

# Week 3: Mental Health education



The impact of mental health stigma and ways in which to reduce this.



## Findings from the research

According to Lemert (1951) “the formal ascription of a deviating characteristic” by means of a label sets off the process of “formal social stigmatisation” following a deviation from social norms.



Labelling is seen as the prerequisite for the very existence of deviance that could justify stigmatisation.



Research on stigma has attempted to throw light on the various components of this process. Much of our knowledge on stigma has been informed by studies on attitudes and beliefs about mental illness among the public.



- Research on public attitudes has produced a negative picture: for example, people with schizophrenia are perceived to be **unpredictable, aggressive, dangerous, unreasonable, little intelligence, lacking in self-control and frightening** (Angermeyer & Matschinger, 1995), and a large share of the general population would reject entering particular social relationships such as sharing a flat with someone with schizophrenia, recommending a person with schizophrenia for a job or having them look after their children (Angermeyer & Matschinger, 1995).
- Studies have shown that large-scale public education campaigns on mental illness and the increasing integration of psychiatric services in the community have done little to alter the stigma associated with mental disorders (Phelan et al., 1997; Phelan & Link, 1998).
- The results of attitude surveys are used to draw conclusions on the negative reactions people suffering from mental illness are exposed to.



A second research tradition in investigating the stigma of mental illness are analogue behavioural experiments. These studies actually measure stigmatising behaviour by making participants believe they are interacting with someone suffering from mental illness and recording their reactions.

Analogue behaviour studies have shown that a fictional mental illness status conferred upon participants led to more negative ratings of their test performances and stigmatising perceptions in the absence of any unusual behaviour (e.g. Farina & Ring, 1965; Piner & Kahle, 1984).

Experimental studies revealed that if a person mentioned a mental health problem, they faced greater difficulty in finding job, renting an apartment or being accepted in a neighbourhood than in the control condition (e.g. Farina & Felner, 1973; Farina et al., 1974; Page, 1977).

- The words and perceptions of people with mental illness were first explored in journals (e.g. Schizophrenia Bulletin) publishing first person accounts of mental illness.
- Experiences of stigma and discrimination such as being avoided or treated as less competent by others are a frequent topic in these statements.
- A further approach taking account of the patients' view on stigma is the Perceived Stigma Scale developed by Link, Cullen, Frank, and Wozniak (1987). Based on the assumption that individuals acquire conceptions of what it means to be mentally ill, the scale measures the extent to which psychiatric patients believe that others ("most people") will devalue them and discriminate against them.
- Link, et al. (1989) investigated patients' responses to their stigmatised status. Here, they found that those who perceived more discrimination towards the mentally ill were more likely to apply strategies such as secrecy and withdrawal in order to avoid negative reactions. This research identified four dimensions of stigma.

# Four dimensions of stigma

**Interpersonal interaction** - The first dimension, interpersonal interaction, refers to stigma and discrimination experienced in the context of social relationships.

**Public images of mental illness** - The dominance of negative images is not merely perceived as a cause of stigma and discrimination, but rather experienced as directly discriminating and hurtful: it is an integral part of the stigmatisation experience.

**Structural discrimination** – stigma reaches beyond social interaction. Stigma and discrimination are experienced through imbalances and injustices inherent in social structures, political decisions and legal regulations. The poor quality of mental health services is perceived as the strongest form of structural discrimination.

**Access to social roles** - the stigma also expresses itself in the situation that the illness represents a major obstacle denying access to important social roles. Most frequently, the illness imposes barriers on access to employment and related professional roles. For patients, returning to one's job after a period of treatment was often accompanied by critical remarks, mistrust and the denial of skills previously proven.

## findings...

People suffering from mental illness are violent and dangerous.

Media portrayals of mental illness almost exclusively take place in the context of court and police reporting. Accounts of particularly horrific, apparently unmotivated crimes use the mental illness as an explanation for the seemingly unexplainable.

Mental health professionals are concerned that patients also hold the same stereotypes as the rest of the population as they, too, receive their knowledge on mental health issues mainly from the selective accounts of the media.

As a consequence, patients are confused by their knowledge of their illness and are less prepared to accept a psychiatric diagnosis which limits the chances for a successful psychiatric treatment.

- A second central constituent of stigma is that the public does not differentiate between mental illness and mental retardation. **“People think that we’re stupid”**, says a woman who has schizophrenia. For the patients taking part in research, a diagnosis of mental illness implied that they were considered incompetent, irresponsible for their actions and equipped with below-average intelligence. Facing such reactions made them feel devalued and lowered their self-esteem.
- The public view of psychiatric treatment is described as further adding to the stigma experienced. Although psychiatric treatment has changed dramatically with the introduction of medication and community care, participants stated that psychiatry continues to be associated with the “loony bin”, the large-scale mental hospital.
- The separation of mental illness from physical illness in the public discourse is seen as a further sign of the exclusion of mental disorders from general debates on health and illness. Patients, relatives and mental health professionals complain about the fact that historically there has been hardly any information and advice available for mental illness while public information campaigns and support services target general problems like heart disease or diabetes.



- A further dimension of stigma shows that it reaches beyond the realm of direct social interaction. Stigma and discrimination are also experienced through imbalances and injustices inherent in social structures, political decisions and legal regulations.
- The poor quality of mental health services is perceived as the strongest form of structural discrimination. Patients experience a lack of community-based services. They highlight a particular need for out-patient services and a focus on prevention rather than acute psychiatric care.
- Adequate psychiatric treatment should involve a comprehensive plan for treatment and rehabilitation, taking account of the difficulties patients face outside the hospital, in their everyday lives. They stress the necessity of networking between in-patient treatment, after-care and reintegration services



- Patients further complain about a lack of information about the treatment and about support services available in the community.
- In agreement with the patients' description of the situation, relatives highlight the need for improved treatment as a central step in counteracting the stigma they face.
- Relatives feel that patients often do not receive adequate help in crisis situations. Here, they state that access to in-patient's crisis intervention is increasingly limited due to the strict legal regulations for involuntary commitment, and that they often feel incapable of protecting the patient in times of acute crisis.
- Support services for such situations are felt to be missing.

# Access to social roles



Most frequently, research suggests that mental illness imposes barriers on access to employment and professional roles. For the patients, returning to one's job after a period of psychiatric treatment was often accompanied by critical remarks, mistrust and the denial of skills previously proven. Comments such as “Without you things were running more smoothly.”



Under such circumstances, people feel that they are the first to lose their job.



The employment situation is further complicated by the dilemma as to whether or not to reveal the illness to potential employers.

Patients, relatives and mental health professionals each give emphasis to different types of stigma. For all three groups, the largest share of all stigma and discrimination is experienced in direct interaction with others. Almost half of the stigmatisation experiences described by the patients concern this area.

Relatives and mental health professionals share the view that the reduction of social contacts in the interaction with others is the most central area in which stigma is encountered by those suffering from a mental health diagnosis.

Public images of mental illness are the second most central stigmatisation experience of those suffering from mental illness.

Mental health professionals attach the greatest importance to stigma experienced through negative public images of mental illness.

In their eyes, stigmatisation through negative media reports is nearly as central as stigma encountered by the patients in the context of direct social interaction. Relatives too, place greater importance on the derogatory treatment of patients in the public discourse than the patients themselves.

- Looking closely, subtle differences between the perception of the three groups become apparent.
- The patients' experience of stigma is dominated by the hurt they experience through the loss of social contacts and the fact that the illness shapes people's perception of themselves
- For relatives, they feel that patients are discriminated against through deficits in the quality of the treatment they receive, especially compared with health services available for patients with physical illness.
- In their eyes, the quality of mental health care is an indicator for the recognition of a mental illness diagnosis and the equal treatment of mental and physical illness.



It is evident that the impact of public stigma and self-stigma are far-reaching.

However, researchers have so far neglected the possibility that stigma, as well as contributing to poor quality of life and poor adjustment, may have an impact on the course and outcome of psychiatric illness (Livingston and Boyd, 2010).

This could happen if they impact on psychological mechanisms which in turn affect symptoms, or recovery or both. Two mechanisms which may play this role, are self-esteem and hopelessness, which have been identified as responses to public stigma (Link et al., 2001; González-Torres et al., 2007) and which are often important elements of patients' pessimism about their own illness (Pitt et al., 2007).



- For self-esteem and hopelessness to play the mediating role, they would have to affect symptoms and subjective recovery, and there is evidence that this may be the case (Lysaker et al., 2007).
- Low self-esteem has been identified as a risk factor for psychosis (Janssen et al., 2003) and modern cognitive accounts of symptoms, emphasise the important role of self-esteem in driving symptoms (Bentall et al., 2001; Freeman et al., 2002).
- A longitudinal study found evidence that negative beliefs about the self and others predicted paranoid symptoms in schizophrenia prospectively (Fowler et al., 2013).
- Another study found that self-esteem and negative emotion were major determinants of subjective recovery, and that the impact of symptoms on subjective recovery was largely mediated through these variables (Morrison et al., 2013).
- The role of hopelessness in driving suicidal thinking is well documented (Heilä et al., 1997; King et al., 2001; Nordentoft et al., 2002) and a systematic review identified hopelessness as a major barrier to recovery (Soundy et al., 2015).

Experiences of internalised stigma strongly predict poor subjective recovery judgements. Similarly, internalised stigma appears to predict suspiciousness and persecution, and active social avoidance.

Active social avoidance, guilt and self-blame are predicted by internalised stigma. Passive social withdrawal was also longitudinally predicted by internalised stigma, and by discrimination.

The effect of stigma and discrimination on passive social withdrawal at six month intervals appears to be mediated by self-esteem. The effect of internalised stigma on baseline recovery judgements appears to be mediated through low self-esteem and hopelessness.

However, neither self-esteem nor hopelessness explains the persisting association between internalised stigma and long-term recovery judgements.

# Treated differently

Participants report that others treated them differently because of their mental health problems. Although perhaps not amounting to ill treatment, this differential treatment was nonetheless unwanted: “I don’t think it’s something that they want, to treat me differently but even if they are being nice about it it’s still being treated differently”.

Such experiences included family, partners, friends, mental health professionals and other members of the public being patronising, acting warily when around them and a general sense that people behaved “not the same” towards them.

# Treated badly

More negatively, participants described ill-treatment and overt discrimination directly related to their experiences of psychosis. Examples included being ignored, dismissed, insulted, humiliated, excluded and bullied. Such experiences could have significant impacts on well-being:

Participants reported exclusion from life opportunities and a sense that they were “**never going to get the chance**” in areas of life that others took for granted.

Such marginalisation was most notable with regards to employment. Being unemployed and reliant on state benefits was a significant source of preoccupation and distress for many and was associated with low self-worth.

# Impacts on self

Experiencing psychosis and being labelled “mentally ill” left participants with a distressing sense of difference and abnormality: “since they said I’ve got psychosis, it makes me feel weirder like I stand out [...] like I’m a big, glow-in-the-dark object sort of thing”.

Participants reported feeling different to others, “like a fish out of water”, which put a strain on interactions and created difficulties in day-to-day life.

Public stigma and discrimination had a notable negative impact on participants’ self-worth: “it made me feel really degraded and downtrodden and it really made me feel pretty worthless and useless that other people can really see me like that”.

Participants spoke of themselves disparagingly and described losing confidence in themselves and their abilities, leading to lowered expectations of life: “I don’t think I’m able to do it, I put myself down a bit”.

Participants reported feeling that they had undergone a change in themselves, their identities or personalities: “I don’t feel like I’m the same person anymore”. This sense of a “changed self” was reflected back in the comments and behaviour of others: “my friends always say that I’m not as chatty or as outgoing as I used to be, before I got diagnosed”.

# Emotional responses

Participants reported shame and embarrassment and its impact on their lives: Some participants' reported an emotional fragility and lack of resilience; a sense that they would "go to pieces" if faced with adversity.

Avoidance and withdrawal were often ways of coping when feeling thus exposed.

Stigma was a significant source of worry for participants who described being preoccupied with what others might be saying or thinking about them. Stigma was described as a source of unhappiness and low mood, frequently expressed in hopelessness about the future: "it's just another nail in the coffin is stigma".

# Behavioural responses.

Heightened awareness and threat monitoring. Based on past experiences and beliefs, participants anticipated stigma in interactions with others and report being on high alert for it.

Participants report withdrawing from others due to experienced and/or anticipated stigma.

They avoid socialising, participating in work or education and carrying out routine tasks. Self-consciousness and fear of prejudice, discrimination and having to make disclosures about their mental health resulted in some participants becoming almost completely withdrawn.

Participants describe feeling self-conscious, monitoring their behaviour and making efforts to hide distress and external indicators of their experiences from others.

They describe feeling unable to be themselves, lest being judged negatively: “I’m very successful at hiding it from people [...] I’m constantly trying to be somebody I’m not basically”.

One motivation for masking and hiding difficulties was to protect loved ones from burden, distress and potential embarrassment.

# Barriers to recovery

Stigma is a significant impediment to recovery.



Stigma is reported to hinder participants in “getting on” and “getting over things”, making recovery more difficult to realise.



Stigma is reported to contribute to participants’ experiences, particularly fuelling feeling of paranoia: “it’s like planting a seed in your brain, [...] you end up like building a plot in your head where em, you get paranoid from it and it’s all down to the stigma”.



Participants’ functioning and ability to carry out “normal daily things” can be compromised by stigma, often due to the avoidance and withdrawal it promoted: “I do go to the hairdressers, it takes a lot of strength to get there [...] I really, really have to push myself to go”.

Through lived experiences of mental illness and the related stigma, participants report having developed compassion and understanding for themselves and others in similar circumstances: “I can understand what’s going through their mind because of stigma, and they feel like no-one understands them”.

Participants refer to rejecting stigma and accepting themselves; offering support and understanding to others was said to enhance personal self-esteem and self acceptance: “it makes me more compassionate towards other people, I like to try and help people [...] I feel like I’ve given something back”.