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## **Stigmatization on the way to recovery in mental illness – the factors directly linked to psychiatric therapy**

Magdalena Tyszkowska, Magdalena Podogrodzka

III Psychiatry Clinic IPiN in Warszawa  
Head: prof. dr hab. n. med. M. Jarema

### **Summary**

The aim of this study is to draw attention to the ambiguity of the relationship between the process of recovery and implemented psychiatric treatment. With getting the diagnosis, a mentally ill person is automatically assigned to a certain society group and is involved into the mental health care system. People with a diagnosis of serious mental illness have to face not only their new health condition and adapt to the available health care system, but also to deal with the reaction of their environment. The process of recovery in mental illness includes remission of symptoms, getting back to the normal functioning, recuperating the life satisfaction, but also means the personal transformation and opposition to stigma. The most of the public demonstrates the stigmatizing opinions and discriminatory behavior in relation to the mentally ill, which does not foster their recovery and social reintegration. The nearest surrounding of the mentally ill is dominated by psychiatric staff, other mentally ill, psychotropic drugs and psychiatric hospital. These factors directly linked to the diagnosis and treatment of a psychiatric patient are supposed to help in recovery. In fact, at the same time they may contribute to recovery, and be a source of additional suffering or impede recovery. Despite symptomatic and functional remission, the mentally ill people stay outside the mainstream, remain socially isolated and excluded.

**Key words:** stigmatization, recovery

### **Introduction.**

Shortly after hearing the diagnosis, people with serious mental illness have to deal not only with their own health new condition, but also with the reaction of the surroundings. Since then, in the perception of the majority of the population they will be significantly different from the others. They are going to be permanently accompanied by their psychiatric diagnosis, struggling to beat the symptoms of the disease in order to keep themselves. As a result, a mentally ill shortly finds in his nearest surroundings only a psychiatric staff, the other mentally ill, psychiatric drugs, psychiatric hospital and maybe the family or friends, if they have not left him yet. The above mentioned elements associated with a diagnosis and treatment of mental illness are supposed to help in recovery. In fact, to varying degrees, they may at the same time contribute to

recovery, and be a source of additional suffering or impede recovery. The aim of this publication is to draw attention to the complex and ambiguous relationship between the process of recovery and implemented psychiatric treatment, referring to the data from the literature.

Label of mental illness diagnosis – recovery despite the diagnosis. For many years, a common belief, there is no hope for recovery in serious mental disorders, has stimulated the passive and conservative attitudes in therapeutic procedure. The apparent ineffectiveness of pharmacological treatment, further associated with the significant adverse events, resulted in a lack of faith in the possibility of achieving a well-being and good functioning of the patients and the possibility of their recovery. Mental illness were placed among the incurable and terrifying conditions, which contributed to stigma and social exclusion of patients [1]. In particular, the diagnosis of schizophrenia was associated with an unfavorable course of the disease and a noticeable difference of patients who have struggled with the symptoms of the disease or with the side effects of the medication. The diagnosis of schizophrenia was considered a verdict, shortly indicating a progressive mental deterioration and unpredictable, violent behavior. As a consequence, there were many justified actions taken by the public aimed at taking control over the presence of the mentally ill persons in the community.

In the recently published paper on the phenomenon of stigma, based on reports from 14 European countries, the authors emphasize the steady common ignorance about mental illness [2]. The studies assessing the public attitudes and opinion in many countries conclude that the diagnosis of schizophrenia is the most negatively perceived among psychiatric diagnosis [2-5]. There was less frequently demonstrated that such negative perception like schizophrenia, had also the following mental disorders: depression, bipolar affective disorder, anxiety disorders, eating disorders, alcohol dependence [2, 5]. It seems, there may be cultural differences, especially in dealing with depression and alcohol addiction. In Norway a mentally ill person, regarded as a less valuable “loser with a weak character”, is opposed to the ideal of a reasonable and independent character. At the same time the alcohol dependence is viewed a very negatively there, but mostly as a social phenomenon – a consequence of failures in life, with a big responsibility of addicted person for it [2]. The situation is different in Romania, where stigma affects mostly people with schizophrenia, while depression, anxiety disorders and alcohol dependence are treated as a result of the daily life difficulties [2]. In a study conducted in Germany the diagnosis of depression practically did not change the behavior and attitudes towards patients [3]. The prognosis of mental illness – the possibility of improvement or the recovery? Pessimism about the prognosis and the feeling of hopelessness do not foster recovery. The introduction of the term “recovery” in severe mental illness in the 90s of the twentieth century seemed to be a breakthrough, as well as the necessity [5, 7]. The inspiration was the experience with chronic, incurable physical illness. In these cases, it would be excessive to assure patients that it is possible to achieve a complete recovery and a permanent regression of the disease. But it is hard to leave people with the belief that they have nothing to do in search for good health and to deprive them of hope. The same right shall also serve for the mentally ill. Recovery in schizophrenia is the most often understood as a

lack of symptoms disease, a return to normal functioning and satisfactory well-being [8, 9]. Some authors recognize the personal and social autonomy achieved by patient as a goal of the treatment, and at the same time the indicator of recovery [10, 11]. Recovery and psychotropic drug treatment.

Taking antipsychotic medication is associated with falling ill with a serious mental illness [12]. The authors of the report, based on the review of the literature made at the initiative of the WHO in 2010, identify the believes because of which psychotropic drugs are rejected. Patients and their relatives think that psychotropic drugs are addictive, that they are working only for the symptoms of the disease, not for its cause, they affect personality, and reduce the feeling of emotions. Some studies have shown that patients treat medication as a last choice, preferring psychotherapy as a first-line intervention. Patients emphasize that antipsychotics or antidepressants need to have a long time to show the final result and in the end, they often seemed to be ineffective. Despite of this, it was proved that the chronically ill patients and their families have a more positive approach to taking medication, especially those who had already been hospitalized [4]. Stigma associated with psychotropic drug treatment is significantly related to the occurrence of visible adverse effects. This applies especially to antipsychotics. In the patients opinion, weight gain, sedation, and the attention deficits affect the normal functioning more than symptoms of the disease [13]. The stigmatizing nature of taking psychotropic medication is deeply rooted in the public awareness – the evidence is a trend observed not only among patients, to stop taking drugs as soon as the symptomatic remission is achieved [11]. Good health condition is associated with an genuine well-being which does not require pharmacological support. Recovery criteria in schizophrenia, according to some researchers opinion, assume that recovered patient does not take antipsychotic drugs at all or is taking only their subtherapeutic doses [14, 15]. Patients who achieve long-term remission, after many years of taking medication often make a decision by himself to withdraw psychotropic drugs. Additionally, they also break up all contacts with mental health care settings and refuse even to talk about their psychosis experience from the past [14].

Probably due to the wider social tolerance towards depression, the approach to antidepressive drugs is significantly different. The first new-generation antidepressant drug – Prozac (fluoxetine) was initially called “a happy pill” and gained a status of a cult antidepressant brand. In subsequent years, a new generation antidepressants (SSRIs) were accused of increasing the risk of suicide and of being abused. Next years followed up studies did not confirm these allegations. It was demonstrated that in the last 10-15 years, the incidence of suicide among persons aged 15-24 years has decreased, at the same time with the increased usage of antidepressants [16]. However, it is also known that people suffering from depression avoid or even refuse to take antidepressants, because they do not want to be considered as weak and unable to cope with the emotions [17] or do not want to be labeled as a mentally ill [18]. Inconsistent information about psychotropic treatment neither facilitates the recovery of the mentally ill, nor helps the psychiatrists to lead the therapy. It may be difficult to maintain the motivation of the patient to continue psychotropic treatment, in both situations – high efficacy and good tolerance (“I feel healthy and I do not need drugs”) and when

adverse events or unsatisfactory results are observed. People affected by mental illness striving for recovery, feel stigmatized just because they have to take psychotropic medication regularly. Drugs remind them about the disease, even during the periods of symptomatic remission, normal functioning and satisfactory well-being [15, 19].

**Mental Health Care Professionals** People with mental health problems and their families often regard even contact with psychiatrist as a stigma in itself, as a synonym of a diagnosis of mental illness. Clinical studies confirm a socially stigmatizing nature of psychiatric consultation. A fear of stigmatization and getting a psychiatric diagnosis is often the cause why they delay the moment of the first contact with psychiatrist, and the treatment initiation [20]. Usually the psychiatrist is responsible to provide the patient and his family with the information on the diagnosis. The manner of doing that can affect the future course of the treatment and patient's motivation to cooperate. Üçok, based on the reviews of studies from different countries, shows that psychiatrists often do not tell patients and their families about the diagnosis of schizophrenia in a fair and honest way. In Switzerland, only 7.3%, and in France only third of psychiatrists always inform patients about the diagnosis of schizophrenia. In Turkey, 42.7% of psychiatrists never inform patients about this diagnosis [21]. Avoiding a direct confrontation and a strict wording, psychiatrists contribute to an increasing anxiety and a sense of hopelessness in patients. Acting this way psychiatrists undermine own competence in making a diagnosis and the offering treatment. Psychiatric staff, including psychiatrists, may be a source of stigma itself. Since the psychiatrists are seen as experts, their attitude seems to play a crucial role in creating a public opinion. Meanwhile, a British study results show that only 71% of psychiatrists and 35% of non-medical staff would take antipsychotic medication, and 23% would not recommend taking it to their relatives in case of having schizophrenia [22]. Üçok showed that psychiatrists have rarely expressed more positive opinion about a mentally ill compare to general population. Their opinions are often equally negative, and in the vast majority of studies – more negative than the views of the general population [21]. The psychiatrists' pessimism may result from their daily work experience (called "clinician's illusion"). The most patients seek psychiatric help only in the acute phase of the disease [23]. Usually, in hospitals the most seriously ill patients are treated, often with chronic and irreversible deficits [21, 24]. Psychiatrists not being able to treat quickly and effectively, can be seen as less competent. The stigma phenomenon in psychiatrists is not without significance, specially its impact on their therapeutic relationship with patients. On the one hand, psychiatrists are influenced by the stigma transferred from their patients (patients with a poor prognosis and a low social status). On the other hand, they often feel burned out, undervalued or not efficient in action. They are blamed for the diagnosis (a lack of acceptance), the diagnostic doubts, insufficient treatment or lack of efficacy or drug adverse events. They are accused of taking excessive control over patients and tending to intrude their minds. They are also blamed for spending too little time to talk with patients [4, 24]. Psychiatric staff, who are experiencing stigma, transfer it to patients, who then often report the feeling of stigma and less satisfaction with treatment. In studies patients have emphasized the role of unsatisfactory medical care and psychiatric labeling in developing a sense of stigma [25,26].

Nevertheless, although psychiatrists share the similar negative stereotypes with the public, they are more likely to stand against the restrictions on patients' individual freedom and their right to self-determination [27]. Patients and their families tend to have an ambivalent aproche to psychiatrists. Hospitalized patients and those hospitalized in the past more frequently expressed opinion that psychiatrists were trustworthy and helpful [4]. Strategies to combat stigma generally base on the social education. In the light of some studies results, the raise of awareness about mental illness and direct contact with the mentally ill may not bring the expected results. On the one hand, psychiatrists have contact with patients, have all medical knowledge, but on the other hand "after work" they transform to the ordinary members of the society, sharing its opinions and attitudes [4, 21]. Psychiatric hospitals. **The conditions of mental health care**, psychiatric hospitals and other facilities, often are depressing and represent a sub-standard quality compared to other medical specialties. There is common a model of a psychiatric hospital as a place of isolation, staying away from other medical services. Such places are neither providing patients with the sense of security and dignity, nor to encourage them to fight for recovery. In the public eyes, stay in a psychiatric hospital means suffering from a serious mental illness [24]. The mental health care reforms implemented in many countries, asume the integration of psychiatry with other medical disciplines (multidisciplinary hospitals), and all above tend to reduce to minimum the time spending by patients in the closed hospital wards. In Poland, according to these trends, the National Mental Health Care Program shall assume the intensive development of community mental health care services. These services should take care of the most of psychiatric patients, be more friendly and accessible for them [28]. A mentally ill – a person "with symptoms". Symptoms of the disease and the certain behaviores of patients, which distinguishes them from the others are the major source of stigma. Fink and Tassman, referring to study results, specify the symptoms of mental illness which cause the reaction in social environment. The most often they were depressive symptoms (38%), tension (37%), suspiciousness (35%), binge drinking (19%), hallucinations (19%), suicide attempts (16%), physical complaints (15%), emotional withdrawal (14%). In another study it was shown that students perceived as depressive, compared to the control group, were avoided by their peers. Depressive mood of the students affected the mental well-being of the others [24]. Physical appearance has an impact on social relationships. Psychiatric patients are perceived as less physically attractive [29-31]. As evidenced in a number of studies on the non-hospitalized mentally ill, the physical unattractiveness is tied to poorer social adjustment. Napoleon showed that physical unattractiveness causes mental health problems in humans, and not vice versa [21 str.179, 31]. Farina has shown that as better appearance of patients was evaluated after a discharge from a psychiatric hospital, especially in the case of women, as easily they were welcomed back in the community [30, 24]. Another objection to social reintegration and getting work are the tension and visible fear in the behavior and the appearance in people with mental health problems perceived by the others [24, 30]. Despite of the disease, the significant number of patients could work. The labor market data show that only 10-30% of patients with mental illness are employed, in fact with about 30% of those unemployed

are capable to work [32, 33]. Good social adjustment and good functioning of patients go together with employment. It is not clear, what is the direction of this relation, whether the patients who are in good mental condition are able to find and keep a job, or whether being employed results in a full recovery [34]. It also seems that limitations in patients social functioning are not resulting only from the real barriers associated with symptoms or the treatment issues. In fact, the stigmatizing believes of the society seem to be responsible for the actual size of the social exclusion of the mentally ill. It is worth noting that the mentally ill, despite of the stigma experiences, remain the members of their community. It is difficult for them to give up social stereotypes and prejudices, when they get a mental disease diagnosis. The feeling of being different makes them expect discrimination (anticipated stigma), share unfavorable opinions and understand the behavior of their community very well (self-stigma). They may feel guilty for being ill and for their relatives who are socially stigmatized as well. They have distorted sense of identity, low self-esteem and poor life satisfaction. Link et al showed that patients who suffer from stigma the most, had their self-esteem 7-9 times lower compared to patients, who experience less stigma [36]. Recovery of the mentally ill despite of stigma related to disease and treatment. Promotion of 'recovery' as a therapeutic target in serious mental disorders, such as schizophrenia, involves the activity of the patient and is mainly based on patient's perception: what is disease and what should recovery be. The patient becomes a partner in therapeutic decision making [35]. Harvey and Bellack emphasize the role of motivation of the patient to return to normal functioning, apart from the objective ability to achieve it. The introduction of recovery as the therapeutic target gives a hope for a better future and social integration, encourages to take responsibility for yourself, increases a self-esteem and brings a life satisfaction [10, 19]. For many years mental health care system and its quality has been identified as a significant obstacle in achieving the recovery of the mentally ill people [19].

Antipsychiatric movement, developing in the sixties of XX century, based on the disagreement for the paternalistic treatment of mentally disturbed people, the common permission for using the force, compulsion, isolation and other controversial therapeutical actions called "health care of the mentally ill". The representatives of antipsychiatry, among them Szasz and Laing, questioning the existance of mental disorder, specially "schizophrenia" in medical terms, emphasized the lack of competence to recognize mental health norm even by professionalist – psychiatrist, who remained always the representative of community (the authority) in their opinion [37-39]. Szasz, representing deeply humanistic approach, claimed: "Having an illness does not make an individual into a patient" [38]. The antipsychiatric followers and continuators point out strong social, ethical and cultural background of mental disorder phenomenon, its legal, political links and consequences [39]. The role of psychiatrist was questioning and the feasibility to meet expectation to be able to asses professionally the mental health norm in disinterested and free from external influences manner [38, 39]. Michael Foucault was continuing the criticism of mental health care system, standing up in defence of personal freedom. He indicated mechanisms, when it became the tool of repression, hidden element of control, to restrict freedom of person, who existed beyond

the scope of norm, set by specific social subgroups [39, 40]. Despite of fact, that the antipsychiatric claims had more philosophical than medical features, often demagogic and full terminologically internal opposites (e.g. if there is no mental disorder, so there are no also mentally ill people who need therapy), they specifically contributed to the breakdown of dominated paternalistic and schematic approach towards the mentally disturbed. The question remains still actual about the border, the right to rank somebody beyond the scope of mental health norm, who is not understandable for us or we can not communicate with. The possible posing question may be also about the right to intervention, in the meaning of permissible size and shape of the treatment and the care of people regarded as mentally disturbed.

The mental health care is changing, but it still remains to do a lot [28]. The particular components of mental health care system and their relationship with recovery process suggest the co-existence of contradictory influences. On the one hand, the implementation of appropriate treatment and taking care of patients for their safety are the last decades achievement, which enables humanitarian treatment of the mentally ill with respect for their rights [UoOZP, 1994]. On the other hand, it too often becomes a source of additional suffering and stigma, leads to secondary disabilities and social exclusion. For many years, both in Poland and worldwide, mainly on the initiative of the WHO, there have been conducted the campaigns to counteract the phenomenon of stigmatization and exclusion of the mentally ill ([www.openthedoors.com](http://www.openthedoors.com)). In 2000, a group of Polish experts, working on the project “Open the Doors”, published “10 theses on schizophrenia” – a proposal to create a common standpoint for a multilateral public discussion on social attitudes towards schizophrenia. One of the theses, „Schizophrenia is not an incurable disease,” then discussed as a very controversial, in fact, announced the arrival and the dissemination of a new approach to prognosis in schizophrenia, and hit one of the strongest belief in the society justifying exclusion of patients [41, 42]. Referring to the possibility of recovery in mental illness, especially in schizophrenia, generally perceived as the most serious of mental diseases, the question could be made: what means in the real world “a person with schizophrenia in remission”, a patient who has been released of symptoms disease as a result of the treatment. Remington and Kapur reply that these patients often remain socially isolated, unemployed and excluded [43]. Even patients have achieved symptomatic remission and potentially normal functioning, it does not guarantee success in the daily life – they still remain outside the mainstream of social life [44, 45].

### Conclusions

1. Stigmatization associated with the treatment of mental illness may be a significant obstacle on the way to recovery in mental illness, regardless of the benefits taking from therapy.
2. A mentally ill is often an object of stigma and at the same time, as a person, who comes from a stigmatizing society, often shares the opinions of the public and becomes a victim of self-stigma.

3. Despite of the conducted public educational anti-stigma campaigns, there is still no clear evidence that they bring the expected results and significantly reduce the phenomenon of stigma. The reason for this may be a multifactorial nature of stigma and its prevalence in all social groups [2, 42].

**Стигматизация на пути выздоровления при психических болезнях  
– факторы, непосредственно связанные с психиатрическим лечением**

**Содержание**

Заданием работы является показание неоднородных связей между процессом выздоровления и вводимым психиатрическим лечением. Вместе с диагнозом психически больной человек сразу же причисляется до общественно диагностированной группы и охватывается системой психиатрической опеки. Лица с диагнозом тяжелой психической болезнью вынуждены столкнуться не только с собственной новой ситуацией состояния здоровья, но и приспособиться к доступной системе оздоровительной опеки, но также совместится с реакциями их окружения. Процесс выздоровления при психических заболеваниях охватывает также – кроме ремиссии симптомов и возвращение к нормальному образу жизни, а также и удовлетворения жизнью, т.е. личностное изменение и противопоставление стигматизации. Значительная часть общества демонстрирует стигматизирующие мнения и дискриминирующие поведения по отношению к психически больным, что не облегчает больным возвращения к здоровью и реинтеграции в обществе. Самое близкое окружение больного подвержено влиянию персоналу больницы, иных больных с психическими расстройствами, психотропных лекарств и сама психиатрическая больница. Указанные факторы связаны непосредственно с диагнозом и лечением, что может облегчить время возвращения здоровья. В действительности, они могут в различной степени одновременно помогать в выздоровлении, так и быть источником дополнительного страдания больного. Могут также затруднять возвращение к здоровью ввиду своего стигматизирующего характера. Психически больные часто, несмотря на улучшение здоровья и функционирования в окружении, остаются вне основного ритма жизни, исключения и в изоляции социальной среды.

**Ключевые слова:** стигматизация, выздоровление

**Stigmatisierung auf dem Wege der Genesung in psychischen Krankheiten – unmittelbar mit der psychiatrischen Behandlung verbundene Faktoren**

**Zusammenfassung**

Das Ziel der Arbeit ist die nicht eindeutigen Zusammenhänge zwischen dem Genesungsprozess und der eingesetzten psychiatrischen Behandlung zu zeigen. Mit der Diagnose wird die kranke Person in eine sozial erkennbare Gruppe eingewiesen und im System der psychiatrischen Betreuung einbezogen. Die Personen mit der Diagnose einer schweren Krankheit müssen nicht nur die neue eigene Gesundheitssituation bewältigen, sich an das zugängliche Gesundheitssystem anzupassen, und auch sich mit der Reaktion der Umgebung messen. Der Genesungsprozess in den psychischen Krankheiten umfasst auch – außer der Remission der Symptome und Wiederherstellung der normalen Funktionsweise und Zufriedenheit mit dem Leben – eine persönliche Umwandlung und Widersetzen mit dem Stigma. Der bedeutende Teil der Gesellschaft zeigt die stigmatisierenden Einstellungen und diskriminierendes Verhalten gegenüber den psychisch Kranken, was für diese keine Erleichterung bei der Rückkehr ins normale Leben ist. Die nächste Umgebung des Kranken ist vom psychiatrischen Personal und anderen psychisch Kranken, von psychotropen Mitteln und vom psychiatrischen Krankenhaus beherrscht. Die erwähnten Faktoren, direkt mit der Diagnose und Behandlung verbunden, sollen beim Genesungsprozess des Kranken mitwirken. In Wirklichkeit können sie im unterschiedlichen Ausmaß gleichzeitig bei der Genesung helfen, und dabei auch eine Quelle der zusätzlichen Qual sein, die Wiedergenesung durch ihren stigmatisierenden Charakter komplizieren.

Die psychisch kranken Personen bleiben oft außer dem sozialen Leben trotz der erreichten Besserung der Symptome und Funktionsweise, sie sind sozial ausgeschlossen und isoliert.

**Schlüsselwörter:** Stigmatisierung, Genesung

### **La stigmatisation durant la guérison des maladies mentales – les facteurs liés directement avec la thérapie psychiatrique**

#### **Résumé**

Ce travail vise à présenter les relations ambiguës du processus de la guérison et la thérapie appliquée. Avec le diagnostic la personne malade mentalement est automatiquement assignée à un groupe social et elle entre dans le système des services psychiatriques. Les personnes avec le diagnostic psychiatrique grave doivent faire face non seulement avec cette nouvelle situation, elles doivent aussi s'adapter au système et encore faire face aux réactions de leur milieu.

Le processus de guérir des maladies mentales embrasse encore – à côté des rémissions des symptômes, du retour au fonctionnement normal, de la récupération de la satisfaction de vie – la transformation personnelle et l'opposition à la stigmatisation. La grande partie de la population manifeste les opinions et les comportements stigmatisant qui rendent plus difficile la guérison et la réintégration sociale. Le milieu social du patient est dominé par le personnel médical, par les autres patients, les médicaments et l'hôpital psychiatrique. Ces facteurs, liés directement avec le diagnostic et la thérapie, doivent aider le patient en voie de guérison. En réalité ils peuvent l'aider mais aussi augmenter la souffrance et faire obstacle à la rémission par leur caractère stigmatisant. Les personnes souffrant des maladies mentales malgré les rémissions des symptômes et l'amélioration du fonctionnement restent en marge de la vie sociale, exclues et en isolation.

**Mots clés :** stigmatisation, guérison

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Address: Magdalena Tyszkowska  
Institute of Psychiatry and Neurology, III Psychiatry Clinic  
Sobieskiego Street 9, 02-957 Warszawa