

Affiliate Stigma and Compassion Satisfaction Amongst Mental Health Service Providers at A Regional Psychiatric Hospital in Nigeria

Omoaregba Joyce^{1,*}, Uteh Blessing²

¹ Consultant Psychiatrist at Federal Neuropsychiatric Hospital Uselu, PMB 1108, Benin City, Nigeria.

² Department Medicine, University of Medical Sciences, Ondo, Ondo state Nigeria.

Abstract

Objective: Just like their patients, mental health service providers also face stigma. Internalisation of these negative stereotypes could lead to the development of affiliate stigma, reduce their compassion satisfaction and reduce their effectiveness in delivering quality health care to their patients. This study investigated the relationships between affiliate stigma and compassion satisfaction in frontline mental health service providers in a mental health facility in Nigeria.

Method: This was a cross-sectional study which recruited 183 mental health service providers working in a mental health facility in Nigeria, and who completed questionnaires on affiliate stigma and compassion satisfaction.

Results: Affiliate stigma among mental health service providers in this study was relatively high (41.5%), and psychiatrists were significantly more likely to report higher levels of affiliate stigma compared to the psychiatric nurses ($p=0.03$, $OR=0.38$, $95\% CI=0.15 - 0.94$). Psychiatrists and Psychiatric nurses who worked for longer hours (> 42 hours per week) reported significantly lower Affiliate stigma ($t=2.148$, $df=28$, $p=0.04$; $t=2.118$, $df=135$, $p=0.04$ respectively). Psychiatrists with high levels of affiliate stigma were more likely to have lower compassion satisfaction, but this was not true of Psychiatric nurses. Mental health service providers who endorse the psychosocial aetiology of mental illness, are significantly more likely to report having experienced high affiliate stigma ($F=3.980$, $df=2$, $p=0.03$).

Conclusion: The levels of affiliate stigma among mental health service providers in this study was relatively high, particularly among the professional group of psychiatrists. There is an urgent need to address internalization of negative stereotypes among mental health service providers in order to prevent experiences of discrimination among their patients.

Corresponding author: Omoaregba JO, Federal Neuropsychiatric hospital, Uselu, Benin City, Nigeria, Tel- +2348023345948, Email: jomoaregba@yahoo.com

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Introduction

Stigma has been described by the World Health Organisation as the most important single barrier to the effective delivery of mental health care in the community.¹ Stigma has been classified as public stigma –experienced as stigma from direct interpersonal interactions², structural stigma or structural discrimination -expressed as institutional stigma^{3,4} and internalised stigma or self-stigma. Previous studies have reported that public stigma may be directed at those people who are in close association with the stigmatised individuals (such as family, caregivers, friends and service providers). Public stigma arising from being closely associated with stigmatised individuals is referred to as courtesy stigma⁵, or associative stigma.⁶ Mak & Cheung⁷ coined the term affiliate stigma to delineate the self-stigma developed by the close associates of stigmatised individuals

Mental health service providers are supposed to provide de-stigmatizing care, yet face stigma because mental health is stigmatized more broadly. Mental health service providers are well aware of the various negative stereotypes about mental illness and themselves held by the public, other health professionals and spread by the print/electronic media in films and advertising.^{8,9} Popular public (including the media) negative stereotypes of mental health service providers include the perception that they are, queer, abnormal, corrupt, evil, hostile towards their patients.¹⁰ Other medical doctors and medical students perceives them as being somewhat different and more neurotic than other health professionals,^{11,12} ascribe them low status,¹³ and sometimes say 'psychiatrists must be crazy because they are able to deal with crazy people'.¹⁴

These predominantly negative images of mental health service providers could be experienced as directly discriminating and hurtful. Internalization of hurtful and discriminating experiences could lead to experiences of social isolation and disturbed social identity.⁷ This eventually leads to reduced self-esteem and self-efficacy.¹⁵

Mental health service providers may attempt to reduce their affiliate stigma by avoiding mentally ill individuals or even discriminating against them.

Stigmatizing attitudes of mental health professionals could therefore have a negative influence on the delivery of effective mental health services to the people with mental disorders. It has been observed that Services that are perceived as more stigmatizing have higher drop out and default rate.¹⁶ Furthermore, these services could affect mental health professionals' satisfaction with working in a caring profession and reduce their effectiveness in delivering quality health care to their patients.

Compassion satisfaction is a positive and rewarding aspect of caring for others and may be experienced by health care professionals and other caregivers.¹⁷ Pearlman & Caringi¹⁸ had stated that participating in the helping work could be vicariously transforming and this is reflected in the sense of happiness or pleasure that sometimes comes with working as a carer or that carers receives from their work. Caregiving was found to be related to personal growth and maturity and better tolerance, strengthened social ties and expanded social network among the caregivers of children and adults with mental illness and intellectual disabilities.^{19,20} Martins & colleagues²¹ in their study in the USA have shown that higher stigma is a significant predictor of lower compassion satisfaction and that stigma reduction efforts is required to strengthen human resources in health care services.

Most researches about stigma and mental illness had focused on investigating the attitudes of the stigmatising majority and only a minority of these studies have tried investigating self-stigma amongst the stigmatised minority group.²² The aspect of self-stigma amongst close relatives, friends and service providers of these mentally ill individuals have been largely neglected. Mak & Cheung⁷ had assessed affiliate stigma among Chinese caregivers of individuals with mental illness and intellectual disability. Mak & Kwok²³ assessed for internalised stigma in Chinese parents of children with autism spectrum disorder in Hong Kong, while a study in Pakistan²⁴, investigated the effects of affiliate stigma on social identity and social isolation among family caregivers of psychiatric patients. A Belgian study²⁵ had also studied associative stigma amongst mental health professionals working in the Flanders region of Belgium using non-standardized measure of

associative stigma. However, to our knowledge, no study has directly investigated affiliate stigma among mental health service providers in Nigeria. There is a need to ascertain the affiliate stigma and compassion satisfaction in this group of health service providers.

Methodology

This study aimed to assess the levels of affiliate stigma amongst mental health service providers at the Federal Neuropsychiatric Hospital Uselu, Benin City and to ascertain its relationship (if any) with their compassion satisfaction. We attempted to answer the following research questions;

- To what extent do mental health service providers in the study centre experience affiliate stigma and do the various subgroups of professional differ in their experiences of affiliate stigma?
- What is the relationship between compassion satisfaction, aetiological attributions of mental illness and duration of work hours with the affiliate stigma experienced by the mental health service providers.

Settings

The study was carried out at the Federal Neuropsychiatric Hospital Uselu, Benin City, Edo State in the South-South Region of Nigeria. The hospital is a 260-bed stand-alone Psychiatric facility which provides inpatient, outpatient and a 24-hour emergency service to walk-in and referral cases from the state and four other neighbouring states.

Study Design

The study design was cross-sectional. The outcome variable (measure) is affiliate stigma. The independent variables consist of compassion satisfaction, the socio-demographic profile, subgroup of mental health service providers, working hours.

Ethical Considerations

Ethical approval for the study was sought for and obtained from the Research and Ethics committee of the hospital and permission duly obtained. The nature and purpose of the study was explained to the mental health service providers before a signed written informed consent was obtained from them. They were reassured of confidentiality and anonymity of the data to be collected from them. Only those who gave a written

consent to the research and met the inclusion criteria were recruited.

Study Population

All the mental health service providers in the hospital, whose names appear in the hospital's nominal roll, who had worked for at least 6 months in the hospital and who consented, were recruited for the study. These included psychiatrists (including trainee-psychiatrist), psychiatric nurses, clinical psychologists, social workers, occupational therapists and pharmacists.

Inclusion/Exclusion Criteria

Mental health service providers working at the Federal Neuropsychiatric Hospital, Uselu, Benin-City for up to six months, and who consented were included in the study. Excluded from the study were mental health service providers working in the hospital who declined to consent and those who were on special training or on leave as at the time of data collection.

Study Measures

The Study Questionnaire was Divided into Three Sections

Section A

is a semi-structured socio-demographic questionnaire designed by the researchers to capture relevant variables including gender, age, religious affiliation, level of education and occupation. Other variables including average working hours and duration of employment were also captured in the questionnaire. There was also an open-ended question which elicited the views of the mental health professionals concerning their beliefs of aetiology of mental illness. These aetiological attributions were later subdivided according to themes such as biological causes (e.g. genetics, chemical imbalance and physical illnesses), psychosocial cause (e.g. stress, nervous breakdown, bad character, poor upbringing), and spiritual causes (e.g. crises of faith, offending the gods, 'spiritual attack' etc.)

Section B

The affiliate stigma questionnaire - developed in 2008 by Mak & Cheung as a 22-item scale to measure internalization of stigma by caregivers of mentally ill individuals and those with disability. This followed their

review of associative stigma and focus group discussion.

This scale measures various aspects of affiliate stigma such as cognitive component e.g. 'as one of my family members is a person with mental illness, I feel that I am inferior to others'; affective component e.g. 'I feel sad to have a family member with mental illness'; and behavioural component e.g. 'I dare not tell others that there is someone with mental illness in my family'. Mental health service providers in this study rated the degree of their endorsement of the statements on the scale on a 4- point Likert scale which ranges from 1= strongly disagree ,to 4= strongly agree. This generated a total score for the 22 items and it is the mean score that was used. Lower scores indicates lower levels of affiliate stigma. The affiliate stigma score has good psychometric properties. It achieved excellent internal consistency with a Cronbach alpha of 0.94.⁷

For the present study, the questions were modified to reflect the participants (mental health professionals). For example a statement like 'I feel bad to have a family member with mental illness/disability' was replaced with 'I feel bad to have a patient with mental illnesses. Also the statement 'as one of my family members is a person with mental illness, I feel inferior' was replaced by 'as one of my patients is a person with mental illness, I feel inferior'. Similarly, the statement that reads 'I dare not tell others that there is a person with mental illness in my family', was modified to 'I dare not tell others that I work with patients with mental illness.' Psychometric properties was calculated for the modified version and the alpha reliability coefficient was 0.96.

Section C

The compassion satisfaction subscale of the Professional Quality of life Scale (ProQol-5). Developed by Stamm in 2005,¹⁷ the professional quality of life scales is divided into three subscales which are: Compassion Satisfaction and Compassion Fatigue which has two components: Burnout and Secondary Traumatic Stress. Compassion satisfaction tries to elicit the pleasure derived by professionals in doing their work effectively. Burnout consists of difficulties and feelings of hopelessness encountered by the professionals in the course of carrying out their duties, while secondary traumatic stress scale tries to measure stress on

professionals from being exposed to the traumatic experiences of others. A score of 43 or less signifies low point on any of the subscale, a score around 50 is average while scoring 57 and above is regarded as high. This study utilised only the Compassion Satisfaction subscale of the scale. Reliability scores of 0.87, 0.72 and 0.80 have been confirmed for the subscales.¹⁷

Procedure

The study was carried out over a period of 4 weeks. The researchers sought and obtained permission from the management of the hospital to hold a meeting with all the heads of unit of the concerned subgroups of health professionals included in the study. During the meeting the aim and purpose of the study was explained in detail and their support solicited. Subsequently, the total number of mental health service providers who fulfil the inclusion criteria, were assessed. The researchers then distributed the questionnaires to all the mental health service providers individually and was available to answer questions. The psychiatrists (including trainees) and pharmacists were assessed by the researcher during each of their respective clinical meetings. The nurses, clinical psychologists, occupational therapy staff and social welfare staff were assessed at their duty post during their various shift duties. An explanatory note about the study and a consent form was given along with the questionnaires to each participant. After all the questionnaires have been given out, the participants were approached individually and given further explanations where needed and their phone numbers were recorded in a sheet. The questionnaires were pre-numbered and distributed according to the various wards offices and units. The researcher then went round to retrieve the completed questionnaires. Reminders were sent to the participants, through the various heads of units and via text messages. About four reminders were sent over four weeks.

Data Analysis

Data was analysed using the Statistical Package for Social Sciences Version 16 (SPSS 16). Descriptive statistics was used to summarize demographic profiles and other variables. Comparison between categorical and continuous variables were undertaken using the chi-square and t-test respectively. The t-test was used

for comparison of the means of continuous variables amongst two different classes of professional subgroups. Correlation analysis was used to determine the linear relation between outcome variables.

For the purpose of analysis, the scores on the instruments used in this study were classified into dichotomous or trichotomous groups. Affiliate stigma was dichotomized (based on the mean score of 31.31 ± 8.64 years) into 'Low stigma' and 'High stigma'; Compassion Satisfaction scores were classified as 'Low', 'Average' or 'High'. When comparing the subgroups of mental health service providers' scores across the study instruments, occupation of the mental health service providers was trichotomized into 3 groups; Psychiatric Nurses, Psychiatrists and others (for ease of analyses and because of the small number of subgroups of other mental health service providers, other than doctors and nurses, working in the hospital).

Response Rate

The total number of mental health service providers at the study site (Federal Neuropsychiatric Hospital), was 241 professionals. Out of these, 32 mental health service providers could not be reached during the study duration for various administrative reasons (vacation, maternity leave, postings, sick leave etc.), and so only 209 participants got the questionnaires. Of these, 18 mental health service providers declined to give a written consent, resulting in the return of only 191 questionnaires. Of those returned, 8 of the participants only partially filled their set of questionnaires which were discarded during data cleaning. Therefore, 183 participants participated in the study and a total of 183 sets of questionnaires were analysed for this study giving a response rate of 75.9%.

Result

Majority of the mental health service providers surveyed were nurses (74.9%), married (82%) and were females (65.6%). The mean duration of employment at the study centre was 8.63 ± 6.73 years, and the average working duration per week of the participants was 42.37 hours per week.

About two-fifths of the mental health service providers surveyed reported experiencing high affiliate stigma (41.5%). Compassion satisfaction was 'average'

for more than half of the respondents (54.1%). Almost half of the mental health professionals studied expressed the belief that the aetiology of mental illnesses was predominantly psychosocial (49.7%)

When the professional subgroups of Psychiatrists and Psychiatric Nurses were compared across the subdivisions of the affiliate stigma scale, more Psychiatrists significantly experienced high affiliate stigma compared with nurses ($p=0.03$, $OR=0.38$, 95% $CI=0.15 - 0.94$). (Table 1).

Psychiatric Nurses who worked for more than 42 hours per week reported significantly lower Affiliate stigma than nurses who worked for 42 hours per week or less ($t=2.118$, $df=135$, $p=0.04$ respectively). The same was true for Psychiatrists ($t=2.148$, $df=28$, $p=0.04$). (Table 2).

Psychiatric Nurses who reported high stigma on the affiliate stigma scale were significantly more likely to have high compassion satisfaction ($(X^2 = 10.040$, $df=1$, $p=0.002$).). This was also true for the subgroup of Other professionals ($(X^2 = 4.000$, $df=1$, $p=0.005$).). However, Psychiatrists who had high scores on the affiliate stigma scale were more likely to have low satisfaction with their work and this difference was not statistically significant.

Mental health service providers who endorse the psychosocial aetiology of mental illness compared to the biological or spiritual, are significantly more likely to report having experienced high affiliate stigma ($F=3.980$, $df=2$, $p=0.03$) (Table 3).

Discussion.

The present study set out to investigate the presence of affiliate stigma among mental health service providers and to ascertain how this affiliate stigma could influence the satisfaction they derive from their caring work.

The main findings in the study were that Mental health service providers experienced high affiliate stigma (significantly more in the subgroup of psychiatrists), and that this high affiliate stigma was significantly associated with working shorter hours and endorsing a psychosocial aetiological model for mental illness. High affiliate stigma was also associated with low compassion satisfaction in Psychiatrists, but surprisingly, for Psychiatric Nurses and the Other mental health professionals, it was

Table 1. chi square comparison of psychiatrists and psychiatric nurses across the affiliate stigma scale

Variable	Frequency (%)		X ² (df=1)	p
	Psychiatric Nurses	Psychiatrists		
Affiliate Stigma				
Low stigma	76 (55.48)	23 (76.67)	4.58	0.03 OR=0.38 95% CI=0.15 – 0.94
High stigma	61 (44.52)	7 (23.33)		

Table 2. Relationship between Affiliate Stigma and clinical profile (number of work hours) for the Psychiatrists and Psychiatric nurses

Variable	Mean Affiliate Stigma score	t	p
Working Hours/week (nurses)			
≤42	32.34 (±9.18)	(df=135) 2.118	0.036
>42	27.20 (±5.34)		
Working Hours/week (psychiatrists)			
≤42	30.14 (±5.63)	(df=28) 2.148	0.041
>42	25.25 (±5.12)		

Table 3. Analysis of variance (ANOVA) comparison of the relationship between affiliate stigma and belief about aetiology of mental illness among the psychiatrists.

Beliefs about etiology of mental illness	Affiliate Stigma score Mean (±SD)	Statistics
Predominantly Biological	26.29 (±5.19)	F = 3.980 df = 2 p = 0.03
Predominantly Psychosocial	30.84 (±5.76)	
Predominantly Spiritual	23.75 (±1.50)	

significantly associated with high compassion satisfaction.

The finding of high Affiliate stigma among mental health service providers in this study was not surprising. Previous studies have reported that just like the uninformed members of the general public, stigmatizing views about mental illness are also endorsed by health workers and even amongst mental health service providers.^{26,27} Mental health service providers could be influenced by the prevailing societal distaste for the bizarre behaviour of some persons with mental illness which leads to the rejection of mentally ill individuals. When these mental health service providers internalise these endorsed negative views and apply it to themselves, affiliate stigma results. These could have grave consequences since affiliate stigma could reduce the effectiveness of therapeutic interventions initiated by these mental health service providers towards the resolution of patient's psychological problems. It has been noted that mental health service users are likely to experience poor interpersonal performance from mental health service providers who themselves have suffered some form of stigma which now act as a stressor.²⁸ Cohen²⁹ in his review article affirms that this stress suffered by mental health service providers could lead to a decreased sensitivity towards the patients they cater for, resulting in making them less likely to offer a helping hand, being more aggressive, ignoring individual differences and generally being less involved in their caring job. This can affect the relationship between mental health professionals and service users and could in turn worsen the stigma already being experienced by the mental health service users.³⁰

In this study, psychiatrists were significantly more likely to report higher levels of affiliate stigma compared to the psychiatric nurses. This is in contrast to findings from the study by Verhaeghe & Bracke²⁵ in their study of associative stigma amongst mental health professionals in Flanders region of Belgium. They reported that Psychiatric Nurses in their study reported having encountered more stigma experiences than other groups. Since the present study set out to investigate affiliate stigma amongst mental health service providers, no measure of associative stigma was used. Corrigan & colleagues³¹ asserted that individuals may be aware of prejudices or stereotypes against the group which they

belong without necessarily endorsing this view.

Therefore, they could avoid the development of self-stigma since there has been no subjective internalisation. It is possible that nurses in the present study could have experienced high levels of associative stigma experiences without necessarily endorsing this stigma and hence their low levels of affiliate stigma reported in this study

Another finding from this study was that mental health service providers (psychiatrists and psychiatric nursing staff) who worked for longer hours per week reported significantly lower levels of affiliate stigma compared to those who worked lesser hours per week. This is in contrast to the finding by Lauber and colleagues³² in their study of mental health professionals in Switzerland where they found that work hours did not influence the development of attitudinal stereotypes. Though longer hours of work could be regarded as a stressful experience which could worsen the experience of stigma, it is possible that psychiatrists and psychiatric nursing staff in the present study who worked for longer hours choose to do so because they have a passion for their caring profession and derive some measure of satisfaction for the caring work which they provide for the end users. This could be responsible for them reporting lower affiliate stigma. Further studies needs to be done in this area to clarify this.

Expectedly, psychiatrist who reported high levels of affiliate stigma in this study also reported experiencing low compassion satisfaction. Similar findings were reported by Verhaeghe & Bracke²⁵ in their study of associative stigma amongst mental health professionals in Flanders region of Belgium. They found that stigma could lead to emotional exhaustion which in turn reduces the satisfaction obtained from doing their caring job. They posited that the link between stigma and well-being is similar for families of mentally ill individuals and mental health service providers. Kitson,³³ had warned that there is sometimes exaggeration of the differences between lay caring and professional caring and that both are quite similar since emotions cannot be completely eliminated from professional care.

In contrast to the above, psychiatric nurses and other mental health service providers in this study who reported higher levels of affiliate stigma also reported

higher compassion satisfaction. Though the internalisation of stigma has been shown to contribute to greater psychological distress and lowered self-esteem, however, Corrigan & Watson³⁴ have noted that some individuals may remain indifferent or otherwise actively retaliate with "righteous anger because they have not endorsed this view. They may therefore respond alternatively to stigma by becoming advocates against it. This could have been responsible for the high compassion satisfaction reported by the psychiatric nursing staff and other mental health service providers in this study who also reported high levels of affiliate stigma.

Majority of the mental health service providers studied endorsed the psychosocial and biological aetiology of mental illness rather than the spiritual aetiology. This is in contrast to previous reports that have suggested that the spiritual beliefs about the aetiology of mental illness is widely held by Africans, irrespective of their educational attainment.³⁵ A possible reason for this contrast is that this present study was amongst mental health professionals working in a tertiary health facility. These mental health service providers in the course of their development would have received various training which includes the aetiology of mental illness. Furthermore, most of them have worked for a long time and have experienced the positive influence of pharmacological and psychosocial interventions in the resolution of service users' problems.

Conclusion and Implications

The levels of affiliate stigma among mental health service providers in this study was relatively high, particularly among the professional group of psychiatrists. This high level of affiliate stigma was significantly associated with low compassion satisfaction among these psychiatrists. Though this study is a cross sectional, the findings above may imply some kind of causal relationship between the high levels of affiliate stigma and reduce compassion satisfaction. These findings may have serious implication for the mental health service provider/ mental health service user therapeutic relationship. Mental health service providers who initially sees themselves as victims of stigma and discrimination and internalises these views, may in turn

become offenders by stigmatising service users. Mental health service providers who have suffered from stigma could become indifferent and insensitive to the plight of service users thereby worsening morbidity and treatment outcomes for these service users. Therefore, intervention programmes to reduce stigma and discrimination to individuals with mental illness should involve sections to deal with affiliate stigma among mental health service professionals.

The findings from this study also has serious implication concerning the professional quality of life of these mental health professionals ,particularly in a country like Nigeria where the ratio of mental health service providers to the population is very low. Caring for patients by mental health service providers can be traumatic, and in the setting of high levels of affiliate stigma, then the levels of stress is even higher. All these could easily result in high burnout and low compassion satisfaction of these professionals, which could lead to reduction in their quality of life. This could be Therefore, measures taken to reduce affiliate stigma among these professionals, may in turn reduce burn out and improve their quality of life.

These findings also have important implications for mental health policy makers. Educational and counselling programmes could be developed to increase mental health service provider's awareness of affiliate stigma, and to encourage them to seek help when they are overwhelmed. The importance and utility of self-help groups and preventative programmes in these professionals cannot be overemphasized. Mental health service providers need to be protected from the deleterious effect of affiliate stigma so that they can carry out their professional caring role effectively and so that their patients will receive optimal care.

Limitations

This study was carried out at a single health facility and this limits generalisation of the use of the results. A country -wide study will be more scientifically beneficial to the generalization of the results for a study of this nature. Furthermore, the adaptation of the affiliate stigma scale could affect its psychometric properties. However, steps were taken to ensure that this was not the case and the reliability score after adaptation was still very high. Our research design calls

for caution in the interpretation of our results. The study was a cross-sectional study which considers actions retrospectively and does not provide causal explanation for phenomena.

Conflict of Interest

The authors wish to state that there is no conflict of interests.

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