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# Global Trends in Stigma of Mental Disorder

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## Abstract

Stigma is a strong feeling of disapproval that some people in a society have about something, especially when this is unfair. Despite the dearth of empirical evidence about how to address mental illness-related structural stigma effectively, there is a robust body of knowledge offering brilliant ideas about the most promising methods for beginning to break down the structural barriers facing people with mental illnesses. This review has been centered on what is known about mental illness-related structural stigma. It begins with an overview of the nature of stigma and structural stigma, including its relation to beliefs, attitudes and knowledge in cognitive construct of the individual. The second goal of this review is to explore the development of stigmatizing as a behavioral reaction and response. The third goal is to highlight the consequences and impacts of stigmatizing on personality. The final sections of this review is to synthesize the existing knowledge pertaining to addressing structural stigma. Conclusions for clinical and intervention programs of mental health domain on one hand and for future research of psyceducational scope on the other hand.

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Mental illness is a predominant issue in public health, contributing to substantial economic and emotional community burden (Gibbons, Thorsteinsson, Loi, 2015). 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 (Patrick, & Watson, 2002).

The attitude is relatively enduring system of evaluative, affective reaction based upon and reflecting the evaluative concepts or beliefs which been learned about characteristics of a social object or class of social objects. Belief is defined as "the emotional acceptance of a proposition or doctrine on what one considers to be adequate ground". Opinion is similar to both attitude and belief. This term is defined as " a belief that one holds to be without emotional commitment or desire, and to be open to reevaluation since the evidence is not affirmed to be convincing". Opinions are verbalisable, while attitudes are sometimes mediated by nonverbal processes are" unconscious" and opinions are responses, while attitudes are response predispositions (Das & Phookun, 2013, Stephanie, Mantler, Andrew, 2017).

There is growing evidence of stigmatization of people with mental disorders all over the world (Alonso., *et al*. 2008)). Research has established that mental illness is more stigmatizing than physical illnesses (Lee., *et al*. 2005) and that more stigmatizing attitudes are

directed toward people diagnosed with schizophrenia compared with depression and eating disorders, demonstrating not only that mental illness is more stigmatizing than physical illness, but also the existence of a hierarchy of stigma within psychiatric diagnoses (Aromaa, 2011).

Stigmatizing attitudes and discriminatory behaviors towards persons with mental illness are of international concern ( Stuart, Arboleda-Flores J, Sartorius, 2005) and have negative personal and social impact on patients and their families (Perlick, Rosenheck, Clarkin, Sirey, Salahi, Struening , (2001).

Persons with mental disorders must not only cope with the psychological, cognitive and biological symptoms of their psychiatric condition but also with many negative consequences that go along with highly prevalent stigma. Examples would be social exclusion, unsatisfactory housing, and restricted opportunities for employment and education, which impair the quality of life (Rüsch., *et al*. 2005, Kadri, Sartorius, 2005).

**The nature of stigma**

Stigma is a term originating with the ancient Greeks, denoting a visible mark placed or branded on members of tainted groups such as traitors or slaves (Goffman, 1963). All members of society therefore knew instantly of the degraded status of the stigmatized individual. The modern starting point for defining the stigma of mental illness is Goffman's "an attribute that is deeply discrediting" and that reduces the bearer "from a whole and usual person to a tainted, discounted one" (Goffman, 1963).

Stigma has been described as -a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses‖ (When stigma leads to social exclusion or discrimination (experienced‖ stigma), it results in unequal access to resources that all people need to function well: educational opportunities, employment, a supportive community, including friends and family, and access to quality health care (Corrigan., *et al.* 2004). These types of disparities in education, employment, and access to care can have cumulative long-term negative consequences. For example, a young adult with untreated mental illness who is unable to graduate from high school is less likely to find a good paying job that can support his or her basic needs, including access to health care. These disadvantages can cause a person to experience more negative outcomes. Being unemployed, living at or below the poverty line, being socially isolated, and living with other social disadvantages can further deflate self-esteem, compounding mental illness symptoms, and add to the burden of stigma (Sartorius, 2005 Wahlbeck & Aromaa (2011). Sometimes stigma is simply -felt‖ in the absence of being discriminated against and results from internalizing perceived negative attitudes associated with a characteristic (e.g., age), a disorder (e.g., HIV-AIDS), a behavior (e.g., smoking), or other factor (e.g., place of birth). Whether stigma is experienced as social exclusion or discrimination or felt as a pervasive and underlying sense of being different from others, it can be debilitating for people and poses a challenge for public health prevention efforts. Different opinions exist regarding the implications of different labels associated with describing mental illness (e.g., brain disease) and felt or experienced stigma (Corrigan & Watson 2006). However, the prevailing view of health-related stigma is that it refers to perceived, enacted, or anticipated avoidance or social exclusion, and not to an individual blemish or mark (Wittchen, & Jacobi (2005).

Goffman (1963) categorized the attributes of the stigmatized into three main groups: (1) Abominations of the body, (2) blemishes of individual character e.g. mental illness, criminal conviction or (3) tribal stigmas e.g. race, gender, age. The work of Jones and colleagues built on these categorizations with a focus on the study of "marke d relationships" (Jones., et al. 1984). In this definition, stigma occurs when the mark links the identified person via attributional processes to undesirable characteristics which discredit him or her. They propose six dimensions of stigma:

1. Conceivability: how obvious or detectable a characteristic is to others
2. Course: whether the difference is life-long or reversible over time
3. Disruptiveness: the impact of the difference on interpersonal relationships
4. Aesthetics: whether the difference elicits a reaction of disgust or is perceived as unattractive.

5. Origin: the causes of the difference, particularly whether the individual is per-ceived as responsible for this difference.
6. Peril: the degree to which the difference induces feelings of threat or danger in others (Stuart H, Arboleda-Flores J, Sartorius N. (2005, Goffman, 1963).

Stigma is a "label" that the individual " patient": (1) is abnormal, (2) has unadaptive behavior or unhealthy personality, (3) undesirable or unfamiliar, (4) should be excluded, and (5) dysfunctional. These characteristics reflex the criteria of abnormal personality or maladaptive behavior, according to DSM-V. The criteria include what we terming "Three D.": Dysfunction, Deviance, Distress that we depend for diagnosing mental disorder (Abdullah, 2016).

**Development of stigmatizing and its characteristics**

Stigma develops within a social matrix of relationships and interaction and has to be understood within a three dimensional axis. The first of these dimensions is perspective, that is the way stigma is perceived by the person who does the stigmatizing (perceiver) or by the person who is being stigmatized (target). The second dimension is identity, defined along a continuum from the entirely personal at one end to group-based identification and group belongingness at the other. The third dimension is relations, that is, the way, the stigmatiser and stigmatized react to the stigma and its consequences. Reactions can be measured at the cognitive, affective and behavioral levels (Aromaa, 2011, Stephanie, Mantler, Andrew, 2017).

The stigmatizing mark also has three major characteristics: (1) visibility, or how obvious the mark is; (2) controllability, or whither the mark is under the bearer's control; (3) impact, or how much who do the stigmatizing fear the stigmatized. Stigmatizing attitudes get worse if the mark is very visible, is it is perceived to be under the bearer's control, and if it instills fear by conveying an elements of danger (Arboleda-Florez, 2003).

Three major elements are required for stigmatizing attitudes to happen: an original "functional impetus" that is accentuated through "perception" and subsequently, consolidated through "social sharing" of information. The sharing of stigma becomes an element of a society that creates, condones, and maintains stigmatizing attitudes and behaviors (Aromaa, 2011) Corrigan has proposed a framework in which stigma is categorized as either public stigma or self-stigma. Within each of these two areas, stigma is further broken down into three cognitive and behavioral core features: stereotypes (cognitive knowledge structures), prejudice (cognitive and emotional consequence of stereotypes) and discrimination (behavioral consequence of prejudice) (Corrigan Rusch, 2002) (see Table 1).

| Public Stigma | Self-Stigma |
|---|---|
| Stereotype: Negative belief about a group such; as incompetence, character weakness, dangerousness | Stereotype: Negative belief about the self such; as incompetence, character weakness, dangerousness |
| Prejudice: Agreement with belief and/or negative; emotional reaction such as anger or fear | Prejudice: Agreement with belief, negative; emotional reaction such as low self-esteem or low self-efficacy |
| Discrimination: Behavior response to prejudice such as: Avoidance of work and housing opportunities,<br>with-holding help | Discrimination: Behavior response to prejudice, such as: Fails to pursue work and housing opportunities, does not seek help |

(Aromaa, 2011).

***Table 1:*** *Public Stigma V Self-Stigma.*

**Consequences of negative attitude toward mental illness.**

Attitudes and beliefs about mental illness are shaped by personal knowledge about mental illness, knowing and interacting with someone living with mental illness, cultural stereotypes about mental illness, media stories, and familiarity with institutional practices and past restrictions (e.g., health insurance restrictions, employment restrictions; adoption restrictions) (Corrigan., *et al*. 2004; Wahlbeck, & Aromaa, 2011). When such attitudes and beliefs are expressed positively, they can result in supportive and inclusive behaviors (e.g., willingness to date a person with mental illness or to hire a person with mental illness). When such attitudes and beliefs are expressed negatively, they may result in avoidance, exclusion from daily activities, and, in the worst case, exploitation and discrimination.

Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders, especially severe disorders such as schizophrenia. It reduces patients' access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation, and hopelessness. Stigma assumes many forms, both subtle and overt. It appears as prejudice and discrimination, fear, distrust, and stereotyping. It prompts many people to avoid working, socializing, and living with people who have a mental disorder. Stigma impedes people from seeking help for fear the confidentiality of their diagnosis or treatment will be breached (FC-CMH, 2017).

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, (Deegan, 1990).

Stigma can interfere with self-management of mental disorders (tertiary prevention) (Sirey., *et al*. 2001). Untreated symptoms can have grave consequences for people living with mental illness and negatively impact families affected by these disorders. For example, most people with serious and persistent mental illness (mental disorders that interfere with some area of social functioning) are unemployed and live below the poverty line, and many face major barriers to obtaining decent, affordable housing (Stephanie, Mantler & Andrew, 2017). These individuals may need a number of additional social supports (e.g., job training, peer-support networks) to live successfully in the community, but such supports may not be available. Other individuals with depression and anxiety might avoid disclosing their symptoms and instead adopt unhealthy behaviors to help them cope with their distress (e.g., smoking, excessive alcohol use, binge eating). These behaviors can increase their risk for developing chronic diseases, worsening their overall health over time. Recent studies have found an increased risk of death at younger ages for people with mental illness (Stephanie, Mantler, & Andrew, 2017, Das, & Phookun, 2013).

It has been revealed that knowledge, attitude, perception and belief of patients relatives was independent of diagnosis of and relation with patients as well as age, sex, marital status, types family and occupation. However, knowledge attitude, perception and belief was dependent on locality, educational level and socioeconomic status. Relatives from rural locality were better informed about treatment and outcome while those from urban locality exhibited positive attitude towards authorianism and interpersonal etiology (Aromaa, 2011, Aboleda-Florez, 2003). There was negative relation between attitude toward social restrictiveness and level of education, as well as knowledge about treatment and outcome and socioeconomic status, (Das, & Phookun, 2013).

People's views of their illness and feelings of shame may in part be a symptom of their depression (Thorneycroft, Rose, Kassam, & Sartorius, 2007). Negative stereotypes associated with depression were most powerfully predicted by gender. Women were less likely to hold negative attitudes towards people with depression, as were those with a higher education and people with Swedish as their

mother language. A stronger sense of mastery and higher perceived social support predicted more positive attitudes. In addition, a person's own depressive symptoms and knowing someone who has had mental health problems were related to more favorable attitudes towards people with depression.

## Conclusion

Opinion about mental illness plays vital role in long-term care of mentally ill patients. Not only people but patients who are mentally ill also frame a different picture about their illness, which can be neutralizing by public's familiarity with serious mental illness, which subsequently will decrease stigma. People frame a picture about mental illness and mentally ill patients in their mind, which generally guides their behavior, so public must be educated to bring about positive changes in attitude, (Mahto, Verma, Singh, Chaudhury and Shantna, 2012). It has always been an important area of investigation among mental health professionals (Corrigan P, Miller F, 2004).

Stigma experiences are aroused or strengthened by seeing the way mental health services are organized or through having contacts with mental health professionals. It is interesting to note that although those with depression agreed with the view in the statement on perceived stigma "the professionals in health care do not take mental problems seriously", agreement with this statement did not have a connection with actual service use (Stuart, Arboleda-Flores, Sartorius 2005).

Educational programs for relative of patients including educated and affluent section by developing psych educational intervention and sensitization campaigns are needed. 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 (Holmes E, Corrigan P, Williams P., *et al.* 1999).

Stigma can pose a threat to the self-esteem, relationships and job opportunities of psychiatric patients. However, the meaning of mental illness is a social, and therefore changeable, construction. Adequate information may demystify mental illness and help to reduce the fear and prejudice surrounding it (Lai, Hong, & Chee, 2000).

In future research, it may be useful to include other negative as well as positive Stereotypes and the connection between positive indicators of mental health and stigma need to be verified in other samples and with other mental health resources. The impact of addressing these topics in public campaigns should be evaluated in future research.

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