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Stigma towards mental disorders: characteristics and interventions

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Review article

ABSTRACT

Mental disorders in Latin America are highly prevalent and represent a significant burden on service users and their families. Very often, these people have to deal with the stigma attached to the diagnosis they receive. Stigma towards mental illness causes negative consequences for patients and family members, becoming the main barrier to full social inclusion. Considering the above, the first objective of this paper is to analyze the main characteristics of stigma towards mental illness and the psychological and social variables with which it is associated. Secondly, we describe the main strategies for reducing different types of stigma. Finally, we propose approaches to assess and reduce stigma in the context of Latin America and the Caribbean.

Key words: Stigma, discrimination, mental disorders, social inclusion.

RESUMEN

Los trastornos mentales en Latinoamérica son altamente prevalentes y representan una carga significativa para usuarios y familiares. Dichos individuos usualmente deben lidiar con el estigma que se asocia al diagnóstico que reciben. El estigma hacia la enfermedad mental provoca consecuencias negativas en los pacientes y sus familiares, transformándose en la barrera principal para lograr su plena inclusión social. Considerando lo anterior, el primer objetivo del presente documento es analizar las principales características del estigma hacia la enfermedad mental, y las variables psicológicas y/o sociales con las que se ha asociado. En segundo lugar, se describen las estrategias preponderantes para reducir los diferentes tipos de estigma. Finalmente, se proponen abordajes para evaluar y reducir el estigma en el contexto de Latinoamérica y el Caribe.

Palabras clave: Estigma, discriminación, trastornos mentales, inclusión social.

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INTRODUCTION

Mental disorders are highly prevalent in Latin America, and represent a significant burden for those who suffer with them.[1] These individuals usually have to deal with barriers and social obstacles in their daily interactions with other people or institutions. In this respect, a type of social interaction that can have negative consequences for people with mental disorders is what is known as stigmatization, or simply, "stigma". Due to prejudices and discriminatory acts towards stigmatized people, it is frequently the case that they have low self-esteem and a poorer quality of life, as well as low adherence to treatment and significantly reduced social networks.[2] It has also been observed that frequently, these people cannot access normalized work or educational spaces, or establish friendships or partner relationships. As a consequence, stigma transforms into a phenomenon that is counter-productive in achieving clear social inclusion of individuals with a psychic disorder.

Stigma towards mental illness has been assessed by various studies all over the world.[3] In the particular case of Latin America, however, research has been scarce. However, some studies carried out in Brazil, Argentina, Mexico, and Chile have determined that people perceive patients as potentially dangerous, unpredictable, violent, and incapable of working.[4-7] On the other hand, research carried out by Vicente et al.[8] identified that concepts such as "fear of diagnosis" and "what others may think" - arguments directly linked to stigma - were the justifications most widely used by people surveyed to avoid seeking help from the mental health system.

Considering the above, we believe that it is pertinent to understand how stigma towards mental illness is currently understood and approached. As such, our first objective for this paper is to analyze the most relevant characteristics of stigma and the psychological and/or social variables with which it is associated. Secondly, we will describe the primary strategies used to reduce stigmatization in its different forms.

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Finally, lines of work will be set out to assess and intervene in stigma in the context of Latin America and the Caribbean.

DEVELOPMENT

Definition

In the classic publication by Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity*, the author defines the phenomenon of stigma as attributes of an individual that generate profound social discredit and devaluation. According to Goffman, processes of stigmatization emerge from the discrepancy between a "virtual social identity" (the characteristics that a person must have, according to social norms), and an "actual social identity" (the attributes that the person effectively presents).[9] The sociologist Bruce Link et al.[10] proposed the "labeling theory" to explain stigmatization towards mental illness. According to this theory, human beings, by means of language, learn and internalize conceptions of people with mental illness, which are later transformed into "signs" with which they label, classify, and discriminate. It should be noted that according to Yang et al.,[11] these conceptions are sustained by sociocultural norms established by each community or social group. In the particular case of people with mental disorders, these signs or stereotypes commonly refer to the eventual danger, weakness, and uselessness of these individuals. The above generally leads to discriminatory acts and attitudes of rejection or omission of people with mental illnesses.[12]

Typology and associations

Some researchers in subjects relevant to stigma[13] have proposed that this condition, in mental health, can be classified as follows: stigma in people with a mental illness, stigma of (or from) the family, institutional stigma, and public stigma.

In terms of stigma in subjects who suffer a mental disorder, its most serious manifestation is internalized stigma, or self-stigma. This condition refers to internalization by the stigmatized individual of the negative attitudes they have received.[2] Internalized stigma has been related to beliefs of devaluation and discrimination, with reduced quality of life, self-esteem, self-efficacy, and aggravated symptoms.[14] It is important to note that various current investigations have determined that around 40% of people with severe mental disorders have high levels of self-stigma.[15,16]

Stigma in the family is a condition in which social devaluation is transmitted by being associated with a stigmatized person. Various kinds of impact on families of people with a mental disorder have been documented, for example, sleep disorders, alterations in interpersonal relationships, worsening of wellbeing and quality of life.[17-19] A level of isolation and social exclusion similar to that of the patient themselves is frequently experienced.[20] However, it should be noted that in Latin America, it has been reported that relatives can also be a source of prejudice and discriminatory acts against the family member who has a mental illness.[21]

In terms of institutional stigma, this is linked with policies from both public and private institutions (including the professionals and officials who work within them). Some studies indicate that despite attitudes of healthcare professionals towards mental illness being more positive than those of the general public, paternalistic or negative attitudes are also frequent, especially around prognosis and the (supposed) limited possibilities for recovery of people with mental illness.[22,23]

Finally, public stigma is produced when the community shares prejudices and negative stereotypes towards the patients and as a consequence, acts in a discriminatory manner towards them. These stigmatizing attitudes can take root at an early age of life by means of the socialization process.[24]

Various studies have identified stereotypes that usually include information regarding the danger, weakness, and incapacity of the patient.[3] At the level of discriminatory acts, people with mental illness frequently have low access to work or a home, as well as to legal and healthcare systems.[25-28]

Regarding discrimination, social rejection is usually greater facing human conditions considered controllable (personal responsibility) than those which are not. For the particular case of stigmatization due to a mental illness, it has been established that independent of public perception of a specific type of mental illness, social rejection is usually greater for those individuals with psychiatric disorders which are related to greater personal responsibility, a feeling of danger, and strange behavior.[29]

It has been described that the belief of danger is highly prevalent when it regards mental disorders such as substance abuse and schizophrenia, but it is much lower for depression.[30,31] On the other hand, public attribution of responsibility towards those who suffer from a mental disorder is mostly established when referring to people who have addictions such as alcoholism, but much less so towards those who have depression or schizophrenia.[32,33] Another distinction has been noted in relation to efficacy of treatment, noting that belief in effectiveness is greater for alcoholism and depression, but lower for schizophrenia.[34]

An analysis of public stigma related to etiology of mental illnesses has shown that despite the public having developed a causal neurobiological perspective of mental illness over time, and that perspective having increased the tendency to support treatment, stigmatization has not been reduced.[35]

Intervention Strategies

Corrigan et al.[36] propose that "personal empowerment programs" would be the best strategy to reduce internalized

stigma. These programs are about encouraging the personal resources of each person with mental illness, generating greater self-value and control over their lives. It should be noted that these programs are developed by both professionals and ex-patients from the healthcare system (pairs). A facilitating factor for this type of intervention is to establish a more balanced role between professionals and patients, in which patients have an active role in their healthcare plans[37] and exercise their right to autonomy.[38] In individuals with mental disorders, this type of intervention generates greater motivation to seek information and group together with other individuals with similar conditions,[39] as well as generating better adherence to treatment.[40] On the other hand, individual interventions have been reported by means of cognitive behavioral therapy (CBT) for people with internalized stigma, confirming the efficacy of CBT in increasing self-esteem, self-efficacy, and subjective wellbeing, as well as reducing negative beliefs associated with the illness.[41,42]

In terms of stigma towards the family, among the interventions applied most often are community-type interventions.[43] These are based on support, control, psychoeducation, and training strategies to moderate potential crises that may happen with the patient. One study carried out by Perlick et al.[44] reported that in a group of 158 relatives-carers of people with a mental disorder, a family community intervention strategy to reduce stigma, primarily led by other family members, significantly reduced family stigma ($p=.017$).

In terms of institutional stigma, the role of healthcare professionals can take various forms: the professional as a stigmatizing agent, the professional as a stigmatized subject, and the professional as a de-stigmatizing agent. Strengthening professionals' adoption of the latter of these roles has been the objective of training and qualification programs for both healthcare professionals in general as well as mental health professionals.[45] According to Beate Schulze,[45] involving healthcare professionals in anti-stigma programs is key, with the aim of committing them to a task which implies constant closeness and support for patients and family members affected by stigma. If these programs focus on self-care by professionals, it is hoped that as well as continuous professional development and direct and close contact with patients, stigmatizing attitudes will also reduce or remain at a low level.[46]

Finally, in terms of public stigma, the literature has reported three different strategies to modify stigmatizing attitudes. Firstly, there is protest that challenges stigmatizing attitudes as well as the behaviors that promote them. Even if protest as a strategy to reduce public stigma can be useful, the majority of the time, its impact is marginal and can even worsen public attitudes.[47] Secondly, there is psychoeducation, which aims to modify people's beliefs, replacing them with more objectifiable knowledge. Just as with protest, psychoeducation has reported results that are not very significant, which suggests that the effects of this type of intervention are limited.[48] Finally, personal contact with people from stigmatized groups is the third strategy to reduce stigma. This type of strategy has been shown to be more effective than the former two, particularly if they take place in community participation programs.[49] Furthermore, as stated by Corrigan,[49] if interventions including contact with patients or ex-patients are aimed at "key" social groups such as employers, mental healthcare providers, criminal justice professionals, policymakers, and the media, they are more likely to be effective.

DISCUSSION

The aim of the present paper was to describe and analyze the different types of stigma towards mental illness, and the interventions that have been created to reduce them. The four types of stigma represent various (inter-related) manifestations of the complex and multiple process that is stigma. In internalized stigma, for example, people with mental illnesses incorporate into their own process of personal meaning the stereotypes and prejudices present in the community, which in turn we have defined as public stigma. These negative public beliefs and judgments are projected onto the patients' families, who in turn go through their own process of internalization, which can ultimately generate feelings of humiliation, shame, and social exclusion. In terms of stigma coming from healthcare services, it is interesting to point out that these play an essential role in generating new stigmatizing attitudes, and they are also positioned as agents whose authority tends to perpetuate processes of stigmatization by means of the social power they represent. Because of the above, stigma towards mental illness is currently a priority within global public health, because of which significant joint investment by both the authorities and the communities is justified and required.

Given the above, since the early 2000s, the World Psychiatric Association (WPA) has led anti-stigma intervention campaigns through the different types of approach that have been described in this paper.[50] In spite of each strategy having shown some levels of efficacy both at patient/family level as well as public/institutional level, their long term results are insufficient and unstable, as well as being difficult to evaluate.[51] As a consequence, it is pertinent to establish new strategies which integrate focuses to intervene in all dimensions that make up the phenomenon, as well as more effective methods to evaluate stigma and interventions that tackle it.[52]

There has been little characterization in terms of the types of stigmatization around mental health in Latin America. This is self-evident in a systematic review of studies on public stigma done by Angermeyer and Dietrich.[3] Of the 62 studies analyzed by these authors, none were on Latin

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American populations. The above is in line with the findings of Peluso and Blay,[53] who did another systematic revision, this time centered on the perceptions of the general public in Latin America towards mental illness, and found very few works on the subject (as well as presenting serious methodological limitations). Given that the characterization, comprehension, and intervention of stigma in Latin American countries is an incomplete task, it is ethically pressing to take the attitude of resolving this issue.

Considering all of the above, the present group of authors proposes the following strategies to consider in order to encourage the field of study around stigma in Latin America:

1. Develop lines of research to characterize and assess the various types of stigma in Latin America. To achieve this objective, it is necessary to adapt instruments designed by other research teams (in Europe, the US, etc) which have shown good psychometric indicators (for example, *Internalized Stigma of Mental Illness*, ISMI), considering the sociocultural characteristics of the community or area at which it is aimed.[11] The recently-published article by Mora-Ríos et al. is an excellent contribution to generating standards of adaptation and validation of instruments on stigma in Latin American contexts.[54]
2. Deriving from the above, generate interventions socioculturally adapted to the various regions in Latin America. According to what has been reviewed, these interventions must aim to encourage that patients and their families seek their civil and social rights, as well as for specific groups (of power and influence) in the community to facilitate the opening of spaces for social inclusion.[48]

As a consequence, a) the patients themselves and their families should be included in implementing these interventions, so that they can take the role of "agents of change" and build a positive discourse around mental illness and recovery; furthermore, b) it is necessary to articulate collaborative networks between "key" actors in the population, i.e. employers, adolescents, ethnic minorities, journalists, healthcare professionals, among others. Furthermore, c) anti-stigma messages should be broadcast throughout wide-reaching media with regional and national coverage, which brings the subjects of mental health and social inclusion to the table; d) resources should also be combined between intervention teams (who conduct and apply the programs), research teams (who design and implement the evaluations), and decision-makers (who basically grant the political support for initiatives to continue). Finally, e) different types of intervention should be integrated and combined; in other words, strategies are implemented that are characterized by a complementary approach. In the same way, this integrated approach must incorporate all mental health provisions currently operating in Latin America.

In relation to the above, it is important to remember that within influential social groups are healthcare professionals. As such, as well as their inclusion in anti-stigma programs, consideration should also be given to intervening in other factors such as high workload, primarily due to their provision of healthcare.[49]

We propose that, under the guidelines set out, it could be possible to cement in the medium term, a significant and lasting contribution to achieving patients' and families' wellbeing through mental health services. Inspired both by knowledge (scientific and technical) and a comprehensive ethical position (autonomy, equality, and welfare), we can firmly advance towards establishing dignified and equitable conditions for those who find themselves in a mental state of lower social functioning, both now and in the future.

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Conflict of Interest

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