypes as applicable to themselves. As a result, majority of them don’t confront negative reaction, and lose self-esteem, isolate themselves and get worse. Our data from patient verbatim also highlighted that patient focus on the stigmatization experiences and on their ideas of the cause of stigma; while hardly offering any suggestions for anti-stigma intervention. Suggestion of participant mainly concerned the improvement of information on mental health issues among the public (66.7%). Participant did not seem to envisage many opportunities for positive change and found it difficult to formulate specific proposal on what could be done to improve their situation. Sorting out this difficulty might help reducing perceived stigma, discrimination and their consequences. Spending more time with a patient, may reduce stigmatizing and discriminating attitude presumably through the mechanism of exposure induced reduction of negative stereotype about the mental illness. Alexander & Link concluded that increasing personal contact with psychiatric patient could reduce people’s stigmatizing
attitudes.\textsuperscript{25} Couture & Penn also concluded that both retrospective and prospective contact tends to reduce stigmatizing views of persons with a mental illness.\textsuperscript{26} Our findings suggest that people with schizophrenia are not fully accepted in the family, especially in rural areas. This suggests that certain factors could be more powerful than negative stereotypes in interpersonal stigmatization which can be overcome by provision of the scientific knowledge of the mental illnesses and re-integration of the patient in the community through psychosocial approaches.

Similar to our findings, Chinese families too, frequently concealed the mental illness of their members.\textsuperscript{27} Family members act as both stigmatizer as well as victim of stigmatization themselves.\textsuperscript{28} Because of this paradoxical role dualism, family members might project their anger towards a patient for causing them added suffering. This negative affective state, we suspect, could heighten the chronic burden of care. Providing adequate non-pharmacological measures may help family members in such circumstances of negative affective state. Provision of psychiatric care must move beyond symptoms control to diminish intentional as well as subtle forms of stigmatization in the patients’ social life. Effective anti-stigma intervention should target on improving attitudes and the condition for social integration in the community, empowering people with schizophrenia to challenge self-stigmatization and discrimination behavior towards them. Regarding the work-related stigma, we believe that a combination of corporate education programme, legal measures and advocacy efforts are needed.

CONCLUSION

Stigma experience is pervasive: it deeply affects the social, occupational and emotional wellbeing of patients with schizophrenia and should be included in clinical management. Higher level of stigma is related to low education level, unemployment status. The provision of accurate information through trusted community sources and open dialogue may help to dispel myths, correct faulty assumption and increase the involvement of participation of community in dragging out the root source of stigma. Family programmes should be started early in an attempt to reduce stigma from significant others and to transform the family into a long recourse for psychiatric rehabilitation. Effective anti-stigma intervention should address chiefly two targets: improving attitudes and condition for social integration in the community and; empowering patients with schizophrenia to challenge self-stigmatization and discriminatory behavior towards them.

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REFERENCES