A STUDY ON THE IMPACT OF STIGMA ON MENTAL DISABILITY

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Abstract – Many people with serious mental illness are challenged doubly. On one hand, they struggle with the symptoms and disabilities that result from the disease. On the other, they are challenged by the stereotypes and prejudice that result from misconceptions about mental illness.

As a result of both, people with mental illness are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people. Although research has gone far to understand the impact of the disease, it has only recently begun to explain stigma in mental illness.

Much work yet needs to be done to fully understand the breadth and scope of prejudice against people with mental illness. Fortunately, social psychologists and sociologists have been studying phenomena related to stigma in other minority groups for several decades.

In this paper, we integrate research specific to mental illness stigma with the more general body of research on stereotypes and prejudice to provide a brief overview of issues in the area.

Keywords: Stigma, Disability, Mental illness

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INTRODUCTION

Public stigma is the reaction that the general population has to people with mental illness. Self-stigma is the prejudice which people with mental illness turn against themselves. Both public and self-stigma may be understood in terms of three components: stereotypes, prejudice, and discrimination. Social psychologists view stereotypes as especially efficient, social knowledge structures that are learned by most members of a social group.

Stereotypes are considered "social" because they represent collectively agreed upon notions of groups of persons. They are "efficient" because people can quickly generate impressions and expectations of individuals who belong to a stereotyped group.

The fact that most people have knowledge of a set of stereotypes does not imply that they agree with them. For example, many persons can recall stereotypes about different racial groups but do not agree that the stereotypes are valid. People who are prejudiced, on the other hand, endorse these negative stereotypes and generate negative emotional reactions as a result.

In contrast to stereotypes, which are beliefs, prejudicial attitudes involve an evaluative (generally negative) component. Prejudice also yields emotional responses (e.g., anger or fear) to stigmatized groups.

Prejudice, which is fundamentally a cognitive and affective response, leads to discrimination, the behavioral reaction. Prejudice that yields anger can lead to hostile behavior (e.g., physically harming a minority group) In terms of mental illness, angry prejudice may lead to withholding help or replacing health care with services provided by the criminal justice system. Fear leads to avoidance; e.g., employers do not want persons with mental illness nearby so they do not hire them. Alternatively, prejudice turned inward leads to self-discrimination.

Research suggests self-stigma and fear of rejection by others lead many persons to not pursuing life opportunities for themselves. The remainder of this paper further develops examples of public and self-stigma. In the process, we summarize research on ways of changing the impact of public and self-stigma.

RESEARCH STUDY

Stigmas about mental illness seem to be widely endorsed by the general public in the Western world. Studies suggest that the majority of citizens in the

United States and many Western European nations have stigmatizing attitudes about mental illness. Furthermore, stigmatizing views about mental illness are not limited to uninformed members of the general public; even well-trained professionals from most mental health disciplines subscribe to stereotypes about mental illness.

Stigma seems to be less evident in Asian and African countries, though it is unclear whether this finding represents a cultural sphere that does not promote stigma or a dearth of research in these societies. The available research indicates that, while attitudes toward mental illness vary among non-Western cultures, the stigma of mental illness may be less severe than in Western cultures.

Fabrega suggests that the lack of differentiation between psychiatric and non-psychiatric illness in the three great non-Western medical traditions is an important factor. While the potential for stigmatization of psychiatric illness certainly exists in non-Western cultures, it seems to primarily attach to the more chronic forms of illness that fail to respond to traditional treatments. Notably, stigma seems almost nonexistent in Islamic societies. Cross-cultural examinations of the concepts, experiences, and responses to mental illness are clearly needed.

Several themes describe misconceptions about mental illness and corresponding stigmatizing attitudes. Media analyses of film and print have identified three: people with mental illness are homicidal maniacs who need to be feared; they have childlike perceptions of the world that should be marveled; or they are responsible for their illness because they have weak character.

Results of two independent factor analyses of the survey responses of more than 2000 English and American citizens parallel these findings:

a.   fear and exclusion: persons with severe mental illness should be feared and, therefore, be kept out of most communities;

b.   authoritarianism: persons with severe mental illness are irresponsible, so life decisions should be made by others;

c.   benevolence: persons with severe mental illness are childlike and need to be cared for.

Table 1

Comparing and contrasting the definitions of public stigma and self-stigma

Public stigma	
Stereotype	Negative belief about a group (e.g., dangerousness, incompetence, character weakness)
Prejudice	Agreement with belief and/or negative emotional reaction (e.g., anger, fear)
Discrimination	Behavior response to prejudice (e.g., avoidance, withhold employment and housing opportunities, withhold help)
Self-stigma	
Stereotype	Negative belief about the self (e.g., character weakness, incompetence)

Although stigmatizing attitudes are not limited to mental illness, the public seems to disapprove persons with psychiatric disabilities significantly more than persons with related conditions such as physical illness. Severe mental illness has been likened to drug addiction, prostitution, and criminality.

Unlike physical disabilities, persons with mental illness are perceived by the public to be in control of their disabilities and responsible for causing them. Furthermore, research respondents are less likely to pity persons with mental illness, instead reacting to psychiatric disability with anger and believing that help is not deserved.

The behavioral impact (or discrimination) that results from public stigma may take four forms: withholding help, avoidance, coercive treatment, and segregated institutions. Previous studies have shown that the public will withhold help to some minority groups because of corresponding stigma.

A more extreme form of this behavior is social avoidance, where the public strives to not interact with people with mental illness altogether. The 1996 General Social Survey (GSS), in which the Mac Arthur Mental Health Module was administered to a probability sample of 1444 adults in the United States, found that more than a half of respondents are unwilling to: spend an evening socializing, work next to, or have a family member marry a person with mental illness. Social avoidance is not just self-report; it is also a reality. Research has shown that stigma has a deleterious impact on obtaining good jobs and leasing safe housing.

Discrimination can also appear in public opinion about how to treat people with mental illness. For example, though recent studies have been unable to demonstrate the effectiveness of mandatory treatment, more than 40% of the 1996 GSS sample agreed that people with schizophrenia should be forced into treatment. Additionally, the public endorses segregation in institutions as the best service for people with serious psychiatric disorders.

SIGNIFICANCE OF THE STUDY

Change strategies for public stigma have been grouped into three approaches: protest, education, and contact. Groups protest inaccurate and hostile representations of mental illness as a way to challenge the stigmas they represent. These efforts send two messages. To the media: STOP reporting inaccurate representations of mental illness. To the public: STOP believing negative views about mental illness.

Wahl believes citizens are encountering far fewer sanctioned examples of stigma and stereotypes because of protest efforts. Anecdotal evidence suggests that protest campaigns have been effective in getting stigmatizing images of mental illness withdrawn. There is, however, little empirical research on the psychological impact of protest campaigns on stigma and discrimination, suggesting an important direction for future research.

Protest is a reactive strategy; it attempts to diminish negative attitudes about mental illness, but fails to promote more positive attitudes that are supported by facts. Education provides information so that the public can make more informed decisions about mental illness. This approach to changing stigma has been most thoroughly examined by investigators.

Research, for example, has suggested that persons who evince a better understanding of mental illness are less likely to endorse stigma and discrimination. Hence, the strategic provision of information about mental illness seems to lessen negative stereotypes. Several studies have shown that participation in education programs on mental illness led to improved attitudes about persons with these problems.

Education programs are effective for a wide variety of participants, including college undergraduates, graduate students, adolescents, community residents, and persons with mental illness.

Stigma is further diminished when members of the general public meet persons with mental illness who are able to hold down jobs or live as good neighbors in the community. Research has shown an inverse relationship between having contact with a person with mental illness and endorsing psychiatric stigma. Hence, opportunities for the public to meet persons with severe mental illness may discount stigma. Interpersonal contact is further enhanced when the general public is able to regularly interact with people with mental illness as peers.

SELF-STIGMA

One might think that people with psychiatric disability, living in a society that widely endorses stigmatizing ideas, will internalize these ideas and believe that they are less valued because of their psychiatric disorder.

Self-esteem suffers, as does confidence in one's future.

Given this research, models of self-stigma need to account for the deleterious effects of prejudice on an individual's conception of him or herself. However, research also suggests that, instead of being diminished by the stigma, many persons become righteously angry because of the prejudice that they have experienced.

This kind of reaction empowers people to change their roles in the mental health system, becoming more active participants in their treatment plan and often pushing for improvements in the quality of services.

Low self-esteem versus righteous anger describes a fundamental paradox in self-stigma. Models that explain the experience of self-stigma need to account for some persons whose sense of self is harmed by social stigma versus others who are energized by, and forcefully react to, the injustice.

And there is yet a third group that needs to be considered in describing the impact of stigma on the self. The sense of self for many persons with mental illness is neither hurt, nor energized, by social stigma, instead showing a seeming indifference to it altogether.

We propose a situational model that explains this paradox, arguing that an individual with mental illness may experience diminished self-esteem/self-efficacy, righteous anger, or relative indifference depending on the parameters of the situation.

Important factors that affect a situational response to stigma include collective representations that are primed in that situation, the person's perception of the legitimacy of stigma in the situation, and the person's identification with the larger group of individuals with mental illness. This model has eventual implications for ways in which persons with mental illness might cope with self-stigma as well as identification of policies that promote environments in which stigma festers.

CONCLUSIONS

Researchers are beginning to apply what social psychologists have learned about prejudice and stereotypes in general to the stigma related to mental illness. We have made progress in understanding the dimensions of mental illness stigma, and the processes by which public stereotypes are translated into discriminatory behavior.

At the same time, we are beginning to develop models of self-stigma, which is a more complex phenomenon than originally assumed. The models

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developed thus far need to be tested on various sub-populations, including different ethnic groups and power-holders (legislators, judges, police officers, health care providers, employers, landlords).

We are also learning about stigma change strategies. Contact in particular seems to be effective for changing individual attitudes. Researchers need to examine whether changes resulting from anti-stigma interventions are maintained over time.

All of the research discussed in this paper examines stigma at the individual psychological level. For the most part, these studies have ignored the fact that stigma is inherent in the social structures that make up society. Stigma is evident in the way laws, social services, and the justice systems are structured as well as ways in which resources are allocated. Research that focuses on the social structures that maintain stigma and strategies for changing them is sorely needed.

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