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Stigma, literacy, and intervention: a comprehensive analysis of mental health in education and psychiatric care

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Abstract

Stigma associated with mental health persists as one of the most significant barriers to disclosure, help-seeking, and sustained wellbeing across educational, clinical, and occupational settings. This study synthesizes evidence from recent studies in the India, United States, Australia, the United Kingdom, and the Asia-Pacific, providing a comprehensive analysis of prevalence, risk factors, and intervention strategies. Findings indicate that stigma manifests in public, perceived, and internalized forms, with profound consequences for academic performance, social integration, and employability. Risk factors such as early illness onset, aggression, substance use, chronic health conditions, financial stress, and minority identity further exacerbate these outcomes. Despite growing mental health literacy, stigma remains embedded in cultural narratives and institutional practices, particularly in rural contexts and among male populations. Emerging challenges including imposter syndrome, pandemic-related suicide trends, and the impact of media framing illustrate the evolving complexity of the issue. Promising interventions range from contact-based education and peer support initiatives to culturally tailored counseling, stigma sensitive communication, and technology enabled self-management. The study concludes that dismantling stigma requires systemic reform supported by inclusive policies, faculty and employer sensitization, and sustained cultural change, positioning stigma reduction as both a public health priority and a social justice imperative.

Keywords: Mental health, stigma, psychiatric inpatients, help-seeking, workplace discrimination, imposter syndrome

Introduction

Mental health conditions represent one of the most urgent public health challenges of the 21st century. University students, young adults, and individuals with psychiatric conditions remain disproportionately vulnerable (Martin, 2010) ^[9]. Stigma defined as a combination of ignorance (knowledge deficit), prejudice (attitude), and discrimination (behavior) (Brohan & Thornicroft, 2010) ^[2] perpetuates cycles of underutilized care, academic difficulties, and social exclusion.

Globally, studies confirm that stigma affects not only those living with psychiatric conditions but also the institutions responsible for supporting them (Trunk, Redpath, & Elbert, 2020) ^[16]. Within higher education, students with psychiatric impairments encounter higher levels of stigma compared to peers with physical or learning disabilities, leading to concealment of conditions, lower retention, and increased dropout rates (Martin, 2010) ^[9]. In workplace contexts, stigma shapes hiring and promotion decisions, perpetuating underemployment among individuals with psychiatric conditions (Brohan & Thornicroft, 2010) ^[2].

This study integrates comprehensive reviews, expanding the scope across higher education, psychiatric inpatients, and workplace environments. It addresses: 1. Prevalence and manifestations of stigma. 2. Risk factors shaping mental health stigma. 3. Mental health literacy and awareness gaps. 4. Emerging challenges. 5. Intervention strategies across cultural contexts and 5. Policy and institutional implications.

Outside the specific and organized significances, stigma surrounding mental health brings extensive public costs. It continues inequalities in health care access, contributes to financial losses through concentrated production, and deteriorates public health results by delaying or frightening treatment.

The World Health Organization (WHO) recognizes mental health stigma as a serious barrier to attaining collective health coverage and justifiable growth. Additionally, social descriptions and media illustrations often support categorizes, framing people with mental illness as risky, Dangerous, untrustworthy, or unqualified, thereby developing bias across generations.

Stigma not only disturbs immediate academic acts but also long-term career routes in higher education. Students who sidestep seeking aid due to fear of discrimination may face worsening circumstances, leading to attrition and weakened chances in professional career. For mental health inpatients, the interaction of clinical risk aspects and public stigma confuses rehabilitation into society. Likewise, workplace stigma outcomes in methodical exclusion, discouragement employee welfare and organizational diversity together.

Addressing stigma therefore involves a multidimensional tactic: interventions at the individual level (e.g., peer support, therapy), formal reforms (e.g., inclusive strategies, faculty sensitization), and general strategies (e.g., mass media campaigns, public meetings). This review positions stigma as equally a psychosocial and structural challenge, calling for evidence-based and context-sensitive results that link the gaps among awareness, acceptance, and action.

Materials and Methods

Prevalence and Manifestations of Stigma in Higher Education

Surveys highlight alarming prevalence of mental health challenges among students. In the U.S., 53% of undergraduates report anxiety, 36% depression, 31% suicidal ideation, 13% self-harm, and 3% suicide attempts (American College Health Association, 2023) ^[1]. Over 90% report academic challenges affecting mental health. Despite high prevalence, stigma discourages disclosure due to fear of discrimination (Martin, 2010) ^[9].

Pompeo (2014) ^[11] and Pompeo-Fargnoli (2020) ^[12] further demonstrated that perceived stigma often exceeds actual stigma, amplifying reluctance to seek support. This gap between perception and reality creates a “climate of silence,” where students wrongly assume their peers are more judgmental than they actually are, deterring help-seeking (Peterson, 2018) ^[10].

Stigma also intersects with academic identity. Trunk, Redpath, and Elbert (2020) ^[16] found that students with psychiatric disabilities reported higher concealment of conditions than those with physical or learning disabilities, resulting in reduced retention and poorer academic outcomes. A systematic review by Campbell *et al.* (2022) ^[3] of UK higher education similarly highlighted that stigma, financial pressures, and lack of support services act as compounding stressors for students, significantly influencing dropout rates.

Emerging evidence further suggests that stigma manifests differently across cultural contexts. Shivani and Judge (2022) ^[13] found that Indian students in rural settings displayed lower mental health literacy and greater endorsement of stigmatizing beliefs than their urban peers, while Faizan *et al.* (2025) ^[5] observed that male students consistently expressed more stigmatizing attitudes than

female counterparts. These findings highlight that stigma in higher education is not uniform but stratified along social, cultural, and demographic lines.

Collectively, the evidence indicates that stigma in academic environments operates on multiple levels—individual, peer, and institutional—and directly undermines both mental health outcomes and educational attainment. Table 1 provides an overview of representative studies examining the prevalence of mental health challenges in higher education.

Psychiatric Inpatients

Among Indian psychiatric inpatients, Jith *et al.* (2025) ^[18] found an aggression prevalence of 41.1%, closely associated with psychosis, mood disorders, and substance use. These behaviors, while clinically significant, reinforce stereotypes of dangerousness, thereby deepening stigma. Such findings align with earlier international literature demonstrating that psychiatric patients are often disproportionately perceived as violent or unpredictable, despite evidence that most individuals with mental illness are not violent (Corrigan & Watson, 2002) ^[19].

Moreover, stigma in inpatient contexts extends beyond dangerousness stereotypes. Studies have shown that psychiatric inpatients frequently experience self-stigma and feelings of shame, which can hinder recovery and reduce engagement with therapeutic programs (Yanos, Roe, & Lysaker, 2010) ^[20]. Structural stigma is also dominant, with less facilities and insufficient rehabilitation facilities strengthening social exclusion after release (Thornicroft, 2006) ^[21]. These patterns together demonstrate how inpatient settings both reflect and reproduce broader societal biases, making rehabilitation into societies more challenging.

Workplace Contexts

A study in the UK reveals persistent bias attitudes. Brohan & Thornicroft (2010) ^[2] described that employers cited concerns of absenteeism (29%), impaired performance (20%), and unpredictability (11%) when seeing aspirants with psychiatric conditions. These alarms mirror long-standing typecasts of condensed capability and reliability.

Some more research claim that workplace stigma has overt along with subtle manifestations. Explicit forms include hiring discrimination and lack of promotion opportunities (Hipes, Lucas, Phelan, & White, 2016) ^[22], while more covert forms involve microaggressions, social exclusion, or reduced responsibilities assigned to employees with known psychiatric conditions (Hanisch, Twomey, Szeto, & Corrigan, 2016) ^[23]. Such environments can exacerbate stress, lower productivity, and lead to higher turnover among affected employees.

Encouragingly, evidence also suggests that anti-stigma workplace training programs particularly those emphasizing direct contact with people who have lived experience of mental illness—can reduce prejudicial attitudes and improve inclusion (Morgan, Reavley, Ross, Too, & Jorm, 2018) ^[24]. Yet, the translation of such interventions into sustainable organizational practice remains limited, highlighting the ongoing need for policy-driven change.

Table 1: Prevalence of Mental Health Challenges in Higher Education

Study	Population	Key Findings	Implications
ACHA (2023) ^[1]	55,000 U.S. students	53% anxiety, 36% depression, 31% suicidal ideation	Crisis-level prevalence; need urgent response
Martin (2010) ^[9]	Australian students	Fear of disclosure due to stigma	Necessity of inclusive policy and safe spaces
Pompeo (2014); ^[11] Pompeo-Fagnoli (2020) ^[12]	U.S. students	Perceived stigma greater than personal stigma	Address misperceptions to reduce silence
Peterson (2018) ^[10]	U.S. college students	Contact-based interventions reduce perceived stigma after exposure	Supports contact hypothesis in campus settings
Trunk, Redpath, & Elbert (2020) ^[16]	U.S. students with disabilities	Students with psychiatric disabilities report higher concealment than peers with physical/learning disabilities	Highlights academic risks tied to stigma
Campbell <i>et al.</i> (2022) ^[3]	UK university students	Stigma combined with financial and social stressors contributes to dropout	Holistic policy needed for retention
Shivani & Judge (2022) ^[13]	Indian college students	Rural students show lower literacy and higher stigma than urban peers	Literacy campaigns needed in rural settings
Faizan <i>et al.</i> (2025) ^[5]	Indian medical/nursing students	Male students reported more stigmatizing attitudes than females	Importance of gender-responsive interventions

Risk Factors Compounding Stigma

Multiple interlocking risk factors exacerbate the experience and consequences of stigma across higher education, inpatient, and workplace settings. Clinical risk factors such as early illness onset, prior aggression, and substance use are strongly associated with heightened stigma and poorer outcomes among inpatients (Jith, Rajan, Joseph, & Thomas, 2025) ^[8]. These behaviors not only create management challenges in psychiatric facilities but also reinforce stereotypes of dangerousness, contributing to public fear and exclusion (Corrigan & Watson, 2002) ^[19].

In academic contexts, students with co-occurring chronic health conditions (CHCs) both mental and physical report greater stigma awareness, diminished resilience, and reduced quality of life, which together undermine academic performance (Criswell, 2022) ^[4]. The intersection of disability and mental illness amplifies vulnerability, particularly in educational systems where structural accommodations are inconsistently implemented.

Socio-demographic and contextual factors further compound stigma. Rural residence and lower mental health literacy are consistently linked to higher stigma levels (Shivani & Judge, 2022) ^[13], while male students demonstrate more stigmatizing attitudes than female peers (Faizan, Krishna, Gautham, & Jithendra, 2025) ^[5]. Financial

stress, minority identity, and exposure to trauma create layered disadvantages, as documented in systematic reviews of university populations (Campbell *et al.*, 2022) ^[3]. Evidence also shows that members of racial and ethnic minority groups experience stigma not only from the broader society but also within healthcare systems, producing compounded inequities (Gary, 2005) ^[25].

Identity-related risk factors play a critical role in internalized stigma. Research suggests that individuals who strongly identify with their illness may experience diminished self-esteem and hopelessness, impeding recovery and social participation (Yanos, Roe, & Lysaker, 2010) ^[20]. Similarly, students with marginalized identities—including sexual minorities—are at heightened risk of experiencing intersectional stigma, where discrimination based on mental health status overlaps with pre-existing social stigma (Herek, Gillis, & Cogan, 2009) ^[26].

Collectively, these risk factors illustrate that stigma is not monolithic but intersectional shaped by a convergence of clinical profiles, social environments, cultural norms, and identity positions. Addressing stigma therefore requires not only individual-level interventions but also systemic reforms that reduce inequities in education, healthcare, and employment. Table 2 summarizes these risk factors and their implications.

Table 2: Risk Factors for Stigma and Adverse Outcomes

Risk Factor	Evidence Base	Implications
Aggression, early onset, substance use	Inpatient study linking 41.1% aggression to psychosis, mood disorders, and substance use (Jith <i>et al.</i> , 2025) ^[8]	Reinforces dangerousness stereotypes; need risk assessment and de-escalation training
Co-occurring chronic conditions (mental + physical)	Students with CHCs show higher stigma awareness, lower resilience, poorer QoL (Criswell, 2022) ^[4] .	Integrate disability and mental health services; academic accommodations
Rural context and lower literacy	Rural students show lower literacy and higher stigma (Shivani & Judge, 2022) ^[13] .	Targeted literacy campaigns; community-based outreach
Male gender	More stigmatizing attitudes among male students (Faizan <i>et al.</i> , 2025) ^[5] .	Gender-responsive interventions and peer norms
Financial stress, minority identity, trauma	Systematic review of UK students highlights structural stressors (Campbell <i>et al.</i> , 2022) ^[3]	Expand need-based aid; trauma-informed, culturally safe services
Ethnic minority status	Ethnic minority groups face stigma within healthcare and community, limiting care access (Gary, 2005) ^[25]	Improve equity in care; culturally competent services
Illness identity and self-stigma	Strong identification with illness linked to lower self-esteem and recovery barriers (Yanos, Roe, & Lysaker, 2010) ^[20] .	Recovery-oriented care; peer support to counter self-stigma
Sexual minority identity (intersectional stigma)	Sexual minorities experience compounded stigma across identities (Herek, Gillis, & Cogan, 2009) ^[26]	Intersectional policies; LGBTQ+ inclusive mental health programs

Mental Health Literacy and Awareness

Mental health literacy (MHL) is a consistent predictor of lower stigma, yet improvements remain uneven across populations. Among Indian medical students, knowledge levels were relatively high but stigma persisted at moderate levels; importantly, literacy scores were inversely correlated with stigma (Waghjale, Sharma, & Gupta, 2025) ^[17]. This suggests that increasing knowledge alone may not be sufficient unless accompanied by attitudinal and cultural change.

At the broader population level, misconceptions remain widespread. A systematic review of Indian youth revealed that nearly one-third endorsed beliefs that individuals with mental illness are dangerous or irresponsible, and that psychiatric labels were poorly understood (Gaiha, Salisbury, Koschorke, Raman, & Petticrew, 2020) ^[6]. These findings align with global research showing that poor literacy contributes to stereotyping, delayed help-seeking, and treatment non-adherence (Jorm, 2012) ^[27].

Communication practices further shape stigma in subtle but powerful ways. The use of labels, peril-centric framing, and reductive causal explanations can inadvertently reinforce fear and discrimination (Smith & Applegate, 2018) ^[15]. Media portrayals, in particular, often emphasize violence and unpredictability in relation to mental illness, which exacerbates public stigma (Corrigan, Powell, & Michaels, 2013) ^[28]. Conversely, contact-based storytelling and recovery-oriented messaging have been shown to improve empathy and reduce stigma (Clement *et al.*, 2015) ^[29].

Evidence also shows that literacy gaps are socially stratified. Rural students, for example, display lower MHL and greater endorsement of stigmatizing beliefs than urban peers (Shivani & Judge, 2022) ^[13]. Male students similarly demonstrate more stigmatizing attitudes than females, pointing to gendered dimensions of literacy and stigma (Faizan, Krishna, Gautham, & Jithendra, 2025) ^[5]. Cultural factors play an important role as well: in collectivist societies, stigma may be amplified by concerns about family honor and community reputation, making disclosure and treatment-seeking more difficult (Lauber & Rössler, 2007) ^[30].

Taken together, the evidence highlights that while MHL is a protective factor against stigma, its impact depends heavily on context, culture, and communication practices. Programs that combine literacy with stigma-sensitive framing, peer contact, and culturally relevant messaging are therefore more effective than education campaigns alone.

Emerging Challenges in the domain

Imposter Syndrome

Imposter feelings persistent doubts about one's competence despite objective achievements—are increasingly recognized in medical and health-professional education. In a West Bengal cohort, approximately one among five students informed significant imposter moods, which linked certainly with stress and negatively with coping ability (Gupta *et al.*, 2025) ^[7]. Since imposter syndrome interconnects with individuality and belonging, it can increase internalized stigma and discourage for taking assistance and help.

Universally, imposter syndrome has been considered to excessively disturb first-generation college students, women, and people from underrepresented marginal groups, reflecting wider systemic inequities (Cokley *et al.*, 2013) ^[31].

Study also recommends that imposter feelings are linked with depression, burnout, and condensed academic persistence, which can additionally establish stigma by supporting self-doubt and secrecy (Villwock, Sobin, Koester, & Harris, 2016) ^[32]. Within competitive academic atmospheres such as medical institutions, these dynamics subsidize to a philosophy of silence, where students hide mental health struggles out of fear of being alleged as weak or unqualified. Considering imposter syndrome therefore needs not only individual coping strategies but also organized reforms that control promote mentoring, vulnerability, and inspire peer support systems.

Suicide Trends and the COVID-19 Era

India's National Crime Records Bureau data (2017-2022) analyses indicate a steady growth in suicide rates without a distinct pandemic specific spike (Singh, Pandit, Dave, & Patel, 2024) ^[14]. This pattern claims the salience of systemic drivers viz., educational, economic, and social—over short-term pandemic effects, and provisions inclusive, long-horizon prevention policies.

Similar findings have been documented internationally. For example, studies in the UK and Japan reported stable or modestly increased suicide rates during COVID-19, with variations across demographic groups (Pirkis *et al.*, 2021) ^[33]. Younger populations, women, and individuals facing job or academic disruptions appeared particularly vulnerable (John *et al.*, 2020) ^[34]. In India, suicide among students has become an escalating crisis, with academic pressure, unemployment, and stigma around mental health as major contributors (Patel *et al.*, 2012) ^[35].

These trends underscore the need to treat suicide as a structural and multi-factorial phenomenon rather than a temporary crisis. Prevention strategies should therefore integrate economic support systems, academic reforms, destigmatization campaigns, and expanded mental health services. Importantly, timely identification of at-risk groups and community-based interventions have been shown to mitigate risks and foster resilience.

Intervention Strategies

Contact-Based and Peer-Led Programs

Consistent with the Contact Hypothesis, structured interactions with individuals who have lived experience of mental illness reduce prejudice and fear. U.S. college studies using the National Alliance on Mental Illness (NAMI) *In Our Own Voice* program demonstrated significant post-contact reductions in stereotypes of violence and instability (Peterson, 2018) ^[10]. Similarly, in India, simple prior contact was associated with lower stigma among students (Faizan *et al.*, 2025) ^[5]. These findings are supported by meta-analyses showing that direct or even vicarious contact, such as video testimonies, can effectively diminish negative stereotypes (Corrigan *et al.*, 2012) ^[36].

Peer-led initiatives like buddy systems, peer mentoring groups, student organizations, and lived-experience panels extend this effect by fostering credible messengers within campus culture. Importantly, peer-based interventions normalize help-seeking and empower students to frame mental health as a shared community responsibility rather than an individual burden (Reavley & Jorm, 2010) ^[37].

Education, Literacy, and Stigma-Sensitive Communication: Student-designed campaigns (e.g., mental

health days, film screenings, theatre performances, and social media outreach) have demonstrated feasibility and acceptability across Asia-Pacific institutions (Withers *et al.*, 2022) ^[22]. However, evidence suggests that the content and framing of messages matter campaigns that emphasize recovery, agency, and collective responsibility are more effective than those that highlight risk, peril, or pathology (Smith & Applegate, 2018) ^[15].

In addition, systematic reviews indicate that mental health literacy programs not only increase knowledge but also reduce discriminatory attitudes when coupled with interactive components, such as workshops, Q&A sessions, or facilitated small group discussions (Wei, Hayden, Kutcher, Zygmunt, & McGrath, 2013) ^[38]. Thus, campaigns must be stigma-sensitive and context-specific, taking into account cultural narratives and student identity.

Culturally Adapted Counselling and Digital Supports

Culturally responsive counselling models address stigma by embedding interventions within local belief systems, languages, and social practices. Research demonstrates that stigma can be reduced when interventions integrate cultural idioms of distress, family engagement, and community leaders as advocates (Lauber & Rössler, 2007) ^[30].

Digital innovations including web-based therapy, mobile mental health applications, online support forums, and AI-enabled chat services offer private, lower-barrier pathways for students reluctant to seek formal care (Withers *et al.*, 2022) ^[18]. Evidence from randomized controlled trials shows

that online psychoeducation and guided self-help can reduce anxiety and depression while normalizing help-seeking behavior (Andrews *et al.*, 2018) ^[39]. Importantly, blended approaches that combine digital triage with referral to higher-intensity services appear particularly effective in university settings.

Institutional Policies and Occupational Health

At the institutional level, faculty sensitization, integration of mental health topics into core curricula, and clear accommodation processes help shift campus climates towards inclusivity. Policies that mandate reasonable accommodations for students with psychiatric conditions are associated with improved academic outcomes and lower dropout rates (Trunk, Redpath, & Elbert, 2020) ^[16].

In workplaces, occupational health (OH) policies are critical in mitigating stigma. Brohan & Thornicroft (2010) ^[2] found that employer fears of absenteeism, unpredictability, and reduced productivity drive discriminatory hiring practices. However, evidence shows that workplaces implementing anti-stigma training, supportive disclosure processes, and employee assistance programs report higher retention and job satisfaction among employees with psychiatric conditions (Hanisch *et al.*, 2016; Morgan *et al.*, 2018) ^[23, 24]. These findings emphasize that stigma reduction in occupational contexts requires structural commitment rather than reliance on individual coping. Table 3 summarizes these Evidence-Based Intervention Strategies Across Contexts.

Table 3: Evidence-Based Intervention Strategies Across Contexts

Strategy	Representative Evidence	Core Mechanism	Implementation Notes
Contact-based programs (e.g., NAMI IOOV, lived-experience panels)	Peterson (2018) ^[10] ; Faizan <i>et al.</i> (2025) ^[5] ; Corrigan <i>et al.</i> (2012) ^[36]	Positive intergroup contact reduces threat perceptions	Use trained speakers; include debrief sessions; integrate with curricula
Student-led education campaigns	Withers <i>et al.</i> (2022) ^[18] ; Wei <i>et al.</i> (2013) ^[38]	Normalize discussion; increase literacy	Leverage peer influence; use social media; incorporate interactive elements
Peer support and buddy programs	Withers <i>et al.</i> (2022) ^[18] ; Reavley & Jorm (2010) ^[37]	Foster belonging, social modeling, and shared identity	Train peer leaders; ensure supervision; develop referral pathways
Web-based therapy and self-management	Withers <i>et al.</i> (2022) ^[18] ; Andrews <i>et al.</i> (2018) ^[39]	Provide private, accessible support; early intervention	Ensure data privacy; embed in stepped-care systems; combine digital with human support
Stigma-sensitive communication	Smith & Applegate (2018) ^[15] ; Clement <i>et al.</i> (2015) ^[29]	Reduce labeling, peril framing, and stereotyping	Co-design messages with target groups; pre-test campaigns for cultural relevance
Culturally adapted counseling	Lauber & Rössler (2007) ^[30]	Embed care in cultural idioms and local practices	Involve families and community leaders; use multilingual counselors
Policy reforms and occupational health (OH) practices	Brohan & Thornicroft (2010) ^[2] ; Hanisch <i>et al.</i> (2016) ^[23] ; Morgan <i>et al.</i> (2018) ^[24]	Counter structural discrimination; improve inclusion	Create clear accommodation processes; train managers; embed anti-stigma in HR policy

Research Gaps and Future Directions

Despite notable advances in understanding the impact of mental health stigma, several critical gaps remain. First, much of the existing research is cross-sectional, limiting the ability to establish causal mechanisms and long-term outcomes. Future studies should employ longitudinal and cohort-based designs to capture the evolving relationship between stigma, coping strategies, and mental health trajectories (Campbell *et al.*, 2022) ^[3].

Second, the evidence base is disproportionately concentrated in urban and higher-income contexts, while rural, indigenous, and marginalized populations remain underrepresented. This creates a skewed understanding that overlooks cultural diversity, local narratives, and context-

specific challenges (Shivani & Judge, 2022; Gaiha *et al.*, 2020) ^[13, 6].

Third, the role of digital platforms and social media in shaping stigma remains underexplored. While online environments can perpetuate stereotypes and misinformation, they also offer powerful tools for awareness campaigns, peer support, and collective action. Systematic evaluations of these dual dynamics are needed (Smith & Applegate, 2018) ^[15].

Fourth, although numerous interventions such as contact-based programs, literacy campaigns, and digital tools show promise, rigorous evaluations are scarce. Randomized controlled trials and mixed-methods approaches should assess not only changes in attitudes but also behavioural

outcomes and policy-level impacts (Peterson, 2018; Withers *et al.*, 2022)^[10, 18].

Finally, there is a lack of implementation research examining how anti-stigma initiatives can be sustainably embedded within educational institutions, healthcare systems, and workplaces. Few studies track scalability, fidelity, and sustainability of interventions once deployed (Brohan & Thornicroft, 2010)^[2].

Results and Discussion

Stigma surrounding mental health remains a persistent barrier across higher education, psychiatric care, and workplace contexts, even as literacy and awareness initiatives have made incremental progress. In higher education, misperceived stigma climates where students assume their peers hold more negative views than they actually do deter disclosure and help-seeking, reinforcing a culture of silence and avoidance. In psychiatric inpatient settings, clinical risk profiles such as substance use, aggression, and early illness onset remain to shape categorizes of dangerousness, reinforcing public fear and perpetuating exclusion. In professional settings, employer fears about absenteeism and efficiency sustain discriminatory practices, with employees facing subtle microaggressions along with overt barriers in acquisition and promotion.

The findings reported in this study highlight that stigma is multidimensional operating concurrently at interpersonal, individual, structural, and institutional levels. At the interpersonal level, contact-based interventions demonstrate robust evidence in reducing prejudice, with lived-experience narratives and peer-led support normalizing disclosure and recovery. At the institutional level, socially adapted learning movements and stigma-sensitive communication policies are critical to dismantling misconceptions implanted within curricula, faculty attitudes, and administrative methods. Emerging digital tools *viz.*, web-based therapy, online peer groups, along with mobile applications supplementary rise chances for private, low-barrier engagement, mostly for young adults unwilling to pursue formal treatment. At the structural level, implementing policy and strategies reforms in academic and workplace systems continue vital to secure accommodations, counter discrimination, and normalize mental health as a priority equal to physical health.

Global assessments support these results. Studies from the US, Australia and UK, highlight the persistence of stigma in academic campuses despite years of awareness movements (Campbell *et al.*, 2022; Martin, 2010)^[3, 9]. In low and middle-income countries (LMICs) like India, stigma is combined by gender disparities, rural-urban divides, and cultural narratives that linkage mental illness to social status and family honor (Shivani & Judge, 2022; Gaiha *et al.*, 2020)^[13, 6]. These patterns underline the need of context-sensitive methods: interventions effective in one cultural or institutional setting may not mechanically translate to others. Say, peer-support models have been extensively acknowledged in Western contexts, however in South Asian locations, family participation and culturally resonant idioms of distress may be more operative in dropping stigma and endorsing treatment adherence. Machine Learning^[44-46] techniques used in other domain of health sciences like clustering^[45] or classification can also be used in this domain for better recognition and grouping.

For policymakers, the implications are clear: stigma reduction cannot be siloed within awareness campaigns alone. Instead, governments should embed stigma reduction targets into national mental health action plans, link funding to the adoption of inclusive policies in universities and workplaces, and incentivize institutions to adopt stigma-sensitive practices. For educators, embedding mental health literacy into curricula, normalizing discussions around mental health in classrooms, and training faculty to respond sensitively to disclosure are critical steps in creating stigma-free academic environments. For healthcare providers, adopting trauma-informed and recovery-oriented care models, strengthening occupational health protections, and integrating mental health into primary healthcare delivery remain essential priorities.

Future research must move beyond cross-sectional prevalence surveys toward longitudinal, mixed-methods, and intervention-based designs that can clarify causal pathways between stigma, coping strategies, and long-term outcomes. Equally important is implementation science, which can identify how evidence-based stigma reduction strategies can be scaled, sustained, and adapted across diverse institutional and cultural contexts. Lastly, accepting an intersectional lens one that captures the combined vulnerabilities formed by socioeconomic status, gender, rurality, and minority distinctiveness is vital for designing interventions that do not involuntarily reproduce inequalities.

Considering collectively, the evidence advocates that addressing stigma involves not only changing minds but also changing systems, cultures, and policies. Only through such multilevel, context sensitive methods can societies accomplish meaningful decreases in stigma and advancement in the direction of mental health equity.

Conclusion and Future Directions

Stigma surrounding mental illness remains to challenge growth across education, employment, and healthcare. Evidence from various frameworks establishes that stigma whether public, perceived, or internalized makes significant barriers to help-seeking, disclosure, recovery, and equitable participation in society. Considering students, stigma negatively effects mental health, academic performance, and long-term career prospects. Whereas, in psychiatric inpatients, it complicates treatment adherence, reintegration and recovery. In workplaces, stigma sustains unemployment, cycles of exclusion, and underutilization of human potential.

The conclusions of this review study underline that stigma is not simply an attitudinal issue but a structural and cultural challenge. Risk factors like chronic health situations, early illness onset, rural disadvantage, and gender disparities intersect to yield combined vulnerabilities. Notwithstanding modest growths in mental health literacy, stigma remains extremely rooted in cultural narratives, institutional rules, and everyday practices.

To address the discuss challenges it requires a multidimensional response. At the individual level, interventions *viz.*, peer support networks, counselling, and technology-enabled self-management can empower individuals and reduce internalized stigma. Considering institutional level, faculty sensitization, comprehensive curricula, and clear accommodation methods can help renovate academic and workplace environments. However,

the societal level, accurate media framing, stigma-sensitive communication campaigns, and robust rules and strategy implementation can progressively reform social norms and expectations.

Future study and practice must link persistent gaps. Longitudinal and cohort studies are needed to capture stigma trajectories and establish causal pathways. Study should develop to consist of indigenous, rural, and marginalized populations, confirming culturally sensitive practices and interventions. Organized inquiry into the dual role of social media and digital platforms as both vehicles of stigma and tools for awareness and peer support is increasingly vital. Additionally, rigorous assessment of interventions, including randomized controlled trials, should line up not only attitudinal shifts but also behavioural and systemic change.

Equally critical is investment in implementation science to identify strategies for scaling and sustaining stigma-reduction initiatives within universities, healthcare systems, and workplaces. Policy outlines must embed stigma reduction as a computable target within national mental health action plans. Above all, initiatives should centre the voices of individuals with lived experience in the design, delivery, and evaluation of programs, making stigma reduction participatory and responsive to real-world needs.

In the end, dismantling mental health stigma is both a public health priority and a social justice imperative. By mixing evidence-based interventions with systemic reforms, societies can move beyond fragmented initiatives toward sustained, comprehensive environments where people having mental illness are completely supported, empowered, and able to succeed across education, employment, and healthcare.

Conflict of Interest

Not available.

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Not available.

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