I|J|S|P

International Journal of
Social Psychiatry
2015, Vol. 61(2) 111–120

DOI: 10.1177/0020764014537234
isp.sagepub.com
SAGE

Suggested avenues to reduce the stigma of mental illness in the Middle East

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Abstract

Background: Stigma toward mentally ill individuals acts as a barrier to accessing care and receiving treatment.

Aim: To review current evidence pertaining to stigma toward mental illness in the Middle East in order to inform effective and sustainable interventions in this region.

Methods: We conducted a systematic literature search using the PubMed database and evaluated all identified studies according to specific inclusion criteria.

Results: Stigma toward individuals with mental illness does exist in the Middle East. Stigmatizing attitudes are particularly high toward culturally proscribed mental illnesses like alcohol abuse and lower for other disorders such as depression and psychosis.

Conclusions: We propose the following initiatives to reduce stigma toward mental illness in the Middle East: (a) educate families to enable them to support their affected relatives, (b) increase cooperation between psychiatrists and faith healers and (c) educate young people in schools to increase their awareness and understanding of mental illnesses and to combat negative stereotypes.

Keywords

Stigma, mental illness, interventions, Middle East, education

Introduction

Although it has been almost 50 years since Erving Goffman's (1963) groundbreaking book defining stigma, inspiring researchers to study this social problem and devise interventions to overcome it, stigma persists in the community. Goffman (1963) defined stigma as 'the process by which the reaction of others spoils normal identity'. These reactions come from prejudgment of a person based on limited information. Stigma results in labeling, prejudice, stereotyping, separation, status loss and negative discrimination (Link & Phelan, 2001). It thus prevents many individuals with mental illness from obtaining treatment. Shame and low self-esteem in individuals with mental illness are common by-products of stigma. Societal stigmatization of the mentally ill can be internalized and thus perpetuate exclusion, threaten quality of life, disrupt social relationships and decrease the likelihood that persons with mental illness seek mental health services or obtain employment. Stigma is, therefore, considered a barrier to recovery from mental illness, even for individuals who receive treatment.

We review the available literature on stigma related to mental illness in the Middle East. First, we discuss mental health services in this region and note how they have changed over time. Next, we present an overview on the stigma related to mental illness and explain how it significantly hinders access to mental health services. Finally, we present our literature review and discuss our findings.

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Background

The Middle East region

The Middle East region is defined as 'the countries of southwest Asia and North Africa'. We chose this area because of the relative homogeneity of the populations based on religion and culture. Almost 90% of people in this region are Muslims. Islam is considered not only a religion but also a way of life and the most important cultural factor affecting people's attitudes in this region. The practice of Islam has given people in the Middle East region a common identity in many spiritual beliefs and aspects of day-to-day living (Mohit, 2001). The other religions commonly practiced in this region are Christianity and Judaism, which share roots with Islam; all three religions possess more similarities than differences at their core (Pridmore & Pasha, 2004).

Historical overview of mental health services in the Middle East

The Middle East has an illustrious history in the field of mental health services; the first psychiatric hospitals in the world were built in Baghdad in 705 CE, in Cairo in 800 CE and Damascus in 1270 CE (Murad & Gordon, 2002). There are records of esteemed Muslim physicians like al-Razi (d. 925), who wrote a 24-volume encyclopedia of medicine and treated psychiatric patients (Pridmore & Pasha, 2004). IbnSina (Avicenna; d. 1037), another early Muslim scholar in psychiatric health care, wrote 'The Canon of Medicine', a 14-volume tome used in the west for more than 700 years (Pridmore & Pasha, 2004). On the other hand, popular beliefs in Middle Eastern cultures have traditionally viewed mental illness as a punishment from God, the result of possession by evil spirits (Jinn), the effects of the 'evil eye' or the effects of evil in objects that are transferred into the individual. Scholars like IbnSina did not agree with these supernatural explanations (Pridmore & Pasha, 2004). The Qalaoon Hospital, established in Cairo during the 14th century, was reputed for a mental illness ward that could care for 8,000 patients. The patients with mental illness were rarely isolated from those with other diseases. The Qalaoon Hospital also had a dispensary and research facility that led to advances in knowledge about mental illnesses (Okasha, 2005).

Current mental health services in the Middle East

Despite the historic importance that the Middle Eastern region had in the care and understanding of mentally ill individuals, the human resources and attention given to mental health issues in the 21st century are insufficient. Although improvements have occurred in mental health services in the Middle East in the past decade, there are still many countries in which health services for this population are below accepted standards. Indeed, only three countries have provided estimates of mental health expenditure as a percentage of total health expenditure: Palestine (2.5%), Qatar (1%) and Egypt (less than 1%) (Okasha, Karam, & Okasha, 2012). The psychiatrist/ population ratio is another indicator of the status of mental health services; the highest proportions of psychiatrists are reported in Qatar, Bahrain and Kuwait. Iraq, Libya, Morocco, Sudan, Syria and Yemen have fewer than 0.5 psychiatrists per 100,000 persons. The number of psychiatric nurses ranges from 23 per 100,000 population in Bahrain; 22.5/100,000 in the Gulf Emirates; 0.09/100,000 in Yemen and reported as 0.03/100,000 in Somalia (Okasha et al., 2012). However, there is some indication of a progressive increase in the number of nurses, as well as social workers, with the most substantial increases reported from Bahrain, Emirates, Jordan, Egypt, Kuwait, Libya, Saudi Arabia and Yemen (Okasha et al., 2012).

Stigma related to mental illness

Stigmatization of mental illness existed well before psychiatry became a formal discipline, but was not formally labeled and defined as a societal problem until the publication of Goffman's book (1963). Mental illnesses are among the most stigmatizing conditions, regardless of the specific psychiatric diagnosis (Corrigan et al., 2000; Corrigan & Penn, 1999; Tringo, 1970; Weiner, Perry, & Magnusson, 1988). Unlike other illnesses, mental illness is still considered by some to be a sign of weakness, as well as a source of shame and disgrace. Many psychiatry patients are concerned about how people will view them if knowledge of their condition becomes public (Rusch, Angermeyer, & Corrigan, 2005).

Stigma is composed of interpersonal or public stigma and intrapersonal or self-stigma. Public stigma has three major components: stereotypes, prejudice and discrimination (Rusch et al., 2005). Stereotypes are based on knowledge available to members of a group and provide a way to categorize information about other groups in society. Stereotypes quickly generate impressions and expectations about persons belonging to a particular group (Rusch et al., 2005). Prejudiced persons agree with these negative stereotypes, and these attitudes lead to discrimination through negative behaviors toward mentally ill individuals. These negative perceptions create fear of and social distance from mentally ill persons (Corrigan et al., 2001). When individuals endorse these stigmatizing beliefs, they show higher levels of avoidance and refusal to help a person with a psychiatric diagnosis (Corrigan & Matthews, 2003). Although the media can play an important role in improving public understanding of mental illness (Byrne, 1997, 2000), they often misrepresent

mentally ill individuals as dangers to society (Mehta & Farina, 1988; Hyler, Gabbard, & Schneider, 1991; Wahl, 1995). Self-stigma consists of the same components as public stigma, namely, stereotyping, prejudice and discrimination. Stereotyping occurs when a person internalizes the negative attitudes about mental illnesses, which leads to a negative emotional reaction and low self-esteem (Rusch et al., 2005). Most psychiatric patients experience self-stigma (Corrigan, 2005).

Burden due to stigma

Individuals with mental illness have the dual burden of coping with the symptoms of the mental illness, like hallucinations, depression, delusions and anxiety, as well as the societal stigmatization of their illness (Rusch et al., 2005). Stigma acts as a barrier to recovery; epidemiological research suggests that more than half of the people who might benefit from mental health services refuse to access them (Narrow et al., 2000; Regier et al., 1993) so as to avoid being labeled as 'mentally ill' (Kessler et al., 2001). Sense of shame, low self-efficacy and lack of confidence make patients try to avoid stigma by not seeking the required treatment. The negative effects of stigmatizing attitudes toward people with mental illness (PWMI) can influence all life domains: living, learning, working and establishing friendships (Rusch et al., 2005).

The external effects of public stigma refer mainly to discrimination against PWMI in relation to housing, work and social interactions (Hinshaw & Cicchetti, 2000). In a seminal study conducted in California, United States, 52% of respondents stated that they experienced discrimination after they received mental health services, and 41% indicated they were treated differently all or most of the time after their psychiatric diagnosis became known to others (Campbell & Schraiber, 1989). When people with psychiatric disorders are exposed to public stigma, they often suffer from self-stigma, including diminishing self-esteem, self-efficacy and confidence in the future (Corrigan, 1998; Holmes & River, 1998). This self-stigma can have harmful consequences on their quality of life (Graf et al., 2004). A fear of rejection can have serious negative consequences, for example, people who have been hospitalized for a mental illness may act less confidently and more defensively, and be more avoidant with others (Link et al., 2001). Low self-efficacy in PWMI leads to diminished opportunities to pursue work or independent living that might have otherwise had favorable outcomes (Link, 1982, 1987). Although stigmatizing attitudes are not confined to mental illness, the general public seems to disapprove of persons with psychiatric disabilities more so than of persons with physical deformities or non-psychiatric diseases (Piner & Kahle, 1984; Socall & Holtgraves, 1992; Weiner et al., 1988). The impact of stigma extends beyond the individuals with mental illness; it also affects their families, who report feeling ashamed of a relative's mental illness (Corrigan & Miller, 2004).

Measures of stigma

Several scales to measure the existence of stigma in society are available. Some are based on how people consider mental illness and perceive the mentally ill; others measure the attitudes and behavior of the public toward mentally ill individuals. Social distance is the primary measure used to assess a respondent's willingness to interact with a target individual. It was first defined by Robert Park (1924) as 'the grades and degrees of understanding and intimacy which characterize pre-social and social relations generally'. The first Social Distance Scale was initially used for race/ethnicity studies and later applied to mental illness (Cumming & Cumming, 1957). The Semantic Differential Scale, developed by Osgood, Suci, and Tannenbaum (1957), is used to estimate stigma by quantifying stereotyping, which can be defined as the tendency to link the label 'mental illness' with negative attributes. Struening and Cohen (1963) also developed assess opinions about mental illness scale (OMI) in 1960.

Brohan and colleagues classified stigma measures into perceived, experienced and self-stigma measures. Using this classification, several useful scales are available. The most commonly used measures of perceived stigma include the Perceived Discrimination Devaluation (PDD), Self-Stigma of Mental Illness Scale (SSMIS), Inventory of Stigmatizing Experiences (ISE), HIV Stigmatization Scale (HSS), Self-Esteem and Stigma Questionnaire (SESQ), Depression Self-Stigma Scale (DSSS) and Discrimination and Stigma Scale (DISC). Several other scales are commonly used as measures for experienced stigma such as the Internalized Stigma of Mental Illness (ISMI) scale, Stigma subscale of the Consumer Experiences of Stigma Questionnaire (CESQ), Rejection Experiences Scale (RES), DSSS, Self-Reported Rejection Experiences Scale (SRE), the Stigma Scale (SS), ISE, MacArthur Foundation Midlife Development in the United States (MIDUS), DISC and Experiences of Discrimination (EDS). Self-stigma, which pertains to cognitive, affective and behavioral responses to perceived or experienced stigma, has been assessed using measures including: SSMIS, DSSS and ISE (Brohan, Slade, Clement, & Thornicroft, 2010).

In the Middle East region, the Stigma Devaluation Scale (SDS) was translated into Arabic, modified and culturally adapted by a translation model. Estimation of internal consistency was used to assess the reliability of the SDS. Construct validity was determined by confirmatory factor analysis (CFA). Measurements of content validity and reading level of the Arabic SDS were included. The Arabic SDS was evaluated in a sample of 164 family caregivers in Jordan by Dalky Heyam (2012).

Stigma reduction interventions

Strategies to reduce stigma can be implemented at different levels: the intrapersonal, interpersonal, organizational/institutional, community and governmental/structural (Heijnders & Van der Meij, 2006; McLeroy, Bibeau, Steckler, & Glanz, 1988; Richard, Potvin, Kishchuk, Prlic, & Green, 1996). Appendix 1 includes brief descriptions of these strategies and examples of effective interventions after implementing these strategies. In June 2012, we conducted a search using the PubMed database for stigma-related studies conducted in the Middle East region. We initially identified 2,534 peer-reviewed papers using the keywords 'stigma' and 'mental illness'; when the filter 'interventions' was added, the number of citations reduced to 335. When filtered by manuscripts restricted to mental health in English, 154 manuscripts remained. Of these, only six were conducted in the Middle East (Table 1). Five of these studies estimated stigma of mental illness among participants in the Middle East, and one study implemented an intervention designed to decrease stigma among participants.

Studies that estimated stigma of mental illness in the Middle East

In the following sections, we have reviewed in detail publications from the Middle East that gathered and analyzed data related to stigma. Where appropriate, critiques are provided.

In the United Arab Emirates, Eapen and Ghubash (2004) studied factors that influenced parents to seek help for mental health problems by interviewing selected parents (N = 325). The parents acknowledged reluctance to admit initially that a member of their family had a mental illness. Only 38% of those surveyed indicated that they would seek help from mental health specialists if their children appeared to have mental health problems. Stigma attached to using mental health services and skepticism about the usefulness of mental health services were identified as key factors that hindered them from seeking help for their children (Eapen & Ghubash, 2004).

A study from Egypt reported that psychiatric disorders are particularly stigmatized and often met with social rejection (Coker, 2005). Stigma led to social disapproval, devaluation of families with mentally ill individuals and diminished marital prospects. Stigma also increased the 'social distance' between the individuals with mental illness and other individuals. The authors referred to statements by respondents to the effect that a person was 'mad' or 'crazy', harmful to others or had impaired reasoning. Of great concern, many respondents believed that individuals should be blamed or considered to be responsible for their illness. The cure for such illnesses was placed in the social, but not in the personal or biological realm. Respondents considered social support to be a primary treatment, and expressed moral or religious imperatives to help persons with mental illness. This study also reported that stigmatizing attitudes are greater toward disorders such as alcohol abuse, but less for disorders unrelated to substance abuse, such as depression, possession and psychosis. The study reported that 85.5% of the sample (N = 208) would not accept a psychotic person as a schoolteacher, and 56.6% would not accept him or her as a family member (Coker, 2005). Surprisingly, it was reported in other publications that there are no significant gender differences in stigmatization (Al-Krenawi, Graham, & Kandah, 2000; Baasher et al., 1983; Bassiouni & Al-Issa, 1966; Younis, 1978). This issue needs to be investigated systematically as it has substantial implications for strategies to combat stigma.

In Saudi Arabia, Shahrour and Rehmani measured the stigmatizing attitudes of the staff of King Abdulaziz Hospital toward patients with mental illness. Hospital staff had high scores (6.8/9) for caring attitude for patients with psychiatric illness. They had medium scores for fear (4/9), avoidance (4.8/9) and dangerousness (4.3/9). They had low scores (3.1/9) for angry feelings toward these patients. Discriminatory behavior was found to result from feeling that these patients are dangerous, not because they were thought to be responsible for their illness (Shahrour & Rehmani, 2009).

In Oman, Al-Adawi et al. (2002) examined whether social factors influence a person's attitude toward PWMI; they compared attitudes of medical students, relatives of patients and members of the community toward PWMI. Medical students and members of the community thought PWMI tend to have 'peculiar' and 'stereotypical' appearances, and the majority preferred that facilities for psychiatric care be located away from the community. This study suggested that neither socio-demographic factors nor previous exposure to PWMI was related to attitudes toward PWMI. Although the attitudes of Omanis toward PWMI appear to fluctuate in complex ways, traditional beliefs about mental illness have yet to be altered by exposure to a biomedical model of mental illness. This study largely suggests that the extent of stigma varies according to the cultural and sociological backgrounds of each society (Al-Adawi et al., 2002).

Struch et al. (2008) interviewed patients undergoing outpatient psychiatric treatment in Israel. They reported that more than half of service users expected people to refuse to have a person with a mental disorder as a co-worker or neighbor, or to engage in other types of social contact. A substantial proportion acknowledged that they feared or had experienced rejection. A third of respondents reported they feared or had received inappropriate treatment from their physicians. Most respondents preferred to maintain a social distance from persons with mental illness. The experience of stigma and rejection was not

Table 1. Studies of psychiatric stigma in the Middle East.

Study/country	Design	Target population	Intervention/strategy	Outcomes/results
Eapen and Ghubash (2004)/United Arab Emirates	Community-based study	Parents of children having mental health problems (*N* = 325).	Survey using a semi-structured interview schedule.	Only 38% indicated they would seek help from mental health specialists if a psychiatric problem developed in a family member. Reasons: reluctance to acknowledge that a family member has a mental illness, stigma attached to mental health services and skepticism about usefulness of mental health services.
Coker (2005)/ Egypt	A vignette method was used to elicit judgments of social distance and responses to stories depicting psychosis, depression, alcohol abuse and a 'possession state'	Community dwellers from different work settings (*N* = 208).	Trained researchers interviewed the public using eight clinical vignettes to assess beliefs and attitudes about mental illness and treatment.	Participants reported that behavioral disorders are particularly stigmatized and often met with social rejection. They also think that individual blame is diffused as responsibility for the illness and its cure is placed in the social, not personal (biological) realm.
Shahrour and Rehmani (2009)/ Saudi Arabia)	Measuring the stigma of psychiatric illnesses.	Hospital staff of King Abdulaziz Hospital (Jeddah, Saudi Arabia) (*N* = 860).	A cross-sectional study through internal mail was carried out on all the hospital staff.	Hospital staff had high scores (6.8/9) for caring attitudes for patients with psychiatric illness. They had medium scores for fear (4/9), avoidance (4.8/9) and dangerousness (4.3/9). They had low scores (3.1/9) for anger feelings toward these patients.
Al-Adawi et al. (2002)/Oman	Examine if social factors exert an influence on a person's attitude toward PWMI	Medical students, relatives of patients, and community members (*N* = 468).	Measuring and comparing attitudes of medical students, relatives of patients and general public toward (PWMI) through a questionnaire.	Medical students and non-medical persons thought that PWMI tend to have peculiar and stereotypical appearances, and the majority preferred that facilities for psychiatric care should be located away from the community. Although relatives of PWMI were concerned about the welfare of mental patients, their responses varied and were often contingent upon their expectations.
Struch et al. (2008)/Israel	Addressing the existence and effects of stigma	Adults undergoing outpatient psychiatric treatment (*N* = 167)	Interviews with patients.	Over half of services users expect people to refuse to have a person with a mental disorder as a co-worker or neighbor, or to engage in social contact. A sizeable group acknowledged that they feared or had experienced rejection. A third of respondents reported they had inappropriate treatment by their doctor.
Altindag, Yanik, Ucok, Alptekin and Ozcan (2006)/Turkey	Pre- and post-test with control group, quasi-experimental design (1-month follow-up)	Undergraduate college students (*N* = 60)	One-day pilot program: education – 2-hour lecture; causes of stigma associated with schizophrenia, common myths about schizophrenia, relationship and violence. Direct contact with a person with schizophrenia, indirect contact (watching a film 'A Beautiful Mind').	Post-intervention: participants had more knowledge about causes of schizophrenia and had lower social distance score. Post-intervention: participants had higher scores of social distance.

PWMI: people with mental illness.

confined to those who had been hospitalized. Simply receiving mental health care sufficed to elicit stigma, or the service users themselves felt stigmatized. Consumers of mental health services use a variety of coping mechanisms, like education, withdrawal and secrecy to help reduce stigma (Struch et al., 2008).

Interventions to reduce stigma of mental illness in the Middle East

To our knowledge, the only evidence-based stigma reduction program undertaken in the Middle East region was implemented in Turkey (Altindag, Yanik, Ucok, Alptekin, & Ozkan, 2006). The educational stigma reduction intervention targeted undergraduate medical students. This intervention included a 2-hour lecture about the causes of schizophrenia, screening of a film that depicts an individual with schizophrenia and contact with a person with schizophrenia. Increased knowledge was associated with lower social distance scores between the undergraduate students and individuals with schizophrenia; favorable attitudinal changes were observed in terms of 'beliefs about the etiology of schizophrenia, social distance to people with schizophrenia, and care and management of people with schizophrenia'. Changes in attitudes tended to decrease at the 1-month follow-up point (Altindag et al., 2006).

Discussion and recommendations

Although some have suggested that mental illness does not elicit as much stigma in the Arab world as in other societies (Dols, 1992; Fabrega, 1991), the reports reviewed here suggest that stigma toward PWMI does exist to a substantial extent in the Middle East. Since many of these reports were published over a decade ago, they do not necessarily reflect recent changes in public attitudes. There is generally greater awareness of psychiatric illnesses now, thanks partly to the initiative of psychiatrists spreading awareness of this issue in the media such as local efforts in Lebanon and Egypt, for example, https://www.youtube.com/watch?v=9CXJXdgNax8. Nevertheless, stigma about psychiatric illness likely persists in the Middle East even today, as it does in other parts of the world. This societal stigma influences the treatment of individuals who need mental health care. Some mentally ill individuals can 'somatize' their psychological symptoms and go to non-psychiatric health-care providers before they reach the psychiatric clinics or hospitals (Okasha & Karam, 1998). Goldberg and Huxley (1992) reported that almost two-thirds of patients with psychiatric symptoms first sought a general practitioner and only about half were diagnosed with a psychiatric disorder. This route coincides with a growing movement elsewhere in the world to use the 'medical model' for psychiatric illnesses and to seek evidence for biological bases for mental illness to lessen stigma. Other persons with mental illnesses attempt to avoid stigmatization by seeking traditional or faith healers (Okasha & Karam, 1998). For example, in the United Arab Emirates, approximately half (44.8%) of patients suffering from psychiatric disorders sought non-professional care before attending specialized services (Salem, Saleh, Yousef, & Sabri, 2009). This pattern of health seeking behavior may be influenced by cultural beliefs regarding the role that demonic possession, sorcery and the evil eye play in provoking symptoms of mental illness. Motivated by these beliefs, many seek help initially from traditional healers. In most Middle Eastern countries, there is no interaction between medical professionals and traditional healers (Okasha et al., 2012).

Routes to stigma reduction have been investigated extensively in Western countries, and several solutions have been developed and tested (see Appendix 1). Before they can be recommended in Middle Eastern countries, however, it is important to consider cultural differences between countries in this region and Western countries. It is also important to note that Middle Eastern countries differ from each other in several socio-cultural dimensions, so uniform solutions may not succeed. On the other hand, the majority of individuals in this region belong to the Muslim faith, so consideration of the relevant religious teachings is important. Although it makes no specific statements about the treatment of mental illnesses, the Q'uran states, 'There is no blame on the blind, nor is there blame on the lame, nor is there blame on the sick' (Al-Fath 48:17). This humane attitude is contradicted by some scholars, who suggest that Islam views mental illness as a condition resulting from an unbalanced lifestyle (diet, sleeping pattern, spiritual activities and remembrance of god) (Rahman, 1998). According to other scholars, traditional Middle Eastern culture is not accepting of mental illness; moreover, the traditionally strong family relationships in the Middle East and Arab culture mean that admission of a family member to a psychiatric hospital produces a stigmatizing label not only for the patient but for all members of his or her family (Okasha et al., 2012).

Keeping these concerns in mind, we propose several interventions that could reduce the stigma related to mental illness. Appropriate metrics to investigate the impact of each intervention are also needed.

1. *Educate families to support their affected members in overcoming shame and seeking treatment*. The majority of Egyptian respondents in one survey believed that social support would be the most effective treatment for the disorders mentioned in the vignettes (Coker, 2005). Social support was seen not only as the responsibility of the family, but also of friends, neighbors and the entire community in this survey. Social support can be achieved by building qualified teams in psychiatric hospitals

who can begin to educate families as soon as a family member is admitted to the hospital. Following discharge of the patient from the inpatient unit, the teams should engage in outreach.

2. *Engage traditional healers.* Traditional (faith) healers are often the first line of intervention for mental health symptoms, yet, there is little interaction between medical professionals and traditional healers (Okasha et al., 2012). Cooperation between psychiatrists and faith (religious) healers can be effective in reducing the stigma by enabling healers to encourage patients to seek help from mental health specialists. On the other hand, there is likely to be concern among psychiatrists about erroneous beliefs held by traditional healers that could reinforce stigma.
3. *Engage religious leaders.* Religious leaders could be engaged by marshaling religious teachings that admonish individuals from discriminating against mentally ill persons. If religious leaders in the community 'adopt' particular patients, they can use their leadership to reduce the social distance between the community and the mentally ill patients. Furthermore, the leaders could also direct individuals with mental health problems to seek treatment from mental health facilities.
4. *Educate young persons.* Education, particularly for young people, will help to increase awareness about the nature of mental illnesses. We also recommend that the curricula in high schools, medical, nursing and ancillary mental health training facilities address the issue of stigma related to the mental illness. Some studies have indicated that even mental health professionals do not differ statistically from members of communities in their stigmatizing attitudes toward mental illness (Nordt, Rössler, & Lauber, 2006). Thus, exposing mental health professionals before they start their professional careers could equip them better to deal with this phenomenon.
5. *Use social media.* Social media such as Facebook, Twitter and YouTube are increasingly used by individuals of all ages, particularly youth in the Middle East. Indeed, such media are credited with many of the tumultuous political changes termed the 'Arab Spring'. These powerful resources should be harnessed for spreading information and combating disinformation. In this context, adaptation of informative web sites to local cultural norms would be valuable (e.g. http://www.openthedoors.com).

While the stigma associated with mental illness seems to be relatively widely acknowledged in the Middle East, few culturally appropriate interventions aimed at stigma reduction have been developed, optimized and tested in that region. We hope the short review of the literature and suggested approaches outlined here inspire readers to address this gap in our knowledge about a key factor associated with the effective treatment of individuals with psychiatric illnesses in the Middle Eastern Region.

Funding

This study was funded in part by grants from the NIH (D43 TW008302, TW 009114, R01 MH093246) and the Stanley Medical Research Institute (07R-1712).

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Appendix 1. Strategies and interventions to reduce stigma.

Level	Strategy	Description
Intrapersonal	*Treatment*	Getting the required complete course of treatment from a psychiatric facility is likely to improve symptomology and self-esteem in many persons with psychiatric diagnoses. As the availability of mental health services is inadequate in the Middle East, the first step to improving mental health treatment is increasing the quality and quantity of mental health services (Okasha, Karam, & Okasha, 2012).
	Counseling	Prior (2012) used counseling with young people as a way to improve help seeking in adolescents who suffer from mental illness.
	Cognitive behavioral therapy (CBT)	CBT is a structured approach in which patients are trained to identify and modify negative beliefs and negative interpretations (Corrigan & Calabrese, 2004). Elements of this approach include education regarding symptoms and stress management strategies. Hall and Tarrier (2003) tested the CBT with schizophrenia patients and noted increased self-esteem and improved social functioning.
	Empowerment, self-help, advocacy and support groups	Empowering people to regain their self-esteem is an important part of fighting the negative impact of stigma (Harrow & Jobe, 2007). Support groups can improve participants' identity and self-esteem (Ablon, 2002; Benbow & Tamiru, 2001). Demissie, Getahun and Lindtjørn (2003) studied the effect of support groups on TB stigma and found that their program had positive effects on the attitudes of patients, health workers and community members (Demissie et al., 2003; Lyon & Woodward, 2003).
Interpersonal	Care and support	It is important to educate caretakers of persons with mental illness about diseases, for example, HIV (Heijnders & Van der Meij, 2006; Nyblade et al., 2003).
	Home care teams	For patients with HIV, home care teams regularly visited patients in their homes and educated family members about the disease. These interventions resulted in a more tolerant attitude toward HIV/AIDS patients (Busza, 2001; Gewirtz & Gossart-Walker, 2000; Muyinda, Seeley, Pickering, & Barton, 1997).
	Community-based rehabilitation (CBR)	CBR is a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities (Heijnders & Van der Meij, 2006).
Organizational/ institutional	Training programs	Training health professionals, including psychiatric health-care staff and nursing staff may help reduce stigma. Stigma reduction programs that focus on professionals' attitudes and knowledge should be a structural part of care and rehabilitation programs (Altindag, Yanik, Ucok, Alptekin, & Ozkan, 2006; Corrigan & Matthews, 2003; Gray, 2002).
	Patient-centered and integrated approaches	Movements focused on self-advocacy and patients' rights may be another important factor for improving the lives of psychiatric patients and reducing stigma (Pandya, 2012).
Community	Education	Different forms of educational materials have been used to convey information about the causes, symptoms and treatment of mental illness to different target groups, for example, police officers in England (Pinfold et al., 2003), industrial workers and government employees (Tanaka, Ogawa, Inadomi, Kikuchi, & Ohta, 2003) and high school students (Esters, Cooker, & Ittenbach, 1998).
	Personal contact	Personal contact with people who have a mental illness can help reduce stigmatizing attitudes (Alexander & Link, 2003; Angermeyer et al., 2004; Dovidio & Gaertner, 1996). Contact showed positive results when combined with education; an Austrian study compared education without contact with a combination of both education and contact. A positive change of participants' attitudes was observed when contact and education were combined in the same intervention (Meise et al., 2000). After contact, a person's natural stereotype of a minority group may be replaced by another, more positive image of the group (Rothbart & John, 1985).
	Protest	Protest aims to suppress stigmatizing attitudes toward mentally ill patients and can generate short-term effects on attitude change (Corrigan & Penn, 1999). The National Alliance for Mentally Ill (NAMI) has an email alert system that notifies members about stigmatizing representations of affected persons in the media and provides instructions on how to contact the offending organization and its sponsors (Corrigan et al., 2005). Protest can be useful in stopping the media networks running stigmatizing programs and advertisements.
Government	Legal and policy interventions	Smith (2002) proposes a rights-based approach that counters stigma and discrimination by monitoring and enforcing equal access to health care, housing, employment and justice.