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Attitudes Towards Mental Health Problems: A Scoping Review

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ABSTRACT

Introduction: Understanding attitudes towards mental health problems is essential in the health care setting. Mitigating negative attitudes can promote better mental health conditions by promoting help-seeking behavior.

Objectives: The study aimed to review attitudes towards mental health in different countries, including Nepal.

Methodology: A scoping review of attitudes towards mental health problems included global studies, with a focus on Nepal. Out of 77 articles retrieved, 15 met the inclusion criteria for review, covering 23, 901 participants worldwide. Common themes and patterns in attitudes were synthesized.

Results: The review found widespread negative attitudes and stigma towards mental illness globally, especially among young, single, and less-educated men. Women were more likely to view mentally ill individuals as dangerous. These attitudes hinder the pursuit of mental health services, leading to untreated conditions. The study also identified unfavorable attitudes towards mental health in Nepal, indicating a need for targeted interventions.

Conclusion: In conclusion, negative attitudes towards mental disorders are widespread, including in Nepal. The findings emphasize the need for interventions to address stigma and promote mental health awareness. Further research, especially in Nepal, is crucial to better understand these attitudes and guide evidence-based interventions and policies.

INTRODUCTION

Scholars use the term "attitude" to denote a person's enduring evaluative perspective toward objects, individuals, or events. The term's origin traces back to the realm of painting and sculpture, where it conveyed an inherent state of constancy.[1] Social learning processes, including classical conditioning, instrumental conditioning, and observational learning, actively influence individuals' attitudes, impacting their emotional responses and outlooks on various aspects of life.[2] According to the World Health Organization, mental health is a state where individuals recognize their abilities, handle life stressors, work effectively, and contribute to their communities.[3] Attitude towards mental health problems reflects one's evaluative stance, ranging from negative to positive.[1,3]

Previous studies have found that social stigma associated with mental disorders persists in many countries, including North America (i.e., USA and Canada),[4,5,6] Africa,[7,8] Australia,[9] and the Middle East.[10,11,12,13] It is also found in South Asian countries, for example, India,[11,14] Pakistan,[15] and Nepal.[16,17,18,19] A study showed the increased importance of measuring public attitudes toward people with mental health condition with the advent of community-based mental health care.[20] The social attitudes associated with mental disorder persists across various age groups, religions, ethnicities, and socio-economic statuses.[21]

About 15% and 20% of individuals surveyed in the USA and Canada would not seek treatment for severe emotional problems, with approximately 50% reporting embarrassment related to mental health service utilization.[22] Negative attitudes towards seeking help were most common among young, single, and less-educated men facing socio-economic challenges. They were linked to substance abuse or dependence, antisocial personality disorder, and a lack of previous treatment seeking. The students had a broad understanding of mental health and exhibited largely positive behavior toward people with mental disorders in Canadian universities.[6] However, some students have stigmatizing attitudes and may not feel prepared to interact with people who have mental disorders because of their academic experiences. Schizophrenia was associated with stigma and seen as dangerous and unpredictable, while social phobia was linked to personal weakness. They further found men with mental disorders faced more negative perceptions than women. A tendency to see less stigma in oneself than others was found among Australians.[9]

As in other parts of the world, stigmatizing attitudes prevail in Asian countries. The individuals with mental disorders are often stigmatized in Asia.[23] The concept of familial shame, known as "izzat," has a substantial impact on the experiences of Asian women. Research has found that specific social rules and expectations dictate the acquisition and maintenance of a good reputation, as well as cultural honor systems, also referred to as "izzat," which are tied to the fear of bringing shame to others.[24]

Negative attitudes towards mental health problems exist in the Middle East and Arabian countries that are distinct from other parts of the world in their ethnic background and religiosity (predominantly Muslim). About 80% of participants in Baghdad, Iraq, exhibited moderate stigmatizing attitudes toward mental illness, with gender being a significant factor. The stigma surrounding mental health issues in the United Arab Emirates remains prevalent despite some progress.[13] Studies show that people with stronger values tend to have more negative attitudes towards mental health problems. To address this issue, authorities in the UAE should consider implementing cultural reforms aimed at reducing the stigma associated with mental health problems.[25]

Previous studies suggest that gender and age may also be some of the contributing factors to negative attitudes or stigmatizing attitudes toward mental health problems. Gender and age were associated with attitudes towards mental health problems in Vietnam.[26] In South India, individuals showed hesitancy in social interactions with those with mental disorders.[11] Still, there were no significant differences in attitudes by age, gender, or literacy status.[11,18,25,]

There have been few previous studies in Nepal that have addressed the issues of stigma and attitude towards mental health disorders. The attitudes of the adults residing in the urban community towards mental health disorders were more positive as compared to the adults residing in rural communities.[27] However, the participants had positive or neutral attitudes towards mental illness and psychiatry.[16] Conversely,another study found that attitudes towards mental disorders existed even among the educated population in the Palpa district, with no significant differences in attitudes by age, gender, or education level.[18] Similarly, another study reported that the overall attitude of the participants was found to have a negative attitude towards persons with mental disorders.[28] Similar study found a significant negative association between attitude scores and grade enrolled, gender, and parents' educational levels, as well as for students who had a family member or neighbor with mental disorders, but no significant association with ethnicity or having a family member with a psychiatric/mental health problem.[29] Asian students have a higher emphasis on external and reflected shame compared to non-Asian students, which makes them more prone to experiencing internal shame. However, both Asian and non-Asian students reported similar levels of reflected shame regarding relatives with mental health problems.[7]

Research on attitudes toward mental health is a growing topic in today's world. Around the world there has been extensive research on this subject, especially in the Western world, such as the United States, Canada, and Europe. However, there are limited studies in Asian countries like China, Korea, Vietnam, Saudi Arabia, Oman, Pakistan, Bangladesh, and India. Assessing the general population's attitude and level of stigma towards mental illness is close to non-existent in Nepal.[29]

There is a demand for more research that reveals Nepal's unique cultural, social, and economic factors is an essential work of concerned authorities. Most studies rely on cross-sectional survey designs with limited sample sizes and lack standardized measurement tools, which may limit the generalizability of results. There is a lack of longitudinal studies providing knowledge into the temporal dynamics of mental health stigma in Nepal. Additionally, there's limited research on specific demographic groups and little evaluation of mental health interventions. The lack of sufficient meta-analyses and review articles in this particular field of study is also evident. We have conducted a scoping review in this area of research to cover relevant studies on this subject matter. The goal of this scoping review was twofold. We began by comparing the views of individuals in high-income, middle-income, and low-income nations about mental health issues. Furthermore, our secondary objective was to examine and gain an understanding of the perspectives held by the Nepalese people regarding mental health matters.

METHODOLOGY

We used the reporting format Preferred Reporting Items for Systematic Review and Meta-Analyses Extension for Scoping Reviews Guidelines (PRISMA-ScR).[30]

Search Strategy

We developed a comprehensive search strategy to identify studies on attitudes toward mental illness. We searched electronic databases: Sage Publications, Taylor and Francis Online, Springer Open, Hindawi, and BMC, and performed manual searches by screening reference lists. Additionally, we

performed manual searches on Google scholar and ResearchGate with the keywords. The keywords for searching the articles were 'attitudes towards mental disorders' and 'stigma towards mental disorders' The articles included in this study were published between 2007 and 2022.

Inclusion Criteria

We included studies published in peer-reviewed journals in English language that examined attitudes toward mental illness in the general population and used quantitative or mixed-method designs. We excluded studies based on health professionals, and those only focused on help-seeking behavior or stigma reduction. This approach aimed to provide a comprehensive understanding of attitudes toward mental health across diverse populations and regions.

Samples

A sample of 15 articles was used for the study. All the studies were in English language and published in peer-reviewed journals. A Google search turned up a total of 77 articles. Of these, 18 were duplicates, 31 did not meet the criteria for inclusion, and 13 were not included in the full-text review because they did not meet the inclusion criteria; 23,901 people have taken part in the studies.

Data Extraction

Three independent reviewers extracted the data from the included studies using a pre-designed data extraction form. The extracted data included study design, population characteristics and size, objectives of the studies, countries included in the study, attitude measurement tools, attitude outcomes, and major findings. The studies were extracted from Sage Publications, Taylor and Francis Online, Springer Open, Research Gate, Hindawi and BMC.

Quality Assessment

All of the three independent reviewers assessed the quality of the studies and resolved any disagreements through discussion. We did not employ any standard protocol for quality assessment. This scoping review examined a diverse range of studies addressing mental health stigma across various geographical contexts. The quality of the included studies varied significantly, with several high-quality studies characterized by large sample sizes and robust sampling methods. [9,10,13,22,31] These studies employed techniques such as random-digit dialing [9], multi-stage sampling [10], and simple random sampling [13], enhancing the representativeness of their findings. Conversely, a number of studies were assessed as having lower quality, primarily due to smaller sample sizes and less rigorous sampling approaches. [11,14,18,19,24,25,27,28,29] Some of these studies utilized non-probabilistic or convenience sampling [25, 29], which may limit the generalizability of their results. All included studies were published in peer-reviewed journals, lending credibility to their findings, and were sourced from reputable databases: Sage Journals, PubMed, the National Institute of Health (NIH) and NepJOL. The review's inclusion of diverse study qualities provides a comprehensive overview, but limitations exist. Some studies lack clear sampling method reporting, and one study's exclusive focus on female participants [24], potentially limits generalizability. However, none of the studies were excluded based on their quality. Figure 1 presents a summary of the work at each step of the selection process.

Data Analysis

The extracted data was synthesized using a narrative approach. The findings have been presented in figures or text. The results have been summarized clearly and concisely. The details of the number of articles and participants. Figure 1: CONSORT flow diagram of literature review.

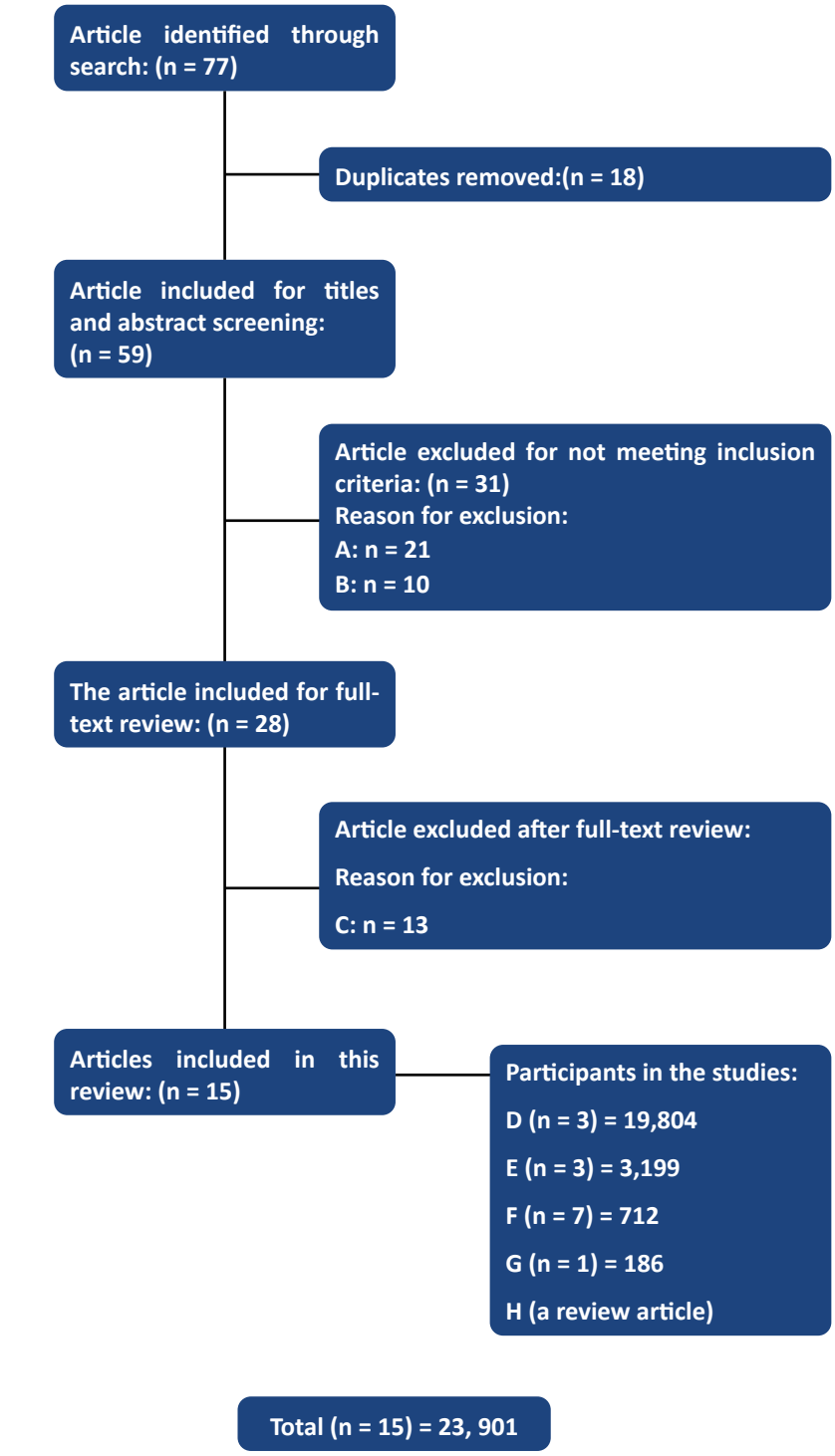

Fig 1: CONSORT flow diagram of literature review.

(Legend: A. articles on mental health problems not including attitudes or stigma. B. Articles not published in authentic journals or sites. C. Articles including attitudes concerning evaluating mental health professionals or community health workers and articles including psychometrics properties or methodological articles. D. Articles from developed countries. E. Articles from the Middle East. F. Articles from South Asia. G. Articles for cross-cultural comparison between Asians and non-Asians. H. A review article)

RESULTS

Data extracted from the eligible papers are provided in Table 1.

Table 1: Detail description of the articles included in the scoping review

Ref. No.	Citations	Country	Objectives	Sample Characteristics	Sample Size	Study Design	Key Findings
22	Jagdeo et. al. (2009)	United States & Canada	Analyze public attitudes on mental health help-seeking and socio-demographics.	Two ntemporaneous population-based surveys sample Age (15 – 54)	5877 & 6902	Surveys (The US National Comorbidity Survey & The Ontario Health Survey)	Negative attitudes to mental health services in Ontario and the US was prevalent; particularly among young adults, lower-educated individuals, and those with substance abuse issues.
31	American Psychological Association (2019)	United States	NA	Adults (18 and above) (education, age, gender, race, ethnicity, geography, household income, household size and marital status)	1,006	Survey	Most Americans held positive views about mental health, but some stigma existed. Young adults reported the poorest mental health and the most shame around mental health disorders. Familiarity with mental health disorders reduced fear and discomfort.
9	Reavley & Jorm (2011)	Australia	Present national survey findings on stigma towards mental health disorders.	15 or over (Participants with depression, suicidal thoughts, early/chronic schizophrenia, social phobia, PTSD)	6019	A cross-sectional survey	Schizophrenia was linked to perceived danger and social phobia was seen as a personal weakness. Greater stigma toward men with mental disorders was found. People anticipated more stigma from others than they admitted.
10	Bener & Ghuloum (2010)	Qatar and other Arab expatriates residing in the State of Qatar	Assess gender differences in mental health perceptions among Qatari and Arab expatriates in Qatar.	Adults (20 and above) Attendees of primary healthcare centers Seeking care for reasons other than mental illness	2,514	A cross-sectional survey	Women endorsed stronger cultural beliefs on mental illness; associated with evil spirits, and favored traditional healers. Men showed better attitudes, preferring psychiatrists.

Ref. No.	Citations	Country	Objectives	Sample Characteristics	Sample Size	Study Design	Key Findings
13	Younis et al. (2020)	Iraq	Examine the prevalence and magnitude of the social stigma towards mental illnesses.	Males and Females from shopping malls and public cafes	300	A cross-sectional study	Approximately 80% of respondents displayed a moderate level of stigma towards mental illness. Around 20% exhibited a low degree. Significant gender differences were observed, but not for age, income, education, or positive family history. 83% favored medical management for mental illnesses.
25	Andrade et al. (2022)	the United Arab Emirates	Measure attitudes towards mental health problems in the study sample	Age, gender, nationality, and emirate of residence – Arabs, South Asians, and the rest of the world.	201	Surveys	No significant associations with gender, nationality, age, or emirate of residency were found. A correlation was observed with adherence to traditional family values, demonstrating gender-based variations favoring higher adherence among males.
11	Salve et al. (2013)	India	Assess community attitudes towards mental illness in South Delhi, addressing social stigma and beliefs.	Age 18 and above, sex, literacy, marital status, family members with mental illness.	100	A cross-sectional study, mixed methods (Quantitative and qualitative)	There were no significant differences in negative community attitudes based on age, sex, or literacy level.
14	Kumar & Pathak (2021)	India	Explore the attitude of the general public toward mental illness in Jharkhand	Age 18 and above level of education Respondents with family members not suffering from mental illness.	240	A cross-sectional study	Both genders displayed positive attitudes towards mental illness, with females exhibiting slightly more positive attitudes. Some domains showed significant differences, and males had higher odds of developing shame towards family members, as per multinomial logistic regression.
27	Singh et.al. (2013)	Nepal		Age (20 to 60), Rural and urban communities. Participants from Jhapa district in Nepal.	150	A correlational comparative study	Urban adults showed more favorable attitudes toward mental health and illness. A positive significant correlation was found between knowledge and attitudes in both communities.
18	Pokharel & Pokharel (2017)	Nepal	Study college students' mental illness stigma and associated factors.	Age (17 to 23), College students (B.Sc.) in Palpa, gender, study year, rural-urban background, mental health history, and relationships with those with mental illness.	78	An observational analytical study	43.6% exhibited high mental health stigma. No significant associations with age, gender, year of study, rural/urban background, mental illness history, or knowing someone with mental illness.

Ref. No.	Citations	Country	Objectives	Sample Characteristics	Sample Size	Study Design	Key Findings
28	Jalan (2018)	Nepal	Study med students' attitudes toward mental illness	Age (NA), Final year MBBS students inclusive of gender, rural-urban residence, history of contact with people with mental illness	68 (Sampling procedure is not provided)	A longitudinal prospective study (Pretest-Posttest design)	The study found that the population held negative attitudes towards individuals with mental illness, as indicated by elevated scores on separatism, stereotyping, restrictiveness, and pessimistic prediction subscales. Although the stigma score was lower, suggesting reduced stigma, benevolence scores indicated kindness and sympathy. There were no significant differences in attitudes before and after mental health education across all assessed dimensions.
29	Nepal et al., (2020)	Nepal	Explore senior secondary students' attitudes towards mental illness.	Age (middle adolescents, late adolescents), grade (11 & 12), gender, ethnicity, religion, type of family, father's education, mother's education, family member with mental health problems	138	A descriptive cross-sectional study	Males showed significantly more negative attitudes than females. Negative correlations observed with grade, gender, parents' education, and having a family member/ neighbor with mental illness.
19	Jha & Mandal (2021)	Nepal	Assess the level of knowledge and attitude on mental illness in community people.	Age (20 to 59), sex, religion, marital status, education (literate & illiterate)	92	Descriptive cross-sectional research design	A higher prevalence of negative attitudes (54.7%) and societal rejection towards individuals with mental illness was found to persist across diverse historical periods, encompassing various social and religious cultures.
24	Gilbert et al. (2007)	United Kingdom	Investigate diverse shame types across communities concerning mental health issues.	Age (18 to 46), Females, Asian (Hindu, Sikh, Muslim) & non-Asian	186	A cross-sectional study	Asian students exhibited higher external and reflected shame, not internal shame beliefs. They prioritized confidentiality by discussing personal feelings/anxieties.
32	Ahmedani (2011)	NA	NA	NA	NA	A literature review	The authors found a Global rise in mental health conditions, with a growing burden. Treatment barriers included stigma, affecting engagement. Health professional stigma added ethical challenges to accessing mental health services.

Note: US refers to the United States, NA refers to not available, PTSD refers to post-traumatic stress disorder, B.sc refers to bachelor's degree in science, and mh-Gap refers to mental health training. CHWs refer to community health workers, MI refers to mental illness and SSRIs refer to selective serotonin reuptake inhibitors, which include citalopram, fluoxetine, and paroxetine.

Stigmatizing Attitudes in the Western Developed Countries

Negative attitudes towards mental health are also common in developed countries like the US and Canada. A study found that 15% of US and 20% of Canadian participants reported they would avoid treatment for severe emotional problems.[4] Approximately 50% of respondents felt embarrassed about using mental health services. Negative attitudes towards seeking help were most common among young, single, and less-educated men facing socio-economic challenges in Ontario and the US. The findings also linked negative attitudes with substance abuse, antisocial personality disorder, and a history of avoiding treatment.[4] On a positive note, a 2019 Harris Poll for the American Psychological Association found that 87% of American adults believed experiencing a mental health disorder is not shameful, and 86% recognized the possibility of recovery for those with mental health disorders.[31] These findings suggest growing acceptance and understanding of mental health issues. They highlight the urgent need to address stigma, raise awareness, and create supportive environments that encourage help-seeking and ensure accessible mental health services.[4,31]

Some studies examined attitudes towards specific mental health issues. The Australian National Survey of Mental Health Literacy and Stigma found that stigmatizing attitudes were prevalent towards chronic schizophrenia, often perceived as linked to dangerousness and unpredictability, and frequently led employers to avoid hiring individuals with this diagnosis.[9] Conversely, social phobia was often viewed as a personal weakness. Men with mental disorders faced more negative perceptions of dangerousness and social distance than women. Additionally, respondents reported perceiving less stigma in themselves compared to others.[9]

Stigmatizing Attitudes in Asian Countries

Stigmatizing attitudes towards mental illness are widespread globally, including in Asia.[23]

The Middle East

In Qatar, 58.1% of women versus 51.5% of men viewed individuals with mental illness as potentially dangerous. Men (82%) were more willing than women (76.8%) to seek psychiatric help ($p = 0.002$), while more women (43.7%) preferred traditional healers ($p < 0.001$). Women (39.5%) were more afraid to interact with mentally ill individuals than men (28.8%) ($p < 0.001$). Only 24.8% of women and 31.1% of men correctly identified schizophrenia as a common mental disorder.[10]

In Iraq, 80% of respondents had a moderate stigmatizing attitude towards mental illness, with 66% being male and 44% female. No respondents had a high degree of stigma. Sixty percent saw the media as a key factor, and 83% preferred medical treatment for psychiatric disorders. These factors were unrelated to the degree of stigma.[13]

A study in the UAE examined the link between demographic variables and attitudes toward mental health problems (ATMHP), including gender, emirate of residence, nationality (Arabs, South Asians, others), and age.[25] The study found no significant association between demographic variables and attitudes toward mental health problems (ATMHP), nor between age and ATMHP. However, a weak but significant correlation ($r = 0.182$, $p = 0.01$) was observed between attitudes toward mental health and family values. Multivariable linear regression revealed that only family values significantly impacted ATMHP.[25]

South Asia

South Asia includes Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka. Studies from India and Nepal that met the inclusion criteria were found.

India: In India, negative attitudes towards mental health are widespread. A meta-analysis showed that patients with depressive disorders had the highest stigma scores, while those with somatoform disorders had the lowest. Mixed disorders had intermediate scores. Stigma correlated positively with depressive symptoms but negatively with somatoform symptoms. Depressive symptoms were perceived as more socially disadvantageous than somatic symptoms.[23]

A cross-sectional study was conducted in a South Delhi urban community to investigate attitudes and perceptions towards mental illness.[11] The study found higher mean scores for stereotyping, restrictiveness, and pessimistic prediction, while separatism, benevolence, and stigmatization had lower scores. The community was caring but skeptical about the future of people with mental illness and preferred limited social interactions. No significant differences in attitudes were observed by age, gender, or literacy.

A study in Jharkhand, India found that females had more positive attitudes towards mental illness than males across all domains of the ATMHP questionnaire.[14] In India, males were 3.7 times more likely than females to feel shame towards family members. A separate study showed 14.2% had very high attitudes towards mental health, 33.3% moderate, 33.8% low, and 18.8% none. High levels of shame included 22.1% with very high external shame, 16.2% internal shame, and 13.8% reflected shame. These findings underscore the need to address gender differences and societal perceptions of mental health in India.

Nepal: A study in Nepal found that adults in urban communities had a more positive attitude towards mental illness compared to those in rural areas.[27] Similarly, a study of 78 randomly selected Bachelor of Science students at Tribhuvan Multiple Campus (TMC) in Tansen, Palpa, found similar patterns.[18] The study used the Discrimination Devaluation Scale (D-D scale) to measure stigma towards mental illness among 78 educated students in Nepal. It found persistent stigma, with no significant links to age, gender, year of study, rural or urban origin, history of mental illness, or knowing someone with mental illness. Another

study found participants held negative attitudes towards individuals with mental illness, scoring high on separatism, stereotyping, restrictiveness, and pessimistic prediction but lower on stigmatization. They showed positive attitudes on the benevolence scale. Mental health education did not significantly change overall attitudes but reduced restrictiveness and increased benevolence scores.[28] A cross-sectional study in Dharan included 138 senior secondary students (grades 11 and 12), with 53.6% females and 46.4% males, selected through convenience sampling.[29] The study used the Belief Towards Mental Illness (BMI) scale and found a significant negative correlation between students' attitudes and their grade level, gender, and parents' education. Students with a family member or neighbor with mental illness also showed more negative attitudes.

In Biratnagar, 88% of community respondents considered mental illness a medical condition.[19] All participants believed mentally ill individuals are not responsible and may be prone to violence. The study found 66.7% viewed mental illness as treatable with regular treatment, while 20.7% preferred traditional healers.

Comparison of Stigmatizing Attitudes between Asians and Non-Asians

Asian and non-Asian individuals differ in their attitudes and perceptions of mental illness. Asian individuals had more positive attitudes towards mental health but reported higher external shame. They also valued confidentiality more and adhered more strongly to Asian values. These findings highlight the need for culturally tailored mental health interventions.[24] People want to share their feelings despite stigma, as ATMHP factors relate to disclosure risks. Concerns about confidentiality were linked to negative community views and judgment. Non-Asians worried about family mental health reflecting poorly on them, while both groups showed strong links between confidentiality fears and disclosure risks. Asian values were associated only with confidentiality, whereas for non-Asians, these values were linked to family mental illness and disclosure concerns.

DISCUSSION

Stigma and reluctance to seek mental health treatment are global issues. Many avoid help due to embarrassment, with negative attitudes more common among young, single, and less-educated men facing socio-economic challenges. Addressing stigma and encouraging treatment-seeking are essential.[22, 31] The Australian national survey found prevalent stigma towards chronic schizophrenia and social phobia. Men with mental disorders faced more negative perceptions than women, and respondents perceived less stigma in themselves compared to others.[9] Stigma towards mental illness is highly prevalent in Asia.[23] Negative attitudes towards mental illness are common in the Middle East, China, and South Asia.

Stigmatizing attitudes are prevalent in Qatar, Iraq, Saudi Arabia, and the UAE. Gender differences in negative attitudes toward mental illness were also noted.[10] Women saw individuals with mental illness as more dangerous and were more afraid to interact with them. Men were more willing to see a psychiatrist, while women preferred traditional healers. In Iraq, 80% had moderate stigmatizing attitudes, more common among males.[13] Whereas, no significant links between demographic variables and attitudes towards mental health, but family values significantly impacted these attitudes in the UAE.[25]

Stigmatizing attitudes are prevalent in India. Lower stigma for somatoform disorders compared to depressive disorders were found in developing countries in Asia, which were seen as more socially disadvantageous.[33] In India, attitudes were caring but negative about the future and social interactions, with no significant differences by age, gender, or literacy.[11] Both males and females had positive attitudes towards mental illness, but females were more positive. Multinomial logistic regression showed males had higher odds of feeling shame towards family members compared to females.[14] In Nepal, negative attitudes towards mental health are widespread, with stigma persisting even among educated populations.[18] However, no significant associations were found between stigma and demographic factors such as age, gender, or rural/urban origin. Research also found that participants held negative attitudes towards individuals with mental illness but showed lower stigmatization and favorable attitudes of benevolence.[28] Urban adults exhibited a more positive attitude towards mental health problems than rural adults.[27]

In Dharan, senior secondary students had negative attitudes towards mental illness, significantly correlated with lower grade levels, female gender, lower parental education, and personal experience with mental illness in the family or among neighbors.[29]Among Nepali participants a higher prevalence of negative attitudes and societal rejection towards individuals with mental illness was found.[19]

Asian students had higher levels of shame and valued confidentiality more, with higher scores in community and family attitudes. Non-Asians showed more concern about family attitudes and confidentiality. Both groups feared confidentiality breaches, but Asian values were linked only to confidentiality, while Non-Asians associated mental illness with poor reflection and disclosure risk.[24]

CONCLUSION

This scoping review highlights the pervasive stigma towards mental illness across diverse global regions, including high-income, middle-income, and low-income countries. The review revealed that negative attitudes are common, particularly among young, single, and less-educated men facing socio-economic challenges. Gender differences in perceptions were noted, with women often viewing individuals with mental illness as more dangerous and exhibiting greater reluctance to engage. In Nepal, despite education levels, stigma persists, with no significant links to demographic variables. Addressing these stigmatizing attitudes and promoting mental health education remain crucial for improving mental health perceptions and treatment-seeking behaviors worldwide.

RECOMMENDATIONS

Comprehensive mental health stigma research in Nepal: an opportunity for longitudinal mixed-methods studies across diverse populations. Examination of cultural, social, and economic factors, particularly in rural communities, LGBTQ+ individuals, and specific diagnostic groups, could yield valuable insights. Exploration of help-seeking barriers, self-help strategies, and healthcare provider attitudes may prove beneficial. Culturally sensitive interventions, policy impact analyses, and media collaborations for awareness hold promise. Ethical research practices and multi-stakeholder engagement could enhance outcomes. Such efforts may significantly improve public perceptions, treatment utilization, and evidence-based mental health policies.

LIMITATION OF THE STUDY

The limitation of this study includes:

1. Narrow focus on a specific field of study.
2. Strict selection criteria limited to articles on public attitudes or stigma around mental
3. Lack of sufficient empirical data from Nepal.

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We express our sincere gratitude to all researchers whose work informed this scoping review on mental health stigma in Nepal. Their pioneering studies across diverse populations have been instrumental in advancing our understanding of this critical issue. We acknowledge their valuable contributions, which have laid the foundation for future research and interventions in this field.

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