Stigma and discrimination: an overview

JULIO ARBOLEDA-FLÓREZ

Queen's University, Kingston, Ontario, K7L 3N6 Canada

Stigma and discrimination permeate every aspect of the experience of mental illness for patients, their families, and mental health professionals. In the last decades, stigma and discrimination have become the focus of professional concern and have been viewed as major barriers to mental health reforms. This paper provides an overview of the concepts of stigma and discrimination, and traces their social origins, including the manner in which mental health systems have contributed to the persistence of stigma. Finally, it summarizes the general approaches for combating stigma and discrimination, including education, protest, contact, and advocacy. In so doing, this paper provides the general context for the remaining papers in this supplement, focusing on selected aspects of stigma and discrimination because of mental disorders.

Key words: Stigma, discrimination, education, protest, contact, advocacy

Within the dichotomy of the focus of attention of mental health professionals, caught between biological postulates, on the one hand, and the psycho-social imperatives, on the other, stigma and discrimination project a powerful shadow on both sides of the divide. Firmly anchored in social dynamics, stigma and discrimination permeate every aspect of the experience of mental illness for patients and their families, as well as the daily work of mental health professionals and researchers. Hence, the importance and renewed interest in the study of stigma as an important explanatory construct in much of what transpires in the management of mentally ill in our societies, among providers, patients, and their caregivers.

Persons with mental illness have engendered stigma through negative and prejudicial attitudes for many centuries in all cultures (1). In the last decades, discrimination – the behavioural outcome of stigmatizing views – has become the focus of professional concern, possibly as a result of changes in the locus of service for most mental conditions. Such locus was (and in many countries still is) the mental hospital, where major human rights violations were rife (2). With the unfolding of deinstitutionalization policies, however, discrimination in the form of denial of social rights and entitlements has become apparent. Stigma and discrimination can be viewed as major barriers to mental health reform.

DEFINITION

Stigma, prejudice and discrimination are highly related and closely interwoven social constructs. Stigma is the result of a social dynamic that may result in different specific manifestations from culture to culture and, within a culture, from era to era. Stigma occurs when negative and prejudicial attitudes are accepted by the dominant culture as defining the stigmatized person, and become ascribed to all members of the group (3).

Since the ancient Greeks, stigma – stizein – has been understood as a negative, demeaning and discrediting “mark” that is visibly worn by the stigmatized person, or it is an attribute that others ascribe to that person. The “mark” could be a physical deformity; tribal identity such as ethnicity, sex, or religion; or blemish of individual character such as mental illness, unemployment, or moral obtuseness (4). Whatever its nature, stigmatizing attitudes tend to worsen if the mark is obvious, perceived to be under the control of the bearer, and if it instills fear by projecting an element of danger. Mental patients, particularly those who manifest obvious signs of their condition either because of the symptoms or the side effects of medications (visibility); who are socially construed as being weak of character, lazy or free-loaders (controllability); and who display threatening behaviours (dangerousness) are among the most stigmatized of all social groups.

SOCIAL AND SYSTEM ORIGINS OF STIGMA

Social origins

While there is an extensive knowledge base concerning what stigmatizing attitudes toward the mentally ill exist, much less is known about why these attitudes develop or how to combat them and their consequences. Stigma originates as a social response to a perceived threat to an identifiable common good. The good may be tangible, such as a material possession or personal security, or it may be symbolic, such as cherished social values or ideologies (5). Perceptions of mentally ill persons as dangerous and unpredictable may encompass a threat to physical integrity, or may engender contamination fears of losing one’s own sanity. The stereotypical characterization of the mentally ill as lazy and a burden to the system may pose a symbolic threat to important social values such as self-reliance (6).

Outright discriminatory policies against the mentally ill are found in every country. In developed countries, policies segregate the mentally ill into inner city ghettos, make prisons a preferred management tool, result in secondary treatment at emergency departments in public hospitals, and allow health insurance companies to openly discriminate against persons who acknowledge that they have a mental problem. These people find it a veritable ordeal to collect
entitled benefits from life insurance and income-protection policies when they claim temporary disability as a result of a mental condition, usually depression or an anxiety disorder. Many patients see their benefits denied or their policies cancelled. In some places, government policies require that mental patients be registered in special files before pharmacies can dispense needed psychiatric medications. More broadly, national research budgets provide only a minimum for research on mental conditions which is incommensurate with the heavy burden of disability caused by these conditions and with research funds expended on equally disabling illnesses (7). In developing countries, national budgetary allocations for the treatment and management of mental conditions are token or none; systems of care remain custodial and institution-based; and access to treatment is hampered by the lack of treatment options. Archaic beliefs about the nature of mental conditions, sometimes enmeshed in religious beliefs and cultural determinants, stigmatize and discriminate patients and their families. For example, in affected families in some cultures, daughters have difficulties getting married as the cultural perception is that all members of the family are “contaminated”.

System origins

Originally, the custodial, institution-based system of care – favoured for the management of the mentally ill since the inception of the asylum in the 17th century – may have been intended as a compassionate and humane method of management when no effective treatments existed and when knowledge about cause and etiopathogenesis was rudimentary. However, this system of care has contributed to the stigmatization of the mentally ill by removing them to far-away, isolated, closed institutions where their relatives, friends, associates and the larger society could soon forget them. In several countries there are still patients living in mental hospitals who have lost their identity and who are known to the staff only by a number or a nickname.

Mental hospitals also contributed to the banishment of mental illness out of the mainstream of medicine. Psychiatrists who practiced in them were not considered to be “real” physicians and were regularly depicted as deranged, depraved, or degenerate – thus painted with the same stigmatizing brush as their patients (8). The abuses of human rights within the custodial system – entailing arbitrary detentions and deprivation of freedom; abuses of the person in the form of violence, sexual assaults, lack of personal care, and loss of privacy – while still present in some places, are slowly disappearing. Protection of human rights in mental institutions and implementation of external controls through advocacy and legal vigilance have had positive impacts on the management of mental institutions and the patients within their walls.

System changes favouring the transfer of the mentally ill to the community-based alternatives to hospital care – often without proper care, with inadequate community support, and with difficult-to-access treatment facilities – have brought about another form of discrimination characterized by the denial of legal and social entitlements. Mental patients make up a disproportionate share of homeless populations, typically live in abject poverty, and gravitate to inner city ghettos and dilapidated neighbourhoods where they may be abused, raped, mugged, robbed, and sometimes murdered. Many end up in prison as their only means of institutional support. Penal institutions have become de facto mental hospitals of our time (9). This situation has reinforced social perceptions that mentally ill are criminal, lazy, free-loaders, and a burden to the system, hence a symbolic threat to social values of self-reliance and social obligations to contribute to the general good.

Patients who live without adequate treatment, supervision, and community-based supports may become involved in violent altercations, but more often as the victim than as the perpetrator, in reaction to environmental attacks on their own emotional or physical integrity. Although the mentally ill contribute to the overall violence in the community only minimally (10), the perceived link between mental illness and violence has reinforced the stereotype of the mentally ill as unpredictable and dangerous – a threat to the tangible good of public security. Thus, deinstitutionalization without adequate community support systems has increased stigma and discrimination against the mentally ill, not just the seriously and persistently disabled, such as those with schizophrenia, but also those battling addictions, depression, anxiety, panic attacks or post-traumatic stress disorders.

COMBATING STIGMA AND DISCRIMINATION

Three general approaches have been advanced to combat stigmatizing attitudes and discriminating behaviour at the level of the individual: increasing mental health literacy through education, stigma busting through protest, and reducing negative stereotypes through increased personal contact. The first technique departs from the premise that stigmatizing attitudes are related to poor knowledge of the facts about mental illness and it seeks to increase such knowledge through generic or targeted education and awareness campaigns that may use media such as radio or television messages, adds, movies, or sitcoms. The second technique is based on the premise that those who openly stigmatize mental patients (such as in the media) do so as a way of attracting interest to sell a product. A more confrontational approach may be adopted to boycott movies depicting violence attributed to mental illness, or to convince advertisers to remove or modify products that may cause harm through their stereotypical messages. “Stigma Watch” organizations typically use a combination of protest and education to improve media images of mental illness. The third technique is based on the premise that increased contact between members of the general public and specially chosen role models who have a mental ill-
ness and are comfortable speaking about this in public will decrease fear and increase feelings of compassion and sympathy, thereby allowing others to see the person with mental illness as a person (11).

Social advocacy is an oft-neglected fourth approach that is designed to bring about change at the level of societal structures and institutional practices (12). Well designed advocacy programs target human rights violations and abuses that victimize the mentally ill, as well as discriminating policies and practices that deny the mentally ill access to and enjoyment of opportunities and legal entitlements that other citizens take for granted. Advocacy programs are based on well-planned, focused and energetic legal or social activism that seeks to bring justice where justice has been denied to an entire class of citizens – the mentally ill.

CONCLUSIONS

Stigma and discrimination preclude individuals with mental illnesses from enjoying their social rights and entitlements and, in so doing, preclude their enjoyment of full citizenship. Approaches to combating stigma and discrimination should be targeted toward every level of social functioning, ranging from policies promoting the promotion of good mental health, through secondary prevention activities designed to reduce the visible signs and symptoms of mental disabilities among those affected by mental disorders, to social advocacy programs aimed at removing structural barriers to full social participation. For this, a concerted effort is required at all levels of government, social institutions, clinicians, caregivers, the public at large, patients, and their families. The aim of further mental health reform must be to maximize all opportunities for recovery from illness by providing more chances for successful social reintegration. These aims would be more achievable for the mentally ill were it not for the spectre of stigma and discrimination.

References