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The stigma of mental disorders

A millennia-long history of social exclusion and prejudices

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Far more than any other type of illness, mental disorders are subject to negative judgements and stigmatization. Many patients not only have to cope with the often devastating effects of their illness, but also suffer from social exclusion and prejudices. Stigmatization of the mentally ill has a long tradition, and the word "stigmatization" itself indicates the negative connotations: in ancient Greece, a "stigma" was a brand to mark slaves or criminals. For millennia, society did not treat persons suffering from depression, autism, schizophrenia and other mental illnesses much better than slaves or criminals: they were imprisoned, tortured or killed. During the Middle Ages, mental illness was regarded as a punishment from God: sufferers were thought to be possessed by the devil and were burned at the stake, or thrown in penitentiaries and madhouses where they were chained to the walls or their beds. During the Enlightenment, the mentally ill were finally freed from their chains and institutions were established to help sufferers of mental illness. However, stigmatization and discrimination reached an unfortunate peak during the Nazi reign in Germany when hundreds of thousands of mentally ill people were murdered or sterilized.

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The stigmatization of mental illness is still an important societal problem. The general population is largely ignorant about this problem, and fear of the mentally ill remains prevalent. Although we no longer imprison, burn or kill the mentally ill as in the Middle Ages or in Nazi Germany, our social standards and attitudes are nonetheless unworthy of modern welfare states. Structural discrimination of the mentally ill is still pervasive, whether in legislation or in rehabilitation efforts.

A comprehensive concept of stigma

Stigma can be described on three conceptual levels: cognitive, emotional and behavioural, which allows us to separate mere stereotypes from prejudice and discrimination. Stereotypes refer to prefabricated opinions and attitudes towards members of certain groups, such as ethnic or religious groups, whites and blacks, Europeans and Latin Americans, Jews and Muslims, and the mentally ill. The most prominent stereotypes surrounding the mentally ill presume dangerousness, unpredictability and unreliability; patients with schizophrenia are most affected by such views.

Stereotypes are not necessarily wrong or negative, as they can help us make quick judgements about persons who share specific characteristics. Stereotypes thereby allow us to deal with or adapt to a specific situation without needing more information about the persons involved. If we asked for directions, we would approach a police officer in a different way than an old lady; our stereotypes of police officers and old ladies would help us to adopt the appropriate behaviour.

To make a fair and rational judgement about individuals, however, would require more information than simply calling up stereotypes. In cases of mental illness, stereotypes can therefore become dysfunctional because they typically activate generalized rather than customized response patterns; contradictory information can even reinforce stereotypes as "exceptions prove the rule". In the case of the mentally ill, we can only determine whether a person is indeed dangerous, unpredictable or unreliable, if we make an effort to know him or her better.

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This scenario becomes even more complicated with prejudices that are consenting emotional reactions to a stereotype or a stereotyped person. A prejudice about the mentally ill might comprise the reaction or attitude "I am afraid of schizophrenics because they are dangerous and unpredictable". This changes the context from "a person who suffers from schizophrenia" to "a schizophrenic", as if this illness characterizes the whole person. Stereotypes and prejudice can subsequently lead to discrimination of individuals or a whole group as a behavioural response: "Mentally ill should be locked away because they are dangerous and unpredictable" or "We can't employ a mentally ill person because they are unreliable".

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Stigma research

Research on stigmatization involves a specialized discipline of social science that broadly overlaps with attitude research in social psychology. A scientific concept on the stigma of mental disorders was first developed in the middle of the 20th century, first theoretically and eventually empirically in the 1970s. The book *Stigma: Notes on the Management of Spoiled Identity*, published in 1963 by the American sociologist Erwin Goffman, laid the foundation for stigma research as a scientific discipline and described how stigmatized persons deal with the challenge.

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Several years later, an essay by Thomas Scheff triggered much discussion as he controversially described mental disorders as being merely the consequence of a labelling process. Scheff's idea was later modified by Bruce Link, who differentiated the various steps in adopting the role of a mentally ill person. The first step in labelling the mentally ill would include societal standards and norms, and the impact of deviating from these: sufferers increasingly withdraw from social interactions to avoid negative reactions, thereby reducing their participation in society and normal life. This social retreat and isolation diminishes self-esteem and, in turn, increases vulnerability to psycho-social stress. As such, the social networks of the mentally ill are usually very small and restricted.

For this reason, Goffman was very critical of mental hospitals because these further increased stigmatization instead of enabling patients to lead normal lives. This was in line with many of his contemporary scientists, including Scheff, Thomas Szasz, Ronald Laing and Michel Foucault, who claimed that the stigmatizing consequences of mental illness could be ascribed to how psychiatry was organized rather than to the mental illness itself. Overall, the 1960s and 1970s were full of an anti-psychiatry attitude, blaming psychiatry for being repressive, coercive and more damaging than helpful to patients. The 1975 movie *One Flew over the Cuckoo's Nest* in particular condensed this attitude against psychiatry. It starred the ingenious Jack Nicholson as Randy McMurphy, a violent crook who pretends to be mentally ill in order to avoid prison. Soon he rebels against the repression he finds in the psychiatric hospital. From today's perspective, McMurphy would instead seem to be a paedophilic sociopath, who shamelessly exploited his fellow patients on the ward.

The size of the problem

The stigma attached to mental illness is ubiquitous. There is no country, society or culture where people with mental illness have the same societal value as people without a mental illness. In a survey that included respondents from 27 countries, nearly 50% of persons with schizophrenia reported discrimination in their personal relationships. Up to 2/3 of these people anticipated discrimination while applying for work or looking for a close relationship [1]. While stigma is universal, the experience of the stigmatized person is influenced by culture. For instance, the role of supernatural, religious or magical explanations of mental illness still prevails in many non-Western countries.

There are also differences in stigmatization depending on the type of disorder. Generally, people want to keep greater social distance from a person with schizophrenia than from someone with depression. For unclear reasons, this social distance has increased during the 21st century [2]. One possible reason might be that the process of deinstitutionalization increased public discussions about community psychiatry and associated perceptions of risk. When looking at the most common stereotypes, about ¾ of the population have a negative attitude towards drug dependency and about 2/3 towards alcohol dependency and schizophrenia, whereas depression finds more sympathy, presumably because more people are familiar with it.

Who contributes?

Since the theoretical foundation of stigma was laid in the 1960s and 1970s, there has been an explosion in empirical research. A PubMed search with the terms "stigma" AND "mental illness" OR "mental health" displayed almost 180,000 entries in April 2016. Because it is impossible to provide even an approximate overview of this research, I will highlight three perspectives of particular interest: the *macro level*, comprising society as a whole and mass media; the *intermediate level*, which covers healthcare professionals; and the *micro level*, which includes the individual with a mental illness, who also contributes to this process via self-stigmatization. Part of the *micro level* includes the caregivers, who suffer in multiple ways from stigma.

An important contributor to falsely applied stereotypes is the mass media. Media coverage of mental illnesses has been consistently and overwhelmingly negative and imprecise. Television news and entertainment programs, films and newspapers play a central role in disseminating biased information surrounding mental illness and strengthen negative stereotypes. Sensationalist reports of violence and crimes committed by individuals with these disorders receive much more attention than similar crimes committed by mentally healthy persons. This crystallizes a biased image of patients with mental disorders as threatening persons who endanger society.

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The term "schizophrenia" is often used metaphorically, usually denoting poor attributes. Consequently, the schizophrenic label itself is associated with negative connotations. Investigations have revealed that a negative characterization is much more frequent when the diagnostic term "schizophrenia" is applied rather than another diagnosis, such as depression. Studies in Japan identified a significant change in levels of stigma after the name of the disease was changed from "mind-split disease" to "integration disorder". Even though the immediate effect was a reduction in stigmatization, there is still risk that a stigma would migrate from one name to another.

Attitudes of healthcare professionals

In theory, one might expect that mental healthcare professionals would hold at least

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neutral attitudes towards patients with mental illness. However, they display at least equal or, in some cases, even stronger negative beliefs and attitudes than persons within the general population.

Psychiatrists might have more positive views about the mentally ill, but express reduced willingness to have contact with them. A Swiss study found that psychiatrists are more in favour of community psychiatry for persons with severe mental illnesses than the general population [3]. But when the willingness for social contact is assessed, there is no difference between psychiatrists and the general population. This probably is a "not in my backyard" phenomenon, in which psychiatrists display politically correct opinions as long as they are not affected personally. Nordt *et al* interviewed mental health professionals and members of the public about their attitudes towards persons with or without psychiatric symptoms, such as depression or schizophrenia. All interviewed persons showed less desire for social contact with patients with schizophrenia compared to persons with either depression or no symptoms [4]. A Brazilian study indicated that psychiatrists have a stronger prejudice against schizophrenia than the general population [5]. Researchers noted that the more a person identifies the clinical picture of psychiatric illness presented to him or her, the more they stigmatize persons with these illnesses. In this study, psychiatrists rank highest when scoring the degree of their stigma, independent of diagnoses.

The most likely explanation for this behaviour is that mental health professionals are often confronted with patients who are reluctant to undergo treatment. It is difficult to build a strong therapeutic relationship with these patients. However, the better the relationship between patient and healthcare professional and the more voluntary the treatment, for instance in outpatient care, the less professionals stigmatize their patients.

Self-stigma and courtesy stigma

Self-stigma usually describes a process in which an individual with mental illness internalizes the stigma and then experiences diminished self-esteem and self-efficacy, limiting prospects for recovery. Social psychologists argue that this process begins even before the person is afflicted with a mental illness because it is during that period that he/she usually learns about and internalizes culturally disseminated stereotypes about such illnesses.

Thus, when that individual has the first episode, those commonly held stereotypes become prominent and relevant to the self. The previously mentioned categorization of stereotypes—prejudice and discrimination—also applies here. In this case, categorization refers to an assumed personality characteristic such as "mentally ill have a weak character, thus I have a weak character too", followed by an emotional approval that results in low self-esteem: "I am unable to achieve anything in my life". The behavioural response is, for instance, a lack of initiative when looking for a job or an apartment: "I do not need to try, because I don't have any chances anyway". Consequently, individuals reduce their social networks in anticipation of stigma-related rejection and isolate themselves. This in turn causes them to lose jobs and other gainful opportunities, and even to refrain from seeking medical help for their symptoms.

Goffman described the notion of "courtesy stigma", which transfers stigma from an already stigmatized person to individuals connected through professional or familial relationships. Family stigma is a special case that applies to parents, siblings, spouses, children and other relatives. For example, parents have been accused of creating a pathological environment that could favour the onset of mental illness, such as the "schizophrenic mother" who induced schizophrenia in her child due to her dysfunctional communication style. Although that attitude was much stronger decades ago, these ideas still persist. Furthermore, if the public assumes an underlying biological basis for mental disorders, courtesy stigma is much more pronounced.

Just as affected persons internalize public stigma into self-stigma, family members also feel shame and guilt, blaming themselves for somehow contributing to the illness. Such reactions might range from emotional distress to the stress of coping with disturbed behaviour and a disruption in household routines. The familial stigma they are confronted with can also restrict social activities or lead to economic difficulties. Sharing a household with someone who is mentally ill is further associated with poorer self-reported physical health, increasingly limited activities, greater utilization of public services and other negative consequences [6]. In a Swedish study on family members of individuals with mental disorders, a sizable number stated that the ill relative would be better off dead and/or wished that the patient and the relative had never met or that the patient had never been born [7].

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Lay concepts

Lay concepts about mental disorders can easily be dichotomized as having either biological or psycho-social causes. With regard to depression, a majority of the public believes that the latter are responsible for relationship problems, work-related stress, financial difficulties or traumatic events. This is not so clear with schizophrenia, where the majority indicates that biological causes are at play, and a considerable proportion of respondents point to psychosocial causes. Whereas approximately two-thirds of survey respondents might characterize depression as a life crisis, less than one-third feel that way about schizophrenia. Those who display a positive attitude towards psycho-pharmacological treatment also favour biological causes, while those who are in favour of community treatment prefer a life crisis model [8].

Interestingly, these lay concepts influence the desire of the public to place social distance between themselves and a mentally ill patient. During interviews, a survey participant might be confronted with various scenarios that vary in degree of social intimacy: a co-worker with mental illness, renting an accommodation to such a person, not opposing your child's plan to marry someone with a mental illness or allowing a formerly mentally ill person to babysit your child. Not unexpectedly, the desire for more social distance increases with the degree of intimacy. The overwhelming majority would never accept a formerly mentally ill person as a babysitter, especially if that person was diagnosed with schizophrenia. This desire for social distance increases if one holds a biological view and decreases if it is based on

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a psycho-social view. Thus, offering biological explanations for these disorders might have detrimental effects in terms of acceptance and integration of the mentally ill.

Treatment recommendations

Lay concepts undoubtedly have an impact on treatment recommendations. As this holds true for stigma research in general, cultural variables will definitely influence public ideas about treatment when different medical services are available. From our surveys, psychologists are the most commonly recommended treatment service, followed by family physicians and psychiatrists. If a patient is described as having a medical illness with a biological cause, family physicians and psychiatrist are preferred while in the case of a life crisis, psychologists are recommended. The same is true for the use of psycho-pharmacological treatments, which are preferred over psychotherapy when the respondent holds a medical illness model. However, psycho-pharmacological treatments are also the mostly likely to be rejected. Moreover, studies have shown that psychotropic drugs are thought to change one's personality and carry a significant risk of becoming addictive [9].

Intervention strategies

Various intervention strategies have been tested to address stigma and discrimination against the mentally ill. Some interventions did not address specific disorders, while others were either directed towards specific disorders such as schizophrenia or depression, or specific groups of persons like policemen, teachers and health professionals. Most of those programmes reported more or less favourable results.

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In principle, there are three general approaches that we can use to reduce stigma and discrimination: information/education about mental illness; protest against unfair descriptions of mental illness; and direct contact with the mentally ill. Three "channels" are used to mediate these strategies: mass media, opinion leaders and persons of trust.

Using mass media can be difficult because the media tends to convey primarily negative information, and are inclined to use psychiatric terms in a metaphorical, mostly negative way. For example, a usual headline would state that politicians adopt a *schizophrenic* policy or that the economy is in a *depression*. However, even if the media refrained from using such terms—because they are obviously politically incorrect—it would by no means guarantee that attitudes are changed. Instead, the life crisis model of mental disorders should be applied, because it has the potential to create proximity and help people identify empathetically with the mentally ill so that they are regarded more as "one of us".

Given their strong credibility and respectability, opinion leaders are in a powerful position to influence public perception of mental illness and related stigma. The exception might be persons from within the medical field whose commitment might seem rather doubtful because they themselves do not often have the best opinions about mentally illness. Persons of trust can have very high credibility, because they themselves have been affected by these illnesses and can report first-hand experiences and comment on treatments. They can receive even more attention if they are well known to the general public.

Finally, many studies have demonstrated that the least spectacular, but presumably most effective channel for reducing stigma is through "contact". We know from educational programs that we achieve the best effect when the mentally ill talk about their disorders to pupils and students. Considering the number of affected persons within our societies—about 50% of the population experience an episode of a mental illness during their lifetime, which needs treatment—it is most likely that we meet someone with a mental disorder each day and that everybody knows someone who suffers or has suffered from such illnesses. If we are more aware of patients in our daily lives, we get a much more realistic picture of mental illness, which helps us to examine our stereotypes and adapt to reality.

Many approaches are used to decrease stigma and discrimination, but only a combination of different measures will have the most success in the long term. For the most part, it is the unspectacular day-to-day work and contacts that help decrease stigma and discrimination against the mentally ill [10].

Conflict of interest

The author declares that he has no conflict of interest.

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