Stigma in Mental Health at the Macro and Micro Levels: Implications for Mental Health Consumers and Professionals

Sharon M. Holder, Eunice R. Peterson, Rebecca Stephens & Lee A. Crandall

Community Mental Health Journal

ISSN 0010-3853

Community Ment Health J
DOI 10.1007/s10597-018-0308-y

Springer

Community Mental Health Journal
https://doi.org/10.1007/s10597-018-0308-y

ORIGINAL PAPER

Stigma in Mental Health at the Macro and Micro Levels: Implications for Mental Health Consumers and Professionals

Sharon M. Holder[1,2] · Eunice R. Peterson[2] · Rebecca Stephens[3] · Lee A. Crandall[4]

Received: 17 July 2017 / Accepted: 28 July 2018

Abstract
Despite increasing mental health promotion and advocacy, stigma persists and poses a significant threat to the healthy functioning at the macro and micro-sociological levels. Stigma is gradually evolving with the incorporation of broader social contexts at the micro and macro levels in which individuals, institutions and larger cultural constructs shape and influence the perception of what is different and therefore stigmatized. This theoretical paper based on literature underscores how mental health stigma discourages individuals from getting proper mental health treatment. The interface of mental illness, stigma, and mental health treatment has ethical and potentially moral implications.

Keywords Stigma · Mental health · Mental disorder · Mental illness · Mental health consumer

Introduction

The burdens and challenges attributable to mental health stigma are profound in the US (Corrigan et al. 2012; Crisp et al. 2000; Sharac et al. 2010). Even though there are a wide variety of mental health treatment modalities available, the number of people who experience mental illness vastly exceeds the number who seek treatment (Clement et al. 2015; Dell'Osso et al. 2013). It has been estimated that in the United States (US) 43 million people or 1 in 5 adults have had a diagnosable mental disorder within the past year; and 1 in 25 have serious functional impairment due to a mental illness, such as a psychotic or severe mood or anxiety disorder (NIMH 2016). Reports indicate that 56% of adults with a mental illness do not receive treatment (NIMH 2016). Stigma plays an important role in limiting mental health care access and therefore contributes to the increasing morbidity and mortality associated with mental illness.

Studies show that a patient's decision to avoid or defer needed mental health treatment can have substantial negative consequences (Clement et al. 2015; Dell'Osso et al. 2013). For example, delays in treating psychosis may contribute to adverse pathways to managing overall mental health treatment (Oliver et al. 2005; Morgan et al. 2004). In addition, increased duration of untreated mental illness is more likely to be associated with poorer outcomes in mental health disorders such as psychosis, bipolar disorder, major depressive and anxiety disorders (Boonstra et al. 2012; Dell'Osso et al. 2013). Although mental health treatments have been shown to be effective in alleviating symptoms and improving individual functioning in society, the majority of people who suffer from mental illness either do not seek or do not receive mental health treatment (NIMH 2016).

There are several possible structural explanations for the lack of participation in mental health treatment in the US population including cost, availability of services, third party coverage, etc. However, two landmark reports, the U.S.

✉ Sharon M. Holder
sholder2@ghs.org

Eunice R. Peterson
epeterson2@ghs.org

Rebecca Stephens
rebecca.stephens@scdmh.org

Lee A. Crandall
lac@clemson.edu

1 Department of Public Health Sciences and the Institute of Family and Neighborhood Life, Clemson University, Clemson, SC, USA

2 Department of Psychiatry & Behavioral Medicine, Greenville Health System, 701 Grove Road, Greenville, SC 29605, USA

3 South Carolina Department of Mental Health, Greenville Mental Health Center, 124 Mallard Street, Greenville, SC 29601, USA

4 Department of Public Health Sciences, Clemson University, 513 Edwards Hall, Clemson, SC 29634, USA

Published online: 01 August 2018

Surgeon General (2000) and the World Health Organization (WHO) (2001) cited stigma as a key barrier to seeking treatment, engaging with professionals, and participating in services. There are multiple pathways through which stigma may manifest at the micro- and macro-sociological levels, all of which have implications for mental health consumers and mental health professionals. Persons affected by mental illness will be referred to as mental health consumers throughout the paper. It is important to understand the underlying theories and the multiple pathways through which stigma can manifest. Hence, this paper explores the interface of micro-and macro levels—stigma, mental illness, mental health care access, and its impact on mental health consumers and professionals.

Defining Stigma and Its Impact at the Macro and Micro Levels

Stigma connotes a process of denigrating something or someone on the basis of perceived negative differences. More specifically, stigma is defined as negative stereotypes that includes labelling, prejudice and discrimination that are attributed to a person or groups of people when their characteristics or behaviors are viewed as different from or inferior to societal norms (Ahmedani 2011; Crisp et al. 2000; Clement et al. 2015; Oliver et al. 2005). There are several categories of stigma in our society, and beyond any definition, stigma has become a marker for adverse experiences both at the macro and micro levels. The three main types of stigmas includes: social stigma, self-stigma and professional stigma. Social stigma is the most common and widely recognized of the three.

Social Stigma

According to Merriam-Webster, *social stigma refers to extreme disapproval of (or discontent with) a person or group on socially characteristic grounds that are perceived, and serve to distinguish them, from other members of a society*. Social theorists view this type of stigma as especially efficient, because it is contingent upon social knowledge structures that are learned by most members of a social group (Bulanda et al. 2014; Corrigan et al. 2012; Ahmedani 2011). In American society, there is a distinction made between somatic illness and mental illness which is rooted in the misperception that symptoms of mental illness are a result of a having a weak character or making a perverse choice (Bishop et al. 2016; Holt and Peveler 2010). The social stigma against mental illness is rooted in this misperception (Wallace 2010). This differentiation, which affects consumers, stakeholders, and providers, contributes to divisiveness and allows for social stigma against mental illness which leads to discrimination in diagnoses, treatment, and social perception (Bishop et al. 2016; Wallace 2010). As a consequence of this social paradigm, people experiencing symptoms are much less likely to acknowledge mental illness and to seek or receive appropriate mental health treatment.

Social stigma, the broadest category of stigma, has both macro and micro-sociological implications as it relates to mental health in the US. On the macro level, the social stigma associated with mental illness has pervaded the organization and financing of health care in US society. On the micro level, social stigma involves the assumption or application of blame which can introduce challenges for those that suffer from mental illness as well as their family members. Wallace (2010) postulated that stereotypes about mental health consumers include the belief that they are responsible for their own mental illness and are culpable and dangerous. Belief in these stereotypes may be endorsed by fear and negative determinants that initiate an adverse and prejudicial response. Individuals are often judged by their behaviors, and unfortunately, behavioral problems associated with mental disorders promulgate stigma resulting in poor self-esteem, limited engagement, decreased treatment (US Surgeon Report 2000), and aversion to participating in mental health services (Bulanda et al. 2014; Moses 2010). This can lead to poor health outcomes and decreased quality of well-being across the life-course (Clement et al. 2015; Oliver et al. 2005). One of the difficulties of stigma is that people who feel that others perceive them as different also perceive themselves differently. As such, stigma can also be a self- perpetuating phenomenon. This perception is likely to lead to self-stigma (Corrigan et al. 2012).

Self-stigma

According to the literature, self-stigma is associated with perceived stigma. Self-stigma exists when those that suffer from mental illness judge themselves and their mental illness negatively or dismissively because they recognize that the public holds prejudice and will discriminate against them because of their mental disorder or illness (Clement et al. 2015; Corrigan et al. 2012). Self-stigma is more likely to generate feelings of shame and lead to poorer treatment and outcomes (Clement et al. 2015; Corrigan et al. 2012). If a person suffering from depression does not feel that they are worth treating, then they are less likely to seek services and or treatment that have been proven to help those that suffer from mental illness. Research shows that negative stereotypes, such as dangerousness or incompetence are often associated with mental illness, and can be damaging to

people living with the disease (Corrigan et al. 2012). Thus, one possible reason behind self-stigma is fear.

A recent systematic review (based primarily on studies from the US and Canada) showed that 56% of the studies reported an association between stigma and help-seeking, and that stigma was more likely to be reported as a barrier to treatment by 21–23% of participants across the studies because of shame/embarrassment, negative social judgment and employment-related discrimination (Clement et al. 2015). Moses (2010) found that 35% of stigma directed at youths with mental health problems was perpetrated by professionals such as teachers and school staff, who expressed fear, dislike, avoidance, and under-estimation of their abilities and were more likely to undermine a youth's wellbeing.

Professional Stigma

It has been postulated that mental health stigma is prominent in the medical profession, at least partly because societal stigma attached to mental illness is given little critical assessment or correction during a physicians' training (Wallace 2010). Professional stigma is not often discussed or cited in the empirical literature, and though it may seem surprising that health professionals would uncritically emulate socially stigmatized lay perceptions of those with mental illness, it does occur (Ahmedani 2011; Moses 2010; Volmer et al. 2008). Professional stigma infers that health professionals convey and reinforce stigmatization of their clients. Healthcare professionals do not want to be perceived as projecting stigma at patients who suffer from mental illness, and therefore their stigmatizing behaviors and beliefs may be subtle and easily denied. Thus, it is important for professionals to seek greater awareness of the ways in which stigma might be projected when working with patients who are mentally ill. It has been noted that professional stigma may develop in ways similar to the development of social stigma in the general public (Ahmedani 2011; Moses 2010). It has also been suggested that health professional stigma may develop in myriad ways that have specific clinical connotations (Ahmedani 2011). For example, recent study found that primary care physicians don't take mental illness as seriously as other chronic diseases. Bishop and colleagues (2016) explored survey data to assess doctors' strategies for treating patients with depression and other chronic co-morbidities compared to those used to treat asthma, congestive heart failure (CHF) and diabetes. Data were collected from over 1000 U.S. primary care practices. The study found that primary care physicians often neglect to follow up with their patients after a depression diagnosis and were less likely to help depressed patients manage their illness. They were also more likely to engage in care strategies with patients who are dealing with a chronic physical illness, like CHF or diabetes (Bishop et al. 2016). The findings are disturbing because many mental health consumers seek treatment for depression from their primary care doctors as a result of the stigma attached to seeing specialized mental health professionals.

Some health professionals, similar to persons in the general public, experience their own mental illness (Moses 2010). Denial of their own stigmatized problems may cause them to fail to recognize similar problems in their clients (Moses 2010; Siebert 2005). However, counter-transference that can occur as a result of the health professional's personal experiences, may impact the overall well-being of clients. Similarly, the client of an impaired professional can become disenfranchised and more vulnerable due to failure to recognize the lack of appropriate treatment. This may lead them to end treatment or seek treatment elsewhere. Ultimately, professional stigma, whether directed at the patient or at the provider's own illness, creates a barrier to the wellness of the individual by preventing adequate treatment, and may also impact the acknowledgement of their disorder, because of the health professional's own stigmatizing beliefs and personal history (Moses 2010; Siebert 2005).

Mitigating of Stigma at the Macro and Micro Levels

Stigma is both complex and pervasive. It does not exist in a silo. Despite increasing mental health promotion and advocacy, stigma persists and poses a significant threat to the healthy functioning at the macro and micro-sociological levels. Stigma is gradually evolving with the incorporation of broader social contexts at the micro and macro levels in which individuals, institutions and larger cultural constructs shape and influence the perception of what is different and therefore stigmatized (Clement et al. 2015; Corrigan et al. 2012; Ahmedani 2011; Wallace 2010; Crisp et al. 2000).

At the micro level, people that suffer from a mental illness deal with societal stigma of their illness and many also may have to deal with broader social stigma levied against them (e.g., institutionalized racism, gender discrimination or negative cultural stereotypes). They also confront their own self-imposed stigma related to their illness. The process of stigmatizing a devalued attribute occurs through social interaction where social relationships, rather than the attribute itself, are central to stigmatization. Mental health stigma contributes to a variety of bad consequences including self-isolation (Wallace 2010), avoidance of seeking mental health treatment (Clement et al. 2015), lack of gainful employment (Sharac et al. 2010), and strained relationships with others (Crisp et al. 2000; Sharac et al. 2010). For example, people who feel that they are being "judged" or discriminated against because of their mental illness are more likely to turn their negative thoughts inward, become isolated from others

and are more argumentative with those who care about them (Elkington et al. 2012). The more people feel judged, misunderstood, and labeled, the more likely they are to become self-stigmatized and the less likely they are to participate in treatment and contribute toward wellbeing. These characteristics can be pervasive throughout the life-course. As such, stigma not only impacts the wellbeing of mental health consumers and professionals, but also can have major economic costs due to the loss of income from unemployment, and expenses for social supports (Sharac et al. 2010; Insel 2008). It has been estimated that individuals who suffer from mental illnesses such as depression have lost earnings of $193 billion a year, whereas, health care costs for those individuals is around $58 billion (Bishop et al. 2016; Sharac et al. 2010).

The US Surgeon General's report on mental health (2000), identified racial/ethnic disparities in mental health service use as a major public health problem, and more recently the Substance Abuse and Mental Health Services Administration (SAMHSA) Report (2015) estimates, noted that black (8.6%), Hispanic (7.3%) and Asian (4.9%) adults were less likely to use mental health services compared to white adults (16.6%). Research also shows that negative attitudes toward health care professionals are more pervasive among some ethnic groups, noting that stigma, religious beliefs, distrust of the medical profession, and communication barriers may contribute to wariness of mental health services. For example, African American males are more likely to reject their symptoms of ill health, choosing to deal with depression by themselves, and are less likely to utilize mental health services because of wanting to avoid letting others know how they are feeling (Lindsey and Marcell 2012; Bailey et al. 2011). Hence, it has been suggested that the continued stigmatization of mental illness is a major factor contributing to the aversion of some individuals to seeking and maintaining mental health treatment (Clement et al. 2015; Crisp et al. 2000; Oliver 2005).

Conversely, concerns about mental illness and substance use by health professionals, particularly physicians, are usually addressed in terms of 'disciplinary responses' to ensure the safety of patients, rather than in terms focused on the health status or treatment needs of the affected health professionals (Wallace 2010; Crisp et al. 2000). Patient safety is clearly of vital importance, but this approach has fostered an ethos that tends to punish and stigmatize ill and or impaired health professionals rather than offering understanding and compassionate care that is usually accessible to non-health professionals or physicians suffering from similar mental health or substance use conditions (Wallace 2010; Pescosolido et al. 2008; Taub et al. 2006). Raising awareness of mental health stigma simply by providing information about the problems may not be an adequate solution, especially if individuals who are most knowledgeable about mental health (e.g. psychiatrists, social workers, therapists) also hold strong stigmatizing beliefs about mental health themselves. The fact that such negative attitudes and stigmatization of those with mental illness continue to be so entrenched in the institutions and cultural structures suggests that campaigns to change these beliefs will have to be multifaceted.

Discussion

Implications for Mental Health Consumers and Professionals

Throughout history, people with mental health diagnoses have been treated differently, excluded and even characterized as demonic. This treatment may come from the errant view that people with mental health problems are more unpredictable or volatile than people without such problems, or somehow just "different", but none of these beliefs has any basis in fact. Similarly, early beliefs about the causes of mental health problems, such as 'divine punishment' or 'spirit possessed' are descriptions that undoubtedly helped to give rise to the stereotypes, fear, discrimination and misguided views of mental illness (Morrison 1999). For the mental health consumers and professionals, stigma also has a detrimental affect on treatment outcomes, and so hinders efficient and effective recovery from mental health problems. However, we now have a better understanding of what mental health stigma is, and how it affects mental health consumers and professionals both in terms of the individual, and their route to recovery (micro) or the role in society (macro). Hence, due to the multifaceted nature of mental health stigma and subsequent barriers associated with accessing care and treatment, organizations and institutions will need to be equally diverse and have to do more than just impart knowledge about the problem. We will need to challenge existing negative stereotypes especially as they are portrayed in our communities, among individuals, intergroups and the media.

Challenging stigma can and should occur on multiple levels. There are a number of initiatives and programs that attempt to address mental health stigma such as National Alliance on Mental Illness (NAMI) and Mental Health America (MHA) and they have worked to improve mental health care, access and decrease stigma through education, advocacy, and research for people with mental illness. However, it is now time for mental health consumers, and professionals to implore their legislators to be more bold, initiate equity for mental health care comparable to other health care, and inform public policy that would stamp out stigma.

Mental health consumers need to be encouraged not to let the illness define them. Further, mental health professionals

should not be fearful of disclosing their condition due to the fear of being ostracized and the dread of professional punishment. They should be revered in being open about their mental illness as they would with any other medical illness. The more open, integrated and aware we are as a society about stigma the stronger we become and are more likely to change hearts or minds about stigmatization. Though mental health stigma is not consistent across communities or cultures, culturally-sensitive ways may be essential to increasing access to, and treatment of mental health care services at the micro and macro levels.

Conclusion

Mental health stigma severely affects those with mental illness and discourages them from getting proper mental health treatment. It has been emphasized that the problem of stigma in mental health is pervasive (Crisp et al. 2000, US Surgeon General 2000; WHO 2001). Though a more accepting society isn't the cure for mental illness, it is certainly an advantage for those suffering with the illness. Stigma towards mental illness, whether social, self, or professional, plays a critical role in limiting mental health care access which in turn increases mental health mortality and morbidity. The interface of mental illness, stigma, and mental health treatment has ethical and potentially moral implications that warrant further investigation, research, education, and advocacy.

Compliance with Ethical Standards

Conflict of interest We have no conflict of interest to disclose and or acknowledge.

References

Ahmedani, B. (2011). Mental health stigma: Society, individuals, and the profession. *Journal of Social Work Values Ethics, 8*(2), 4

Bailey, R. K., Patel, M., Barker, N. C., Ali, S., & Jabeen, S. (2011). Major depressive disorder in the African American population. *Journal of the National Medical Association, 103*(7), 548–557.

Bishop, T. F., Ramsay, P. P., Casalino, L. P., Bao, Y., Pincus, H. A., & Shortell, S. M. (2016). Care management processes used less often for depression than for other chronic conditions in US primary care practices. *Health Affairs, 35*(3), 394–400.

Boonstra, N., Klaassen, R., Sytema, S., Marshall, M., De Haan, L., Wunderink, L., & Wiersma, D. (2012). Duration of untreated psychosis and negative symptoms: A systematic review and meta-analysis of individual patient data. *Schizophrenia Research, 142*, 12–19.

Bulanda, J., Bruhn, C., Johnson-Byro, T., & Zentmyer, M. (2014). Addressing mental health stigma among youth adolescents: Evaluation of a youth-led approach. *Health and Social Work, 39*(2), 73–80.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine, 45*, 11–27.

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services, 63*(10), 963–973.

Crisp, A., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatization of people with mental illness. *The British Journal of Psychiatry, 177*(1), 4–7.

Dell'Osso, B., Glick, I. D., Baldwin, D. S., & Altamura, A. C. (2013). Can long-term outcomes be improved by shortening the duration of untreated illness in psychiatric disorders: A conceptual framework. *Psychopathology, 14*, 14–21.

Elkington, K., Hackler, D., McKinnon, D., Borges, C., Wright, E., & Wainberg, M. (2012). Perceived mental illness stigma among youth in psychiatric outpatient treatment. *Journal of Adolescent Research, 27*(2), 290–317.

Holt, R. I. G., & Peveler, R. C. (2010). Diabetes and cardiovascular risk in severe mental illness: A missed opportunity and challenge for the future. *Practical Diabetes International, 27*, 79–84.

Insel, T. R. (2008). Assessing the economic costs of serious mental illness. *American Journal of Psychiatry, 165*(6), 703–711.

Lindsey, M., & Marcell, A. (2012). We're going through a lot of struggles that people don't even know about: The need to understand African American males' help seeking for mental health on multiple levels. *American Journal of Men's Health, 6*(5), 354–365.

Morgan, C., Mallett, R., Hutchinson, G., & Leff, J. (2004). Negative pathways to psychiatric care and ethnicity: The bridge between social science and psychiatry. *Social Science and Medicine, 58*, 739–752.

Morrison, E. F., & Thornton, K. A. (1999). Influence of southern spiritual beliefs on perceptions of mental illness. *Issues in Mental Health Nursing, 20*(5), 443–458.

Moses, T. (2010). Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Social Science & Medicine, 70*(7), 985–993.

NIMH. (2016). Any mental illness (AMI) among U.S. adults. Retrieved December 2016, from http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml.

Oliver, M. I., Pearson, N., Coe, N., & Gunnell, D. (2005). Help-seeking behavior in men and women with common mental health problems: cross-sectional study. *British Journal of Psychiatry, 186*, 297–301.

Pescosolido, B., Martin, E., Lang, J. K., A., & Olafsdottir, S. (2008). Rethinking theoretical approaches to stigma: A Framework Integrating normative influences on stigma (FINIS). *Social Science & Medicine, 67*(3), 431–440.

SAMHSA. (2015). Racial/ethnic differences in mental health service use among adults. Retrieved June 2015, from https://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServicesUseAmongAdults.pdf.

Sharac, J., McCrone, P., Clement, S., & Thornicroft, G. (2010). The economic impact of mental health stigma and discrimination: A systematic review. *Epidemiology and Psychiatric Sciences, 19*(3), 223–232.

Siebert, D. C. (2005). Help seeking for AOD misuse among social workers: Patterns, barriers, and implications. *Social Work, 50*(1), 65–75.

Taub, S., Morin, K., Goldrich, M. S., Ray, P., & Benjamin, R. (2006). Physician health and wellness. *Occupational Medicine, 56*(2), 77–82.

US Department of Health and Human Services, US Department of Education, & US Department of Justice. (2000). Report of the Surgeon General's conference on children's mental health: A national action agenda. Washington, DC: US Department of

Health and Human Services. Retrieved November 2015, from http://www.ncbi.nlm.nih.gov/books/NBK44233/pdf/TOC.pdf.

Volmer, D., Mäesalu, M., Bell, J. S. (2008). Pharmacy students' attitudes toward and professional interactions with people with mental disorders. *International Journal of Social Psychiatry, 54*(5), 402–413.

Wallace, J. (2010). Mental health and stigma in the medical profession. *Health, 16*(1), 3–18.

World Health Organization (WHO). (2001). *The world health report 2001. Mental health: New understanding, new hope*. Geneva, Switzerland: WHO. http://www.who.int/whr/2001/en/whr01_en.pdf?ua=1. Accessed Dec 2015.