Exploring the Multifaceted Dimensions of Mental Health Stigma: Culture, Religion, and Healthcare Institutions

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Abstract. Background: The stigma against mental illness has attracted more and more attention in various fields in recent years, especially its impact on the willingness of stigmatized subjects to seek help. Most studies examine the underlying factors, such as cultural factors, the influence of mental health institutions, and the impact on the stigmatized target. Methods: This study reviews the literature on the association between the three characteristics and the stigma associated with mental illness and discusses future research potential regarding the study's limitations. Through in-depth analysis and understanding of the literature in the past five years, the present study summarized the different degrees and manifestations of stigma in different cultural backgrounds, the impact of health institutions on stigma, and the impact of stigma on the stigmatized objects. Results: Stigma has varying degrees of impact on the stigmatized person's willingness to seek help, self-esteem, and life efficacy, and may even increase the risk of suicide. In addition, staff working in mental health facilities may also experience external stigma. Compared with Western individualistic cultures, Eastern collectivistic cultures have a stronger stigma towards mental illness, which is also related to patients' low willingness to seek help. Diagnosis of mental health institutions may lead to increased stigma as well. However, these studies still have certain limitations, and future studies can be improved through longitudinal studies and better control of factors such as popularization of mental illness.

1 Introduction

Stigma is a ubiquitous and complicated social phenomenon that relates to the denying, demeaning, and insulting of an individual owing to traits or characteristics. It can express in various forms, including isolation from society, unfair treatment, and intolerance [1]. Stigma is influenced by many factors and has profound effects on the stigmatized object. Understanding the factors that contribute to stigma and its impact on individuals is critical to developing effective interventions and policies to reduce stigma and improve mental health outcomes.

Stigma has a profound impact on the stigmatized target, which may not only lead to lower self-esteem and unwillingness to seek help but may also lead to a high risk of suicide. The impact of the intensity of stigma involves the cultural environment and local health institutions where the stigmatized object is located.

First, an important factor that affects the experience of stigma is culture. The way people perceive and handle mental health issues is influenced by their cultural beliefs, norms, and values, which also affect willingness of individuals who within this cultural context to seek help and access mental health services. In some cultures, such as the Confucian culture of East Asia, mental illness is highly stigmatized, leading people to conceal their condition and avoid seeking treatment [2]. In other cultures, such as individualistic ones, mental health issues may be more openly discussed and accepted, reducing the stigma associated with seeking help [3].

In addition to cultural factors, the structure and operations of health care facilities can also contribute to stigma. Mental health professionals experience stigma because of their profession, which impacts their interactions with patients and the quality of care they provide [2]. Understanding the interplay between cultural beliefs, stigma, and healthcare institutions is critical to addressing barriers to mental health care and promoting mental health equity.

There are currently in-depth studies on the impact of stigma on individuals, the role of culture in stigma, and the relationship between health institutions and stigma. However, there are still many shortcomings, such as the lack of cross-cultural and longitudinal research.

This literature review aims to explore the multifaceted relationships between culture, stigma, and the impact of stigmatized objects, emphasizing the need for culturally responsive methods to mental wellness services and legislation that address the core causes of stigma. The study identifies the limitations of existing research and suggests potential for future research by reviewing recent literature on the influence of cultural perspectives and health institutions on stigma and its effects on individuals.

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2 Stigma on individual

The impact of stigma on individuals is a complex and extensive topic, involving many aspects such as society and culture. Within the disciplines of public health and social psychology, researchers have been exploring the impact of stigma on individuals, especially in the field of mental health. Stigma is harmful to an individual's mental well-being and negatively impacts their social life, relationships, and general standard of life. Firstly, internalized stigma can prevent individuals from seeking outside help and reduce personal engagement in treatment [4-8]. For example, during the COVID-19 pandemic, people are avoiding seeking medical care when they have flu symptoms or a history of travel to disease-affected areas, as social media and news reports continue to spread a flood of false information around the world, increasing stigma, marginalization, and xenophobia [9].

Wu's research sought to determine how university students' utilization of mental health services was affected by both public and self-stigma [8]. The research subjects were 8,285 American undergraduate students from 11 universities in the United States, with an average age of 20 years old. They used a scale adapted from the Perceived Discrimination and Derogation Scale to measure the extent both self-stigma and public stigma. They also used the Community Health Care Study, Patient Health Questionnaire 9, and Mental Health Continuum Short Form to evaluate participants' perceptions of their overall mental wellness, symptoms of depression, and requirements for mental healthcare services. The author conducted descriptive statistics and bivariate correlation analysis on the research data. Based on the findings, the group "low self and public stigma" with the highest percentage of mental well-being services utilized being. This proportion decreased with the increasing of public stigma and self-stigma respectively. Depression levels were lower in both low stigma groups than in both high stigma group. Racial and gender differences were present in the utilization of mental health services among stigmatized individuals and conditions.

Another study from South Korea aimed to explore the association between psychological well-being literacy and social and self-stigma, and perspectives on obtaining mental health treatment among Korean university students [7]. The research participants were 305 college students from six Korean universities, including 124 male and 181 female, averaging 21.76 years of age. The study adopted a convenience sampling method and collected data by completing questionnaires in class. By using the Korean version of Mental Health Literacy Scale-K (KMHLS-K), Stigma Scale for Receiving Psychological Help (SSRPH), Self-Stigma of Seeking Help Scale (SSSHS), Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS-SF) measure participants' mental health literacy, social stigma, self-stigma, and attitudes towards professional mental health services respectively. The data were screened for normality, frequency analysis and descriptive statistics were performed, Pearson correlation analysis was calculated, and gender variables were controlled in the analysis. Research results show that social and self-stigma are negatively correlated with mental health literacy, and they are also negatively correlated with attitudes toward requiring for support.

In addition, stigmatized groups are more likely to experience mental and physical health issues [1]. Higher levels of stigma are also associated with greater stress, and mental health stigma is also positively associated with suicidal behaviour [10,11].

Hirsch and his colleagues study aimed to explore the relationship between mental health stigma, levels of perceived stress, depressive symptoms, and suicidal behaviours among residential students at a rural Southeastern university [11]. Study participants were 913 students, most of whom were white women averaging 20.19 years of age. Hirsch and his colleagues' study adopted a self-report survey, using scales such as the Beck Depression Inventory-II (BDI-II), the Mental Health Stigma Scale (MHSS), the Perceived Stress Scale (PSS), and the Suicidal Behaviour Questionnaire-Revised (SBQ-R) to examine the sample's depressive symptoms, mental health stigma, levels of perceived stress and suicidal behaviour. Data analysis methods included conducting Pearson product-moment correlation analysis and simple mediation analysis. Results demonstrated a strong and positive correlation between perceived stress and suicide thoughts, depressive symptoms, stigma. Depression and mental health stigma were significantly correlated, and suicidal behaviour was positively correlated with depression. Suicidal behaviour and depression had a slightly decreased correlation among people who experienced less stigma related to mental illness. Additionally, there was a notable mediating role played by stigma around mental health on both direct stress and suicide. Stress and depression combine with a high stigma around mental health could raise the risk of suicide.

According to Shrout and Weigel, a total of 124 individuals diagnosed with latent chronic health conditions (CHC) and in romantic relationships participated in two waves study, ranging in age 18 to 59 [10]. Most participants were Caucasian. The study used scales such as Internalized Stigma of Mental Illness, CHC-Related Stress, Health-Hazardous Behaviours, Physical Health Questionnaire, and Relationship Health to assess participants' mental and physical health and relationship quality. According to the data analysis results, higher stigma related to CHC was linked to higher levels of CHC-related stress and physical health problems. The study concluded that stronger CHC-related stigma will lead to more CHC-related stress, which in turn will lead to More physical health issues such as headaches and stomach-aches and ultimately worsening relationship health over time.

Furthermore, stigmatized individuals experience lower self-esteem and general self-worth. Drapalski and his colleagues conducted interviews with 107 people diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder, or major depressive disorder, which lasted about 45-60 minutes [12]. This interview will be used to determine whether they meet the requirements

for participating in this quantitative study, such as relatively stable clinical status, and so forth. Ultimately, 100 participants were identified, ranging in age from 18 to 80 years old, and most were African American. The study assessed individuals' mental health using a range of scales, including the Brief Symptom Inventory (BSI), Rosenberg Self-Esteem Scale (RSES) , Stigma of Mental Illness Scale (ISMI), Sherer's General Self-Efficacy Scale (SES), and Mental Health Recovery Measures (MHRM). The data analysis revealed that internalized stigma was strongly associated with symptom intensity, for example severe depression has stronger self-stigma than moderate depression, but was not connected with age, gender, employment, marital status, or education. Drapalski and his colleagues' study concluded that a considerable percentage individual with serious mental illnesses report suffering internalized stigma, which is linked to several negative outcomes, including lowered self-esteem and self-worth, as well as increased mental discomfort.

In addition, concerns have also been raised about the stigmatization of healthcare providers who work with individuals suffering from mental illnesses. Mental health professionals may be affected by public stigma, leading to the development of self-associative stigma. Verhaeghe and Bracke's 2021 study sought to investigate the perceptions regarding stigma among mental health providers and service users, as well as the correlation with job fulfilment, mental wellness, self-stigma, social exclusion, and stigma expectations [13]. This study evaluated the associative stigma index, mental tiredness index, job fulfilment, relationships with colleagues, and mental wellness of 543 mental health practitioners who participated. The study found that experiences of associative stigma were low in both groups, but varied across professional groups, with nurses reporting the greatest experiences of stigma. In addition, associative stigma was negatively related to job satisfaction but positively related to mental health status and self-stigma. Likewise, a study by Yanos and his colleagues confirmed this while also finding that associative stigma is relatively stable over time [14]. A qualitative investigation exploring the different kinds of stigma suffered by individuals who have mental illness and mental health caregivers in Indonesia reached similar conclusions. Mental health nurses being labelled "crazy nurses," a reflection of stigma encountered by nurses because of interacting with individuals suffering mental disorders, and it was even observed that certain health care providers believe mental disorders are communicable [15].

Overall, stigma may prevent individuals from seeking outside help and reduce individuals' motivation to participate in treatment. Additionally, stigma is associated with greater stress and more severe depressive symptoms and suicidal behaviour. It can also lead to low self-esteem and low self-efficacy. At the same time, the stigma associated with professionals in mental health need to be treated seriously. These findings have significant implications in terms of comprehending the impact of stigma on individuals and how mental health institutions can reduce the negative impact of stigma on individuals while also providing effective care to patients.

3 Culture and stigma

Cultural belief systems are cultural templates, underlying thoughts and actions carried by individuals that shape and pattern beliefs in a systematic way [16]. Culture can engender collective stigma by altering individuals' perceptions or their cognitive models. As a result, cultural considerations such as collectivism, Confucianism, face concerns, and familism have a major influence in shaping stigma rates and displays of stigma, resulting in varied degrees of stigmatization for individuals.

According to Ran and his colleagues, cultural influences have a significant role in mental illness stigma. [2]. Research has found that mental illness stigma can be divided into four types: Social stigma, self-stigma, collateral stigma, and occupational stigma. Cultural values linked to societal perception, for example Marianism, which dictates that women should be self-sacrificing and prioritize the needs of others above their own, and machismo, the cultural expectation that men should embody strength, dominance, and stoicism, are two deeply ingrained Latino cultural norms that perpetuate societal stigma and shape gender roles within these communities. In Indian culture, the traditional role of women as housewives often leaves them devoid of adequate social support networks, thereby fostering a heightened fear of social rejection. The Japanese public also firmly believes that mental illness is related to personal weakness. "Face" was first defined by Hu, can be divided into two components, one is moral "lian", which is the group's respect for people with good moral reputation, and the other is social "mianzi", which represents a person's a reputation and prestige gained by living, succeeding, and showing [17]. Chinese society is influenced by this constructed moral status. As a result, people with mental illness may experience a lower moral status and less access to social capital because of the loss of their face. At the same time, face issues are closely related to self-stigma, which can result from people not disclosing mental illness for fear of losing face. As a result, it is possible to conclude that cultural beliefs have a substantial impact on people's internalization of stigma. Individuals' impressions of mental illness and attitudes toward persons affected by it are influenced by deeply ingrained societal norms and values that exist throughout cultures. Mental illness stigma is very prevalent in the Pacific Rim, which includes nations such as China and the United States of America. East Asian cultures, such as those of China, Japan, and Korea, are profoundly established in collectivism beliefs and Confucian ideals that emphasize the preservation of harmonious social connections and community cooperation. In contrast, predominantly individualistic whites may be less concerned about whether individuals have harmonious relationships but more about whether employees have the skills they need to do their jobs. This prevalence

highlights the significant role that cultural influences play in the establishment and persistence of stigma surrounding mental health concerns.

In addition, even Chinese individuals residing in non-oriental cultural contexts are likely to experience a relatively high degree of stigma. Chen and her colleagues' study in 2020 investigated the impact of culture on mental illness stigma by recruiting approximately 200 participants each from Hong Kong Chinese, Chinese Americans, and European Americans [18]. To assess stigmatizing attitudes about mental disorder and concerns about face problems the study utilized the Attribution Questionnaire and the 21-item Face Loss Scale. The research revealed that both Chinese groups had higher degrees of stigma against mental disorders and barriers to seeking care than European Americans, and that these cultural gaps were the result of face concerns. Compared to Chinese American, the stigma associated with mental disorder and the impediments inhibiting help-seeking behaviours within Hong Kong Chinese were noticeably more. Moreover, Chinese Americans exhibited significantly higher levels of stigma and reported more barriers to seeking help than European Americans. This pattern suggests a gradient of stigma and help-seeking barriers across these three cultural groups, with Hong Kong Chinese experiencing the highest, followed by Chinese Americans, and then European Americans.

Moreover, Mirza and her colleagues' study in 2019 aimed to uncover the relationship between culture and stigma by investigating the cultural identity of South Asians in the UK and their distinctions from white British citizens regarding interaction with mental health services and disclosure of mental health disorders. [3]. The study subjects included 64 South Asians and 64 White British people from the UK, aged between 16 and 20 years old. The study used a Group Identification Scale to test South Asian acculturation into British culture, and three items to measure mental health experiences. The results indicated that South Asians have not fully assimilated to British culture, thus culturally distinct from white British people, providing a foundation for this study to investigate cultural differences in stigma. The findings showed that white British people reported more contact with mental health services and a higher intention to contact, while South Asians reported fewer disclosures of mental health issues, which could be attributed to their tendency to attribute mental illness to supernatural causes. For South Asians, spiritual beliefs associated with supernatural beliefs, with higher spiritual beliefs associated with higher stigma. This is linked to South Asians being more likely to experience stigma associated with mental illness than white British people, as this may prevent them from self-disclosing mental health issues and seeking help. Individuals from the South Asian community perceived mental health issues as a taboo and stigmatized topic and is considered shameful or should be concealed which may also prevent them from receiving information from mental health agencies.

Stigma was also associated with extrinsic religiosity, which is a form of religiosity characterized by a focus on social participation and social benefits as motivations for religious engagement. This kind of religiosity is generally motivated by an attraction for community and social support, which leads individuals to attend religious services. Extrinsic social religiosity is linked to increased stigma, as individuals with mental illness might be perceived as violating social norms. Furthermore, external social religiosity influenced the association between diagnosis and stigma. Diagnostic stigma refers to individual's perceptions of the controllability and severity of mental illness. Diagnostic stigma will be stronger for psychiatric diagnoses with higher controllability and severity. In addition, high levels of extrinsic religiosity influenced the association between diagnostic stigma and whole stigma.

In a 2022 study on religious belief and stigma, the subjects were 334 adult U.S. residents who passed attention and quality checks and mastered English communication skills [19]. The study used the Age Universal I-E scale to measure religious orientation (including extrinsic social, extrinsic personal, and intrinsic personal religious). With terminology adapted to account for people who are not specifically religious, to measure participants' intrinsic orientation toward religious involvement. Additionally, the study used an attribution questionnaire to assess mental illness stigma and a social distance scale to measure participants' desire to socially distance themselves from people with mental illness. Multiple regression analysis revealed that external social beliefs had a relationship with increased blame and stigma about mental illness. However, extrinsic personal religiosity and intrinsic religiosity were not significantly related to stigma. This might because individuals suffering from mental health illnesses have the potential to break societal standards (or just are thought to break social standards), which could be especially disturbing individuals with high levels of external socio-religiosity, prompting these individuals to blame and criticize individuals with mental illnesses more harshly.

In addition, religious coping is also associated with stigma. Religious coping refers to an individual's attitude and behaviours toward religious beliefs and practices. Positive religious coping is the emergence of religious thoughts and behaviours through building a strong relationship with the object of faith and focusing on his love, while negative religious coping is an attitude, including thoughts of abandonment and punishment by the object of faith. In the 2023 study by Erdoğan Kaya and Aydinoğlu, 147 volunteers with schizophrenia aged 18 to 70 were participated [20]. The Internalized Stigma of Mental Illness (ISMI) scale and the religious coping scale were used in the study to measure participants' internalized stigma and religious coping. Multiple linear regression analysis was utilized to determine the effects of age, gender, sickness duration, and religious coping style on internalized stigma. The findings revealed that the perceived discrimination and social withdrawal subdimensions of internalized stigma were negatively linked with positive religious coping while positively related to negative religious coping. The total internalized shame score was positively related to

negative religious coping and negatively related to positive religious coping. However, it is unclear whether religious coping is causally related to self-stigma, whether negative religion is the cause of stigmatizing oneself, or whether behaviours that stigmatize oneself and create a negative view of oneself are attributed to religion. In the future, longitudinal studies on the causal relationship can be carried out to obtain sequential evidence of co-variation between religious coping and self-stigma.

In summary, culture has a significant impact on the stigma around mental illness. Various cultural factors, such as collectivism, face concerns, and familism, influence the incidence and expression of stigma as well as the internalization of stigma. Cultural values related to social image and moral status can lead to different forms of stigma, including public shame, self-stigma, incidental shame, and professional stigma. In addition, cultural differences will affect mental health professionals' perceptions of mental illness and patients' social acceptance in different sociocultural backgrounds. Studies have also shown that extrinsic religiosity is associated with greater diagnostic stigma than intrinsic religiosity. Furthermore, positivity in religious coping was also found to be related to internalized stigma. Ultimately, these findings emphasize the significance of bringing cultural aspects into consideration when understanding and decreasing the stigma connected to mental disorders.

4 Mental health professionals and stigma

There is a strong link between mental health profession and stigma. Psychiatrists, mental health counsellors, social workers, and nurses all interact closely with individuals suffering from mental health issues. This exposure may expose them to stigma, leading them to hold negative views or attitudes toward people with mental health issues [2,15].

Verhaeghe and Bracke's 2021 study examined social exclusion, stigma expectations (which describe perceptions of people with mental health problems), client satisfaction and psychiatric symptom severity of 707 service users among participants and compared their results with 543 professionals' result of associative stigma [13]. Professionals' associative stigma was found to be positively related to service users' self-stigma, but the relationship to social rejection and stigma expectations was unclear. The Subu and his colleagues also noted that some healthcare professionals have a stigma against people with mental illness [15]. This stigma often manifests itself in the use of restraint or isolation or even physical abuse of patients.

Diagnosis in a mental health facility is associated with mental illness stigma, and this is associated with belief in whether mental illness is controllable, with higher stigma associated with belief that mental illness is controllable [19]. In a study that investigated the influence of diagnosis and culture beliefs on mental illness stigma, 334 adults in the United States who passed the Attention and Quality Test and spoke English were studied. Participants received random allocations to vignettes representing individuals with various mental disorders, including schizophrenia, anorexia nervosa, and significant depression. Following the vignette assignment, participants proceeded to complete a battery of questionnaires, among which was the Social Distance Scale, designed to gauge their willingness to engage socially with individuals affected by mental health disorders. Additionally, participants responded to questionnaire regarding their familiarity with mental health disorders and their religious orientation. To mitigate the potential expansion of stigma, the gender of the situational characters in the vignettes was aligned with prevailing gender perceptions associated with mental illness. Data analysis involved employing a regression-based mediation approach to predict stigma specific to different diagnoses. The findings underscored the profound impact of diagnosis on stigma, with schizophrenia emerging as the most socially stigmatized condition, while anorexia nervosa was perceived as the most blame among the diagnoses presented.

Another study testing the impact of a psychiatric diagnosis on stigma recruited participants online via social media and survey-sharing sites and analysed a sample of 665 eligible individuals [21]. The study used a repeated measure, cross-sectional survey design to reduce bias. Psychiatric diagnoses were studied using nine textual case vignettes in which the order of presentation of the case vignettes was randomized and modified to make them gender-neutral and to ensure equal word length. The extent to which participants wished to distance themselves from the characters in the nine vignettes was measured using the SDS and the various attributions participants made to each person described in the vignette using the Attribution 16 questionnaire. Additionally, participants' vulnerability to social desirability bias was assessed using the Brief Marlowe-Cronen Social Desirability Scale (MCSDS). The findings indicate that the most stigmatized diagnoses are schizophrenia and ASPD, while depression, generalized anxiety disorder and obsessive-compulsive disorder are the least stigmatized. More common diagnoses may create greater familiarity, which in turn may reduce stigma.

Overall, there is a complex relationship between the mental health profession and stigma. The stigma associated with mental health practitioners who interact closely with individuals suffering from mental illnesses increases the likelihood that they would hold negative opinions or attitudes about patients. In addition, diagnoses at mental health facilities are associated with mental illness stigma, which is associated with perceptions regarding whether mental disease is controllable. Some studies have found that more common diagnoses may lead to more stigma. Overall, diagnoses by mental health professionals and mental health institutions are associated with mental illness stigma, which may influence perceptions and attitudes toward mental health issues.

5 Discussion

This study explores the influence of culture, society, religion, and healthcare organizations on the stigma associated with mental health disorder, as well as the impact of stigma on stigmatized objects. The results showed that these factors affect individual stigma to varying degrees. First, cultural factors have a significant impact on stigma. People from different cultural backgrounds have great differences in their understanding and attitude towards mental illness, which may affect their acceptance of mental illness and willingness to treat it, and even affect their acceptance of information about mental illness. For example, east Asian cultures emphasize collectivism and Confucian values, which value harmonious social relationships and solidarity, which may lead to a higher stigma against mental illness because mental illness is considered to violate the order of society. In contrast, individualistic cultures may be more open to discussing mental illness and have less stigma around seeking help, which may also be due to greater understanding of mental illness and health institutions. Secondly, religious factors are also related to stigma, and there is a certain relationship between external religious beliefs and the stigma of mental health disorder. Extrinsic religiosity might lead to perceptions that individual suffering from mental illness violate social norms, thereby increasing their stigma. Finally, the impact of health care settings on stigma is also important. A diagnosis of mental illness may lead to increased stigma, and the way health care settings are run may also increase stigma among patients. For example, healthcare facilities may use coercive measures or isolate patients, which may increase patients' stigma, and perceptions of mental illness, such as controllability and severity, are also associated with stigma. Stigma will not only affect the stigmatized individual's willingness to seek help, but also individuals' self-esteem, life efficacy, and so forth.

However, these studies also have some limitations. First, most studies have adopted cross-sectional designs, and unable to infer whether individual attitudes will change within a certain period. Future research can use longitudinal and repeated measurement methods to verify these results. Second, most studies used self-reported data, which may have retrospective bias. In addition, the research results are also affected by what participants are willing to disclose in the questionnaire. Future research should consider using uniform standard interviews or using objective health indicators such as blood pressure, cortisol reactivity. Third, the samples of some studies also have limitations, and cross-cultural studies are relatively rare, which may limit the generalizability of their research. Fourth, for studies on the impact of culture on stigma, questionnaires designed within the framework of the Western medical model may also be less valid for certain cultures. In different cultures, different levels of education and popularization of mental illness may also lead to different stigmas. Future research can focus on addressing the impact of these factors on research by conducting better control of variables. Overall, the findings of this study reveal the impact of factors such as culture, society, religion, and medical institutions on the stigma of mental illness, providing important references for future research and intervention.

6 Conclusion

This article synthesizes multiple studies and explores the impact of factors such as culture, society, religion, and medical institutions on the stigma of mental illness. First, the author introduces the concept and impact of stigma, including its impact on personal self-esteem, willingness to seek help, self-efficacy, and may even lead to suicidal behaviour. Secondly, cultural factors play an important role in stigma. People from different cultural backgrounds have different perceptions and attitudes towards mental illness, which will affect their acceptance of mental illness and willingness to treat it. Third, religious factors are also related to stigma, especially the relationship between external religious beliefs and the stigma of mental illness. Finally, the impact of health care settings on stigma is also important; a diagnosis of mental illness may lead to increased stigma, and the way health care settings are run may also increase stigma among patients. In summary, through a comprehensive analysis of multiple studies, this article reveals the impact of factors such as culture, society, religion, and medical institutions on the stigma of mental illness, providing an important reference for future research and intervention.

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