16 - Interventions against stigma

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© SPMM Course 4. Status loss and discrimination follow soon after. According to Corrigan three different stigma components can be distinguished: stereotypes (e.g. schizophrenics are violent), prejudice (endorse negative stereotypes result in emotional reactions) which lead to social discrimination (the resulting behavioural reaction). Dimensions of stigma (Jones et al., 2000)

1. Concealability - how obvious or detectable the characteristic is to others. Less concealable problems are more stigmatised.
2. Course - whether the stigmatizing condition is reversible over time, with irreversible conditions tending to elicit more negative attitudes from others.
3. Disruptiveness - the extent to which a mark strains or obstructs interpersonal interactions. The degree of stigmatisation is directly proportional to the degree of disruption in social interaction produced by the condition.
4. Aesthetics - the attractiveness or pleasing nature of a presentation to one's perceptions; A disorder that elicits an instinctive, and strong reaction of disgust will be more stigmatised.
5. Origin - one’s understanding of causal factors. A condition thought to be self-inflicted will have a higher stigma.
6. Peril - feelings of danger or threat that a condition induces. Highly threatening problems are highly stigmatised. Interventions against stigma MIND after NIMBY survey proposed 3 types of antistigma interventions: Rights based – legal methods Normalising approach – popularising the fact about how common mental illness are – e.g. 1 in 4 film from Changing Minds campaign, improving contacts between mentally ill and the neighbours, etc Educational media-based approach – highlighting the role of balanced reporting by media. Legislative intervention: Not much experimental evidence available to support that antidiscrimination legislation would or would not change public stereo-types. Legislation may reduce discriminatory acts but not the prejudice or stereotypes held. It may increase debate and self-questioning about stigma. People may change behavior to avoid legal sanctions. But there is a risk that suppressed discrimination will be shown in subtle, unpunishable forms. This may suppress but not eliminate stigma. Affective intervention: e.g. increasing contacts between local neighbourhood and the mentally ill patients living in a hostel. The generalization from a few hostel inmates in a

© SPMM Course locality to the whole category of mentally ill cannot be drawn. It is also noted that when such contacts were encouraged, the mobility of neighbours of such hostels was higher than that of people in a control street. Such measures also have the risk of reinforcing a stereotype by sub typing the better ones and differentiating them from the ‘dangerous’ ones. Public education: had mixed results, but focussed interventions can increase socially desirable responses around stigma in the post-campaign survey but no improvement in behaviour. N.B. ignorance is not the only cause of stigma. Liz Sayce (‘Psychiatric patient to citizen’) provides four different models for addressing stigma and social exclusion. These are A. Brain disease model - also known as ‘no fault’ approach – it’s an illness like any other. This has the danger of lacking credibility, is too paternalistic and may make ill-person ‘a victim of fate’. B. Individual growth model - considers a continuum or spectrum of mental health and illness. In this model, good mental health, emotional distress triggered by bereavement and enduring psychosis are related experiences (dimensional). The continuum approach has been critiqued as advocating for the status quo rather than attitude shifts involving cultural change though it is a popular approach particularly in mental health promotion. C. Libertarian model - advocates equal rights and equal criminal responsibility for mental health service users. The biggest concern is that the net result will be a series of losses for people with mental health problems rather than gains particularly in the courts and workplace. D. Disability inclusion model - the favoured approach that promotes the concept of social inclusion on civil rights grounds and not just paternalistic ‘help’. Disability is the impairment plus the effects of socially imposed barriers and prejudices faced by the individual. Changing Minds was a 5 years campaign spearheaded by Kendell and colleagues at the Royal College of Psychiatrists. In the RCPsych 1998 survey, 70% believed that people with schizophrenia are violent and unpredictable. Various anti-stigma measures were devised and popularized. 1 in 4 is a short 2-minute film aimed at young adults aged 15-25 to challenge preconceptions about mental illness. 1 in 4 refers to how common mental illnesses are. ‘Every Family in the Land’ is a book on stigma published in conjunction. Various other methods such as tube cards, press articles and videos and road shows were also conducted Labelling and stigma: A survey of nearly 5000 German nationals revealed important findings regarding the effect of diagnostic labeling on the stigma (Angermeyer et al. 2003). Labeling as mental illness has an impact on public attitudes towards people with

© SPMM Course schizophrenia. Endorsing the stereotype of dangerousness has a strong negative effect and increases the preference for social distance. By contrast, perceiving someone with schizophrenia as being in need of help evokes mixed feelings and affects people's desire for social distance both positively and negatively. Labeling has practically no effect on public attitudes towards people with major depression. Normalization is a concept that emerged in the context of the deinstitutionalization of people with developmental disabilities. It focuses on providing disabled individuals with a life in “normalized” settings in the community. It can be defined as “the utilization of means which are as culturally normative as possible in order to establish and/or maintain personal behaviours and characteristics which are as culturally normative as possible” (Wolfensberger 1972) Social role valorisation was formulated in 1983 by Wolf Wolfensberger to expand the scope of the principle of normalization. SRV aims to create social roles for devalued people to enhance their competencies. In other words, SRV deals with the enablement, establishment, enhancement, maintenance, and/or defense of valued social roles for people. SRV is primarily a response to the historically universal phenomenon of social devaluation and especially societal devaluation.

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