Fighting the Stigma of Mental Illness

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Abstract: Around the world, people suffering from a mental disorder are experiencing not just symptoms and disabilities, but also with a stigma, a kind of "second illness" that lasts a long time, often even when the mental disorder is cured. Unpredictable, dangerous, affected by a disease. Incurable. These are the clichés that make it difficult for people with health problems to mental recovery and be accepted in professional, emotional and social contexts. Stigma related to Mental illness is declined in two main forms, a social/public one and an internalized one (self-stigmatization). The different forms of stigma, their harmful consequences and the main ones will be analyzed strategies to *counter them.*

Keywords*:* stigma; self-esteem; self-efficacy; empowerment

1. Social Stigma

Almost all people, who have been labeled as "mentally ill", face prejudice and discrimination, associated with a "deviant identity" and expressed by the population generally through negative reactions towards them. According to social psychology, external stigma is given by three components: stereotypes, prejudices and discrimination. Specific signs produce stereotypes, such as psychotic behavior, an inappropriate appearance, or asocial ways of interacting. Stereotypes usually turn into labels, assigned when a person's mental illness is inferred either directly, as it is

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made public, or indirectly through an association, as in the case of a person seen leaving the study of a psychiatrist.

While less blatant than the obvious signs, labels can have just as strong an impact.

There are three stereotypes usually associated with mental illness: dangerousness - people with

Mental illness is unpredictable, and this generates fears and concerns about an alleged

violence; guilt - people with mental illness lack personal integrity, and therefore are responsible for their pathological condition; Incompetence – People with mental illness are unable to succeed in work or in their independent living goals.

The above stereotypes stimulate negative emotional reactions, such as anger, fear and guilt, towards people who have a psychiatric diagnosis and robust prejudices, which trigger discriminatory behaviors, in turn causing three serious consequences: loss of opportunity (not renting an apartment to a person with mental health problems); coercion (an authority makes decisions for a patient, mistakenly considered unable to do so); segregation (confinement of psychiatric patients in institutions or isolation in social contexts).

Therefore, discrimination, the ultimate consequence of the harmful process, decreases quality of life and undermines any possible social inclusion, depriving people of important opportunities, including well-paid jobs, safe and comfortable housing, relationships, community activities and educational opportunities.

The aforementioned chain of stereotypes, prejudice and discrimination form the external stigma, i.e. how the community conceives mental illness and reacts to people affected by mental illness. The effects of stigma work in two ways. First, it becomes difficult for people labeled “mentally ill” to reach life goals due to discriminatory practices by employers, landlords and other groups; Second, health services can be avoided for fear of being stigmatized.

1.1. Social Stigma, Psychiatric Symptoms and Disability of Mental Illness

Many of the assumptions of our stigma model are based on social psychology research on other discriminated groups, including race of color and women. There are, however, two distinguishing characteristics of people with mental illness that

make psychiatric stigma strange. First, unlike other stigmatized groups, declines in self-esteem and self-efficacy are intrinsic to specific mental illnesses such as depression, where self-disqualification or the feeling of not having the strength to face reality can derive directly from pathology and are not secondary to the label assigned to the category of depression.

Therefore, it is necessary to distinguish between problems of self-esteem and self-efficacy resulting from mental illness and those caused by stigma. One way to do this is to determine if the decrease in self-esteem varies with the increase and decrease in dysphoria, thus suggesting that the depressive process is responsible for these fluctuations. Second, serious mental illnesses such as schizophrenia and bipolar disorder negatively impact social skills and social cognition there are suspicions that these dysfunctions It influences both public opinion and positive self-esteem, as happens, for example, when individuals with limitations in social cognition struggle to understand when they are subject to prejudice and discrimination. One last question about symptoms and disability is whether

Discrimination, is or is not a normal response to strange and threatening behavior of people with psychiatric disorders. Search for links and contributors (Link et al., 2001; Link & Phelan, 2001)

suggests that some of the stigmatising responses to serious mental illness are indeed reasonable reactions to symptoms and disabilities, typical for such pathologies. However, it has also been shown that prejudices and stereotypes are responsible for negative social reactions even in the absence of strange or abnormal behaviors and symptoms that could normally have triggered them.

1.2. The Process of Self-Stigmatization in People with Mental Illness

People with mental health problems may internalize social stigma related to their illness. For this to happen, however, they must have first adopted the cultural stereotypes specific to this disorder.

Discrimination, although it is not an indicator of the presence of self-stigmatization, but rather of external stigma, is nevertheless a necessary element to start or reinforce the process of self-stigmatization, which, in order to be realized, needs two other factors: the sharing on the part of the sick individual of the most common stereotypes (for example, people with mental illness are incapable) and their application to oneself (I am incapable because I have a mental illness).

The result is a decrease in self-esteem and self-efficacy, to the extent that the individual himself is agree with negative social and cultural beliefs and help strengthen them, adhering to them. From this point of view, self-stigmatization is the result of a series of consistent processes, in which a person with mental illness must first be aware of stereotypes, agree with them and finally apply them to herself. These are, therefore, perceptual-cognitive processes activated by external stigma, which, however, does not concern all mentally ill people. Some of them react to external stigma by becoming more energetic and assertive, while others remain relatively indifferent and passive.

Research suggests that perceived stigma and internalization of cultural stereotypes about diseases

Mental problems, such as attributing dangerousness, incompetence and blame for the disease, strongly limit the prospect of recovery.

2. Theoretical Model of Self-Stigmatization

Self-stigma and empowerment can be represented as opposite poles, a negative and positive continuum. At the extreme of the negative pole are people who, not being able to overcome expectations pessimists and stereotypes about mental illness, who have low self-esteem, little belief in a better future, are more vulnerable to the process of self-stigmatization.

At the extreme of the positive pole we find, instead, people who, although sick, maintain good levels of self-esteem and do not feel significantly burdened by social stigma, but paradoxically energized by the fight against the labeling process.

Two factors predicting individuals' greater or lesser adherence to stereotypes and the tendency to apply them to themselves: identification with the group (Group Identification) and legitimacy attributed to stigma and discrimination associated with mental illness (Perceived Legitimacy).

Identifying with a group of people who share a stigmatized identity is a crucial variable, which influences how individuals respond to social stigma. If on the one hand members of the stigmatized group can internalize negative beliefs related to this group, on the other hand, they can also develop a positive identity, due to interaction with peers of the stigmatized group.

It has been shown, in fact, that identifying with a peer group can be a protective factor, which reduces the likelihood of agreeing with social stigma and applying it to oneself.

In other situations, members of stigmatised groups appear to be more vulnerable to discriminatory pressure against them and come to consider the consequences of stigma. Crocker and Major (1989) explained this position in light of equity theory:

For example, a negative outcome (not being employed) is perceived as correct if a negative belief (people with mental illness are incompetent at work) is perceived as correct. By applying the theory of fairness to themselves, it is likely that willing people believe that

Prejudices, reactions and social beliefs are less aware of existence and significance stigmatizing and therefore more likely to share negative stereotypes about mental illness, thereby helping to reinforce them.

Data from sociopsychological research support that identification with a group can therefore be a double-edged sword: if people mirror themselves in subjects for which they have great consideration, it is likely that such mirroring is associated with good self-esteem. If, on the contrary, an individual has a negative view of his group, equally strong identification with it can produce the opposite effect, namely that of reducing self-esteem.

This is why some develop effective strategies of "stigma resistance", due to social relationships totally outside the mental health system, excluding those from their friendly sphere

who are or were responsible for these services.

Table 1 presents the main indicators of the self-stigmatization process and its negative effects .

Table 1. Indicators of Self-Stigma

1. Personal identity is lost, replaced by a sense of self defined entirely by illness;
2. All activities of life revolve around being a psychiatric patient;
3. Alienation from others develops;
4. Previous social roles are lost;
5. A devalued and socially undesirable self-idea develops.

2.1. The Impact of Self-Stigma on Achieving Life Goals

The social inclusion and recovery of psychiatric patients is the mission of the

The mental health of the new millennium. The common basis of these principles is the achievement by persons with mental illness of concrete daily life goals, concerning all human beings, whether or not they have a psychiatric pathology and measured in concrete life things, such as work, housing, education, health, relationships and recreational activities.

If functional limitations, due to disability, negatively impact the ability to fully achieve these goals, stigma, both external and internal, also seems to adversely affect their follow-up, undermining the positive effects of the treatments themselves.

As for the latter, the effects of self-stigmatization on the sense of self-worth can produce an attitude that is summed up in the question "Why try?". People who have

Internalized stereotypes such as the following: "The mentally ill have no value, because they have nothing to offer and are lost to society" will fight fiercely to maintain a self-concept and not feel unworthy or incapable. This "discouragement" seems to result, on the one hand, from the lack of basic social skills, essential for achieving aspirations, and on the other hand she starts with great doubts considering stereotypes legitimate, so much so that she declares herself in agreement with them: "Why should I find a job? Others like me – and incompetent like me because of mental illness - failed to achieve this goal"; or: "Why should I try to live independently? Many, in my condition, felt it was not worth investing in this purpose."

When psychiatric patients devalue themselves due to self-stigma and low self-esteem, they also tend to avoid situations where they expect to be disrespected. In short, lack of self-confidence can block progress towards personal goals even in the presence of functioning socially acceptable, taking into account That great doubts arise from legitimately considering stereotypes and agreeing with them, declaring agreement with them undermines the functioning of skills.

2.2. The Relationship between Stigma and Self-Esteem/Self-Efficacy Levels

As has already been stated and consistent with label theory, the demoralization generated by Self-stigmatization reduces self-esteem, prevents the achievement of

personal goals, undermines quality life in the main areas (job satisfaction, housing, economic and physical health), and reduces the ability to seek help (Corrigan, 2009).

But self-efficacy is also fundamental to personal fulfillment. It is a cognitive construct, represented by the perception of acting successfully in specific situations and the conviction of being able to perform actions that influence one's own life . It can also be defined as a group of personal attitudes that favor the beginning and persistence of a behavior . The absence or presence of such perception/belief is the most important indicator of the level of personal effectiveness.

It has been shown that a low degree of self-efficacy is associated with failure to achieve professional, personal or school goals. If patients are not confident in the possibility of adequately engaging in the various circumstances of daily life, they will hardly be able to achieve their personal goals or improve, even if slightly, their condition, unlike those who have a good level of self-efficacy, almost always associated with an acceptable quality of life. It is not clear whether the effects of these constructs – self-esteem and self-efficacy – overlap or remain independent of each other in structuring self-stigma. The results of a study support the last , namely that self-esteem and self-efficacy are not necessarily interrelated: for example, a person may feel effective in achieving satisfactory results at work, but does not consider them important for their self-esteem.

2.3. Self-stigma and Empowerment

Empowerment comes from success in achieving goals, from active participation in treating and fulfilling satisfactory roles in society; It is the result of the combination of internal factors (personal resources) and external factors (paradigm adopted by services; type of treatments offered, skills and attitudes of staff, organizational models in service delivery, possibility of taking advantage of social opportunities), all functions of acquiring skills and support and influencing events that, in turn, condition everyone's life.

Several studies have examined correlations between psychosocial measures of empowerment, self-esteem and self-efficacy, and indicators of hope and recovery, emphasizing that empowerment is associated with sufficient self-esteem, acceptable quality of life, presence of social support, ability to involve in self-help programs, maintaining relational networks and good social functioning: therefore, it is configured as the exact opposite of self-stigmatization.

Corrigan (2009) highlights the main factors that describe the construct of "empowerment": power, active role in the community, legitimate anger for discrimination, optimism/control over the future. A fifth factor—good self-esteem and good self-efficacy—helps place empowerment on a continuum, where self-esteem and self-efficacy are at the other end. This explains the above, that is, why some internalize the stigmatizing message and suffer from diminished levels of self-esteem and self-efficacy, while others seem energized by the same stereotypes, to which they react by becoming not only

more assertive, but also having greater confidence in their ability to achieve their goals, taking a more active role in treatment, and working with caregivers to identify strengths and needs.

Self-stigmatization and EBP Self-stigma also impacts the effectiveness of evidence-based practices, namely those treatments that have survived rigorous control studies and that research has defined as effective for achieving mental health outcomes. But how can stigma reduce EBP's effectiveness? The effect of the belief "Why try", related to low levels of self-esteem and self-efficacy, in turn derived from self-stigmatization, prevents the individual from participating in proposals for care, in which he does not invest because the questions / beliefs: "Why should I engage in treatment if I am not able?", or: "Why continue my studies if I deserve nothing?" prevents the development of motivation for change. And vice versa, when there are levels of acceptable self-esteem and self-efficacy, the subject is encouraged to use services to achieve their personal goals, thus activating a positive vicious circle: they feel capable enough to define their goals and take advantage of life opportunities > grows

Motivation for treatment > achieves the first successes > increases hope in pursuit of results > desired results are maintained > the level of self-esteem and self-effectiveness is further increased >the feeling of empowerment is strengthened. In order to start and sustain the positive vicious circle just described, new services are needed, based on partnership and aimed at strengthening self-determination and achieving personal expectations.

3. Avoid Diagnostic Tag

Stigma can also harm a third group: those who don't yet have a history of mental illness and who avoid mental health services to avoid being labeled. The power of "labeling mental illness" is such that similar decisions are made despite extensive research showing that symptoms, psychological stress and Life disabilities, caused by many psychiatric disorders, can be significantly reduced by a variety of psychopharmaceutical and psychosocial treatments. Unfortunately, many people, who meet the criteria for treatment and who might be better off doing so, either do not seek help from services or do not take the full treatment that has been prescribed. This is evidenced by many studies, including the epidemiological pool and the National Comorbidity Survey, which demonstrate that only 60% of people with schizophrenia undergo treatment, that people with mental illness are no more likely to be treated than people with minor disorders (Kessler, 2001), and that less than 40% receive continuous and systematic treatment.

The bottom line is that many people who could benefit from services do not want to access or access them

Use. Several variables could explain the distance between available treatments and needs Therapeutic.

The unequal distribution of mental health services in different national territories can be one. However, the avoidance of treatment, induced by the desire to avoid the label "mentally ill", generating prejudices and discrimination, seems to be among the most important factors justifying the phenomenon of underutilization of services. Confirmation of the relationship between stigma and access to psychiatric treatment has been provided by epidemiological studies, which identify two main beliefs, which could divert people from treatment (Kessler, 2001): concern about what others might think and the desire to solve their own problems. Use of the perceived stigma scale (Link , 1989), a 20-item instrument representing the devaluation of beliefs and direct discrimination towards people with mental illness, Sirey et al. (2001) found a direct relationship between stigmatizing attitudes and adherence to treatment. Scale scores showed that research participants were less adherent to therapeutic drug prescriptions 3 months after starting drug treatment. Thus, perceiving existing stereotypes about mental illness and identifying with them can hinder people from obtaining assistance for their mental health, thus making their lives even more difficult.

3.1. Fighting Public Stigma: Protest

A review of the research literature in social psychology identified three approaches used to lessen the impact of public stigma: protest, education, and contact (Corrigan and Penn, 1999). First, opinion movements or individuals challenge inaccurate and/or prejudicial representations of mental illness by sending two messages: the first to the media: "Stop misrepresenting mental illness"; the second to the audience: "Stop believing negative opinions about mental illness." Although outrage campaigns are often effective in getting stigmatizing images of mental illness retracted (Wahl, 1999) and limiting Discriminatory behavior by those who intend or unintentionally advocate harm, protest appears to have a partial effect on public stigma, unlike other approaches (education and direct contact) that have been shown to produce more results. However, it has been shown that the media may be less likely to convey a stigmatising message when they know it will be frowned upon not only by public opinion, but also by people with mental illness and their families.

3.2. Combating Public Stigma: Education

Education involves defying myths about mental illness (for example, people with mental illness

are incapable of being productive members of the world of work) in fact (many patients who rehabilitate themselves in work, achieve employment goals). This strategy is based on the principle that a better understanding of mental illness makes it less conducive to supporting stigma and discrimination. Although research has shown that education produces short-term improvements in stigmatizing attitudes and that

the impact might be limited (Corrigan et al., 2001), one advantage of combating stigma through education is its ex-portability. In fact, the development of information materials, including curricula

and videotaped testimonies and their dissemination to the general public can be a relatively simple task.

3.3. Combating Public Stigma: Contact

Contact is the third approach to dealing with public stigma and is based on the assumption that those who interact directly with people with a mental illness are less likely to endorse stigma and more likely to form positive opinions about this category of individuals.

Studies have shown that exposure to contact reduces stigmatizing attitudes to an extent greater than educational interventions alone (Corrigan et al., 2001) and that the effects of contact on stigmatizing beliefs are greater than the effects produced by education (Corrigan, 2002) on two typical biases: people with mental illness are responsible for their disabilities and people with mental illness are dangerous. Another significant fact is that changing attitudes appear to be maintained over time for contact interventions, but not for educational ones (Corrigan et al., 2002). The researchers tested several variables that improve the effects of contact, which produce better outcomes when the mentally ill person interacts with psychiatric patients in respected positions (e.g., a doctor or minister), when they collaborate with healthy people on specific initiatives, and when they have the support of those in power in that group. Despite the promises, the contact strategy has its limits, especially in terms of ex-portability, as it requires individuals to have the courage to "come out", to reveal their illness.

Attempts have been made to reduce these limits by producing videos where people speak

about his mental health or building anti-stigma programs, in which participants they tell their story of illness and recovery which, however, many others keep hidden to avoid etiquette and associated stigma. If even a small percentage of people with a psychiatric diagnosis were revealed, the impact of the contact strategy would be enormous. In this regard, they can learn from the gay and lesbian communities, whose members have learned to come out with success in reducing public discrimination in the areas of employment, housing and civil rights. People with mental illness should follow the same path, which would certainly help them counteract the dramatic consequences of stigma on a personal and social level.

3.4. Strategies and Services to Combat Self-Stigma and Its Consequences

Research on interventions to neutralize internal stigma suggests using narrative approaches as an effective way to allow patients to "re-historicize" their identity,

separating an active self from a self stigmatized by illness, a process that confers the power to rebuild relationships with family and community that are no longer mediated by an alienated and victimized identity. It is, in fact, confirmation that self-stigmatization is also favored by the roles and expectations associated with being a "mentally ill" and from experiences such as hospitalization, psychiatric diagnosis, and emphasis on risks associated with reducing institutional dependence.

But the damaging effects of self-stigmatization also force us to develop new strategies to counter it and foster its opposite, namely empowerment. There is no doubt that a home, a workplace, some leisure facilities are factors that help neutralize the process of self-stigmatization, but they are not enough. There is also a need for a different way of approaching services, which do not constantly replace the person, but equip him with tools to self-direct, as happens, for example, when working workers are helped by the tutor to identify the best way to communicate with the employer, rather than being mediated by operators, which already have pre-established intervention schemes.

Another very important strategy to reduce vulnerability to self-stigmatization is the active participation of patients in their own course of treatment. There are several elements of well-being and treatment decisions that, by improving empowerment, counteract identification with stereotypes of mental illness. First, services, to prevent stigma, need to collaborate and hire professionals who treat patients as partners, rather than being patrons and telling them what to do. In the partnership relationship, users and practitioners have equal dignity and work together to understand the disease and develop a care plan, with the result that the first control an important part of their lives. One treatment-related element that decreases self-stigma is the satisfaction of those who receive the service: people cu Mental illness experiences empowerment when it bases the quality of a program also on their feedback, rather than systematically excluding them from the process of evaluating the services provided. The coaching strategy also facilitates the development of empowerment. Coaches, in fact, provide support that helps patients experience success in different important contexts: work, housing, education, and health. The impact on empowerment increases even more when it is on par with psychiatric illness to provide coaching interventions (Mowbray, Moxley & Collins, 1998).

It is affirmed, therefore, the importance of the growth/responsibility oriented paradigm versus the infantilization/delegation oriented (Table 1) and characteristics of empowerment services (Table 3) .

Table 2. Infantilization/Delegation vs Growth/Responsibility

1. Clinical stabilization
2. The doctor knows what is best for the patient
3. life = disease prevalence with short periods of symptom reduction
4. Staff attitudes: protection, guardianship, exclusion, de-responsibility

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5. acquire skills and support to reconnect with others, exercise valid social roles and influence events that in turn affect their lives
6. patient involvement in treatment through joint decision-making
7. Relapses do not cancel the successes achieved in the previous phase and are considered moments of growth.
8. The goal is to encourage empowerment that fosters the pursuit of life goals and participation in evidence-based practices necessary to achieve them .

Table 3. Characteristics of Empowerment Services

1. services consisting of programmes resulting in:
2. bringing the person closer to context (resocialization)
3. Learning and practicing skills
4. performing tasks that are valid and useful to the community
5. taking responsibility, including being able to take risks

Corrigan et al. (2009) highlight the three main intervention strategies to Counteract the three components of the self-stigmatization process (awareness, agreement and self-contest) and encourage increased empowerment:

1.User managed services and self-help groups, making it easier to identify with group and interactions with colleagues in contexts that enhance empowerment and self-determination.

- Revealing one's own illness.

- Cognitive-behavioral approaches, which teach how to counter beliefs irrational, harmful and self-destructive, but which are considered legitimate and fair (stereotypes), and how to reduce their impact on your own self.

But further research is needed to investigate the mechanisms that are strengthening identifying with the group and countering the legitimacy conferred on stigma at the different stages of the disease, starting from the onset of symptoms to the stabilization and recovery phase.

3.5. User Managed Services

User-managed services are closely linked to empowerment, as they are inspired by two principles of great relevance to this psychosocial dimension. The first is the principle of equality, in which relations between those who share the same condition must not be hierarchical, no one should be considered subordinate, and everyone should participate in the provision of services, which better meet mutual needs and interests. The second is the supporter's principle, according to which

Service users perform peer support functions, sharing with them useful strategies and resources for achieving life goals, frozen by mental illness. It thus increases both the degree of self-efficacy , since the person constantly checks through concrete actions his competence and becomes the carrier of important life experiences, both the degree of self-esteem, as the person, through successful experiences, becomes aware of his value.

Traditionally, user-managed services are of three types; the first is represented by Drop-In Centers, programs to which you can freely access without restrictions and you are not forced to take advantage of the most traditional outpatient services; the second is peer support/mentoring, aimed at supporting those with mental health problems at different stages of the recovery process by offering educational programs, which seek to teach participants basic social skills to pursue personal goals; The third is to carry out advocacy actions, through which users become active actors in service planning at local, regional and national level.

3.6. Disease Disclosure

Knowledge of interventions to neutralize the process of self-stigmatization, induced by the external stigma is still embryonic. As already pointed out, to date, there are few evidence that large-scale media campaigns are effective in changing attitudes, or discriminatory behaviour, although it would appear that more direct and targeted forms have a greater potential to produce a change in attitude. Personal contact and

possibility to .Dialogue and listen to the stories of people with mental health problems prove to be a more effective way to erode self-stigma and at the same time destroy social prejudices. It is in this latter area that the strategy called "revealing one's illness" is placed.

Many people with severe psychiatric disorders choose to counteract self-stigma and the effect of the "Why try" question/belief by keeping their mental illness and related treatment a secret. For others, instead, passing on their experiences with the disease, with the system of services and treatments can be a powerful tool to break self-stigma. The costs and benefits of such openness depend on personal goals and assessments.

The disadvantage is the dismayed reaction of colleagues, neighbors or other people around friends and colleagues. In turn, such a reaction can bring the subject to withdraw and avoid social contacts. The great advantages, however, come from the feeling of well-being experienced when you no longer feel like a "clandestine" hiding something because of shame. Revealing one's illness is not an all-or-nothing decision (i.e., opening up completely or not openly at all), but one can contemplate a number of intermediate options and different ways to do so. Different ways of approaching the problem have been identified and four levels of openness are described.

At the extreme pole, people may choose to continue hiding through social avoidance, keeping away from situations where their illness might be noticed. In this case, they prefer to have contact only with those who have the same problem.

A second group may decide not to avoid social situations, but to keep their experience hidden from people, whose judgment they fear. We are talking here about selective openness, because it selects the subjects with whom they share their disease. Example: it may be considered appropriate to opt for disclosure to co-workers if there is a relationship of trust and friendship with them, but not to neighbors. Selective openness has the advantage of being able to get support from a few people with whom the problem has been shared, but the disease still remains a secret to be ashamed of.

Those who, on the other hand, are oriented towards indiscriminate openness completely abandon the attitude of secrecy, do not take into account the negative consequences arising from revealing the disease and no longer make any active effort to try to hide it.

Sharing your experience is the fourth way to manage your psychiatric condition and consists of sharing your history and experience with mental illness with others, while educating operators, citizens, caregivers, students and politicians about psychiatric issues.

This choice has far greater benefits than that of non-discriminatory openness, since it favors the strengthening of the mastery of experience with disease and stigma, thanks to the fulfillment of a public and universally recognized formative role.

3.7. Cognitive Reformulation

Another strategy to counteract self-stigma is cognitive reformulation, which provides tools to reduce the power of negative self-evaluations that derive from stereotypes internalized stigmatizers. "All people with mental illness are lazy" is a statement, which indicates a disqualifying bias which, when applied to itself, produces the following.

Conviction: "Because I am mentally ill, I must be lazy." As has already been pointed out, these affirmations can lower self-esteem: "I must be a bad person because I'm lazy" – and self-efficacy -: "A lazy person like me is not able to find and keep a job." Cognitive reframing helps manage negative opinions about oneself, teaching the person stigmatized in identifying and challenging self-destructive self-statements. It is due to Kingdon and Turkington (1994), including in cognitive therapy stigma related to mental illness, such as: size to change. Cognitive-behavioral therapy has been shown to positively influence self-esteem and self-stigmatizing people with schizophrenia, encouraging patients who self-stigmatize to challenge their harmful beliefs through different strategies, such as, for example, asking their friends and acquaintances if they agree with the following statement: "Do you think I'm lazy or bad because I have a mental illness?" The process is even more effective if such questions are asked to spiritual leaders or authoritative family or community members.

Once patients learn to combat the internalized stereotype, they can also develop a counter-stereotype, effective in reducing the effects of self-stigma: "I'm not lazy! Even if I'm sick, I can do the following...."

4. Conclusions

The severity of self-stigma depends on how aware people are of stereotypes of mental illness and agree with them, ending up applying them to themselves. The operation undermines the sense of self-esteem and self-efficacy, a phenomenon that, in turn, paralyzes the initiation of effective behaviors to achieve personal goals. As a result, those affected by mental illness decide not to commit to obtaining a job, a home or to the satisfaction of others individual aspirations. The “Why try” question/belief also reduces awareness of the right to adequate and effective mental health services and opportunities to improve quality of life. Reactions to social stigma can also have the opposite effect of implementing empowerment (empowerment), putting in your mind the idea that stereotypes are not so strong so as to block the pursuit of individual goals. Knowledge of the process of self-stigmatization is useful to understand what strategies can reduce its impact and what changes can be made , both as a person and in the service system, to counteract it and, therefore, promote the achievement of patients’ personal goals. The task of service operators is to help patients maximize their ability to resist social processes that undermine their identity, identifying and challenging the stigmatizing, albeit unintended, impact of many professional practices.

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