Myers-JDC-Brookdale Institute
Center for Research on Disability
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Ministry of Health
Mental Health Services

Stigma, Discrimination, and Mental Health in Israel: Stigma against People with Psychiatric Illnesses and against Mental Health Care

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Struch, N.; Shereshevsky, Y.; Baidani-Auerbach, A.; Lachman, M.; Sagiv, N.; and Zehavi, T. 2007.***Stigma in the Field of Mental Health: The Attitudes, Experiences, and Coping Mechanisms of Parents of People Who Cope with a Psychiatric Illness***. Research Report (RR-468-07).

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Executive Summary

Background

In recent decades, there have been considerable developments in mental health care and the rehabilitation of people with psychiatric illnesses. However, the potential of these developments is not being fully realized due, inter alia, to the fact that people who could benefit from the various technologies may choose not to seek treatment because of the stigma associated with psychiatric help and mental health care. Stigma may have a destructive effect on the lives and functioning of people with psychiatric illnesses and on their rehabilitation and integration into society. Stigma is detrimental to quality of life and is expressed in discrimination in housing and employment, in alienation and social distance, and sometimes even in inadequate medical care.

There are a range of intervention strategies to cope with stigma, from structural changes to personal contact. Structural changes, such as moving psychiatric services to a new location where they are less visible and more accessible, do not confront stigma itself but they can reduce its impact. Other interventions try to cope with the stigma itself, for example, by providing factual information about the rates of violence among people with psychiatric illnesses in order to counter a widespread stereotype of "mental illness," or by informing the public about the results of treatment and prognosis. Other programs offer contact with people with psychiatric illnesses. However, interventions of this kind do not necessarily reduce stigma.

The current study is the first step toward the development of intervention programs to reduce stigma, which is being planned by the Ministry of Health in line with World Health Organization policy. The study is based on a representative sample of 1,583 people, who represent the adult population of Israel (age 22 and over). In addition, we took separate samples for the ultra-Orthodox sector and for Arab localities. Altogether, 2,100 telephone interviews were conducted.

Note that this report presents the findings of one of three concurrent studies. Since stigma is not limited to people with psychiatric illnesses and also affects the lives of their families, we conducted another study in which we interviewed 52 parents of people with psychiatric illnesses. Furthermore, because stigma is liable to affect not only people with psychiatric illnesses but also the broader group of individuals receiving treatment at mental health clinics, we conducted a third study in which 167 persons undergoing treatment at these clinics were interviewed in order to examine their experience and perception of stigma. The findings of the additional two studies are the subject of separate reports.

Study Goals

1. To examine stigma against "mental illness," against people with psychiatric problems, and against mental health care and to improve the conceptualization (and assessment) of stigma, including an examination of its various facets:

- The extent to which there are norms, beliefs, and expressions that reflect various types of stigma
- The essence of stigma with respect to its cognitive, emotional, and behavioral components (e.g., examining the role of fear as opposed to hostility or other emotions or examining the cognitive components of stigma, such as knowledge and beliefs) about "mental illness" and about the mental health services.

2. To assess the extent and prevalence of stigma in Israel:
   - The prevalence of various manifestations of stigma within the general population (overall and in subgroups such as the ultra-Orthodox, Arabs, and various age cohorts);
   - The effect of stigma on the utilization of mental health services – to what extent does the general population refrain from seeking mental health care due to the stigma and what are the public's preferences regarding the way it receives care?
3. To elucidate possible directions for intervention (with respect to goals, method, and target subgroups).

Findings

I. Mental Health Care

Knowledge about and Familiarity with Mental Health Care

A lack of suitable treatment can lead to deterioration into a more serious condition and the need for more intensive treatment and care frameworks. One of the focuses of the current study is, therefore, to examine the public's willingness to seek mental health care, with an emphasis on the stigma associated with the care. As background, we examined the public's level of knowledge about mental health care.

The public has some knowledge about mental health care. Many people are aware, for example, of the existence of antidepressants and tranquilizers although fewer know about medication for schizophrenia. With regard to the availability of services, it was found that about a third of the respondents do not know whether there is a mental health clinic in the vicinity.

Attitudes to Mental Health Care and Willingness to Seek Care

We found that only a small percentage of people (13%) would seek help from a mental-health professional if they were feeling tense or anxious or were in a bad mood. However, when the situation was specifically presented in terms of a psychiatric problem or mental difficulty, there appeared to be greater willingness to refer to the professionals (over two-thirds of respondents). Thus it appears that, on the whole, people are in principal open to the idea of seeking treatment. The openness to treatment and its perceived benefits are more positive among people who have been more exposed to treatment and to people receiving mental health treatment.

We examined whether people would wish to conceal the fact that they had sought treatment. A third of the respondents said that if they were receiving treatment they would feel the need to hide the fact, even from people close to them. The negative attitude of people around them is

considered by half of the respondents not only as a barrier that has to be overcome, but also as justification for not seeking treatment. No strong association was found between the extent to which people were acquainted with psychiatric treatment or had contact with people with psychiatric illnesses and their wish to hide seeking treatment. However, as expected, people who had actually considered seeking treatment showed more positive attitudes toward treatment and less desire to conceal the fact that they were seeking it.

Preferences Regarding Ambulatory Care and Hospitalization

In a hypothetical situation with identical costs for both private and public health care, people would prefer to be treated privately – and even more so in the case of mental health care. If under the reform of the health system, mental health care becomes the responsibility of the health plans, one of the issues that will have to be considered is the structural aspect of the provision of mental health care: Should it become incorporated into general medicine or should there be separate settings for mental health care? Given the argument sometimes put forward that general clinics are less stigmatic, it is interesting to note that not only did we find no preference for general clinics, but that we also found the Israeli public shows a preference for clinics dedicated solely to mental health care. Approximately 75% of the respondents who would prefer to receive treatment at a separate mental health clinic explained that their choice was based on the quality of care. The same reason was given by 18% of those who would prefer to receive treatment at a general clinic. The main consideration for respondents who preferred a general clinic was the possibility of consulting with additional physicians. Another consideration was confidentiality: over a fifth of the respondents who had a preference for either of the two types of clinic gave confidentiality and discretion as a reason for their preference.

In the case of hospitalization, the picture is different – there is a clear preference for hospitalization in a psychiatric ward of a general hospital rather than in a psychiatric hospital. This preference is in line with the trend toward altering the ratio of psychiatric beds by reducing the proportion of beds in psychiatric hospitals and increasing the proportion of beds in general hospitals. When the respondent or member of his/her family is in need of a hostel, there is a clear preference for one in the immediate vicinity (72%). The most prominent reasons: the possibility of visiting and of monitoring the care. A minority (19%) prefer the hostel to be further away – apparently chiefly due to stigma.. Respondents in the ultra-Orthodox sector and in Arab localities showed some preference for having a hostel nearby, but their preference was not as strong.

II. People with Psychiatric Illnesses

Familiarity with People with Psychiatric Illnesses

Knowing people with psychiatric illnesses is usually associated with a more positive attitude toward such people. To what extent is the Israeli public exposed to people with psychiatric illnesses? About one-fourth of the respondents reported having a "mentally ill" relative. When this figure is cross-tabulated with reports of respondents living with a "mentally ill" person (now or in the past), we find approximately 6%. We therefore estimate that up to 6% of the respondents have a close relative with a psychiatric illness. About one-fourth of the respondents said they had

worked with a "mental patient," and approximately one-fifth reported that the family had a friend with a "mental illness." Approximately one-fifth reported having a neighbor with a psychiatric illness.

Identifying People with Psychiatric Illnesses and Perceptions about Them

To what extent is the public capable of identifying people with psychiatric illnesses? What are the perceived characteristics of people with psychiatric illnesses? And to what extent are identification and perceptions associated with stigma? In order to facilitate evidence-based interventions, it is important to know what causes negative attitudes, emotions, and behaviors toward people with psychiatric illnesses.

Are negative responses to an individual elicited by specific behaviors that cause him/her to be perceived as "mentally ill"? Or is it the concept/term "mental illness" that is perceived to be associated with certain characteristics and, when ascribed to a specific person, raises a negative orientation toward that person (regardless of his/her specific behaviors)? It is reasonable to assume that both the above paths are relevant to stigma in mental health. The first path, which involves identifying specific people, is meaningful because it concerns everyday situations in which people encounter stigma in response to their behavior. The public identifies some of the people with psychiatric illnesses and responds to them. Obviously, if a person with a psychiatric illness is not identified as such, s/he will be less susceptible to the stigma. The second path, which concerns perceptions of an abstract concept, is meaningful because it represents situations in which the public responds to the term "mentally ill" in a stigmatic way: they are, in fact, responding to the perceived characteristics of a "mental patient," without having a specific person in front of them. So, for example, when there are plans to build a hostel for people with psychiatric illnesses, neighbors will respond to the idea of "mental patients" as they perceive them to be. The two paths have different implications for interventions.

Identifying Psychiatric Illnesses: We found a high prevalence of the perception that it is possible to identify people with psychiatric illnesses. Specifically, 41% thought they could identify patients by their appearance, 69% believed they could do so by the way they speak, and 78% thought they could recognize people with psychiatric illnesses by their behavior. When we presented the respondents with descriptions of people, we found that the public is capable of identifying depression – but that depression is not perceived as a psychiatric illness and that attitudes towards people suffering from depression are characterized, among other things, by feelings of anger. In contrast, when presented with a description of a person with schizophrenia, almost 90% of the respondents believed that the individual described was suffering from a "psychiatric problem." Interestingly, however, about a third did not think the individual had a psychiatric illness. When told that an individual showing no psychopathological symptoms had been hospitalized in the past as the result of a traumatic event (a car crash), respondents considered him to have psychiatric problems to a lesser extent than a person described in the same way without mention of the traumatic event (the accident). On the basis of this finding, we indicate a way in which it is possible, in certain cases, to reduce the stigma associated with

hospitalization: by emphasizing the external background as the reason for the hospitalization (thereby reducing the attribution of mental problems to the person).

Perceived Image of a Person with a Psychiatric Illness: Alongside the issue of identification, there is the issue of the abstract concept of "mental illness." How clear is the distinction between "them" and "us"? We found that "mental illness" is clearly perceived as something that can happen to anyone, even to "us." The findings were not unequivocal with regard to the similarity/dissimilarity between "them" and "us": there is evidently great variance, not only among the respondents, but also in the perceptions of those same respondents themselves. This variance may be reflected in the perceived profiles of a "mentally ill" person and in the complexity of these perceptions.

In some domains there is evidently a normative perception of people with psychiatric illnesses. Most of the public does not associate psychiatric illness with mental retardation and the "mentally ill" are perceived to have a similar level of education to that of the general population. Approximately 75% estimated, correctly, that only a small percentage are hospitalized.

Using an open-ended question, we asked respondents to list three characteristics of a "mentally ill person". We did not suggest responses or answers. The most salient responses were abnormal/unusual outward behavior, violent behavior, and unexpected behavior. Unprompted, over half the respondents noted abnormal/unusual outward behavior as one of the characteristics of a "mentally ill person." They referred to talking loudly, strange facial expressions and dress, and tremors. About two-thirds of those who referred to abnormal/unusual behavior cited strangeness and, in particular, odd, inadequate, or irrational behavior. About a fifth of the respondents cited an imperfect grasp of reality (misinterpreting reality, hallucinating, speaking incoherently, etc.). Unprompted (i.e., without our suggesting any of the options), about a fifth of the respondents said that unpredictable behavior (including inconsistency and loss of control) was one of the characteristics of a person with "mental illness." When asked directly, 80% of the respondents concur that the "mentally ill" behave in an unpredictable manner. Unprompted (i.e., in response to the open question), about a fifth cited violence and aggression as three characteristics of the "mentally ill." When asked directly about violence, it was found that about a quarter of the respondents believed the "mentally ill" to be more violent than others. Moreover, violence is associated with unpredictable behavior – when asked, about a third of the respondents said that people with "mental illnesses" were violent for no reason. This perception of unexpected violence was mentioned whether the respondents believed patients to be either more violent or less violent than others or violent to the same degree as others. Approximately a fifth of the respondents (21%) described the mentally ill as depressive, weak, and unable to function. Approximately 14% of the respondents noted social problems (isolation, self-segregation, and withdrawal).

In general, it appears that the perception of normativity – perceiving the "mentally ill" as people who can work and study like anyone else – coexists with the idea that they are odd, unpredictable, and, above all, violent.

Perceived Etiology

One significant dimension of the perception of patients and illnesses is the etiology. This is because the perceived etiology is liable to constitute the grounds for accusations and for blaming the person for his/her illness. (If, for example, persons with depression are perceived as simply being too easy on themselves and it is considered to be within their power to control their problems, there may be a tendency to blame them for their condition.) Concurrently, it may also be grounds for expecting the patient to recover and be able to function. (For example, if the illness is due to a chemical imbalance, then medication should redress the problem and enable him/her to function.) The prevalent perceived etiology is based both on physiological causes and on stress and traumatic events. About half the respondents indicated one or more physical causes for "mental illness": 42% noted genetic problems and about 14% mentioned chemical/organic problems in the brain. Approximately 73% of the respondents mentioned one or more causes that could be seen as psychosocial etiology – i.e., stress from external events including trauma (36%), unemployment, tension at work and in Israel (20%), domestic crises (34%), failures and disappointment, immigration difficulties, external troubles and complications, etc. However, along with the recognition of biochemical and psychosocial causes, we found a not inconsiderable measure of blame attributed to the patients for their illness, as reflected in the opinion of almost half the respondents (46%) that people would suffer less from mental illness if they stopped thinking negative/bad thoughts.

Emotions: Fear and Anger

The public fears violence from people with psychiatric illnesses especially unexpected violence. Their fear is exaggerated and does not fit reality. We also found it was not uncommon for the respondents to blame the patients for their behavior or condition, while at the same time recognizing the external or biological etiology. Apparently the image produced by the notion of "mentally ill" is closer to emphasizing aspects of schizophrenia than affective disorders, which is also reflected (as noted above) in the perceptions of strangeness and weirdness prevalent in the unprompted responses, in other words, in the responses we obtained to our open questions about three characteristics of "mental illness."

A "mental patient" or a person with schizophrenia arouses more fear than a "normal" person (i.e., one whose description shows no signs of psychopathology) who has been hospitalized or a person with depression. The fear of someone with a psychiatric illness or schizophrenia is associated with the perception that the "mentally ill" have a relatively low ability to function like other people, to benefit from psychotherapy, or to be in control of their condition and change it. Despite the fear, people express more compassion and a greater willingness to help people with schizophrenia who have been hospitalized than "normal" people who have been hospitalized.

Their willingness to help people with depression is somewhere between these two extremes and is not significantly different from either.

In contrast, in the case of anger, it is interesting that a person with depression arouses more anger than a person with schizophrenia or a "normal" person who has been hospitalized. The anger directed at people with depression reflects a lack of empathy and an inability to understand their condition.

Behavioral Intentions and Attitudes

Beyond all the emotions, perceptions, and thoughts, the most meaningful aspect about the orientation toward people with psychiatric illnesses is the actual behavior towards them. We did not examine actual behavior, but we did try to examine several measures that could be considered a proxy for it.

Most of the respondents said that they would be willing to support the establishment of a social club for people with "mental illnesses." There is a large disparity between the respondents' willingness to have a club in a remote neighborhood and their willingness to have one in their own (i.e., the "Not in My Backyard" phenomenon). This indicates that, even when there is – on the face of it – some openness, it diminishes when the matter impinges on the respondent himself. An interesting and informative finding is that the objections to the establishment of a club in a remote location – i.e., objections for which the respondent's personal interest is not clear – are linked to higher levels of anger toward patients. These findings could be significant for the planning of advance interventions as opposed to post-factum interventions regarding the establishment of hostels or employment units.

To what extent does the public express willingness to have contact of various kinds with people with psychiatric illnesses? Willingness to have contact (i.e., the "social distance" scale) is accepted and prevalent in the literature as a proxy for actual behavior. The findings indicate a similar pattern of willingness for contact with someone "mentally ill" or a person with schizophrenia, as described to the respondents. Willingness for contact was greater in the case of a person with depression or a "normal" person who had been hospitalized. With regard to the findings about the "mentally ill," we found that 21% of the respondents would not be willing to sit on a bus next to a "mentally ill" person; 31% would not want such a person as a neighbor; 35% would not be prepared to work with one. In the case of hiring a "mentally ill" person, the figure rose to 52%, and 72% would not want such a person as their boss. Twenty-one percent of respondents would not want to befriend such a person; 34% would not want to continue to be a close friend and confidant of such a person. Finally, 88% would not be willing to have a "mentally ill" person drive their children to school. These percentages concern respondents who are unwilling to have the proposed forms of contact. The percentage of people who declared that they *would* be prepared to have contacts of these kinds should not be ignored. Nevertheless, the percentages of people unwilling to have the various forms of contact are not low and, furthermore, social desirability may be obscuring an even higher percentage. The figures are

significant given the potentially devastating effect on the rehabilitation of people with psychiatric illnesses and their integration into society.

As noted above, 31% of the respondents are not willing to have a person with a psychiatric illness as a neighbor. Responses were more extreme when we asked people what would happen if they had an apartment to rent. About 54% of the respondents would refuse to rent their apartment to a person with a "mental illness." We tried to focus where the problem lay – to what extent this reluctance could be reduced. We found that when the respondents were given a guarantee that the person would pay, the refusals dropped to 39%; if, in addition, there was someone who could be contacted if any problems arose, the percentage of respondents refusing to rent their apartment declined to 22%. In other words, it is possible that through intervention, a significant percentage of people would be willing to consider renting their apartment to a person with a psychiatric illness. A financial guarantee and the possibility of referring problems to a third party could provide a solution, or at least reduce the public's fears and apprehensions. This finding indicates the possibility of reducing the damage caused by stigma not only by changing attitudes but also through structural adaptations (introduction of a system of financial guarantees and a contact person).

Relationship among Variables

Different measures of orientations toward people with psychiatric illnesses – whether general attitudes, subtle discrimination, preferred social distance, or willingness to rent an apartment – tend to be related to age, education, actual contact with patients, and feelings of anger and fear. The strength of the relationship with the different measures and variables varies. Specifically, we found a more positive approach among people under (rather than over) age 60; those with more (rather than less) education; those with some kind of contact with the mentally ill (rather than those with none); and people who are less afraid of or less angry with mentally ill people. Gender differences are small.

Beyond the attitudes and emotions, we examined two measures that are closer in essence to behavior. These examinations focused on social distance and subtle discrimination, which measure two types of discrimination – "regular" and "subtle." The former reflects the extent to whcih a person is willing to have various relationships with others (in the case of a "mentally ill" person). The latter is considered subtle because the discrimination appears to be justified – i.e., the discriminatory behavior is accompanied by justifications. People who behave in this way are unaware that they are being discriminatory. They do not think that their behavior is a response to a person's group affiliation (the "mentally ill"); rather, they believe they are responding to the individual's own characteristics, skills, etc. The importance of distinguishing between the two types of discrimination is not merely theoretical. It is also important with regard to interventions. In the case of subtle discrimination, it is possible to consider an intervention to clarify the problematic nature of these "justifications." Certain types of discrimination are characterized by "following the norm." As long as it is clear what constitutes appropriate behavior, the individual

will try to conform to it. In such situations, it is better to focus on pointing to the discrimination itself and on the fact that it deviates from the desirable norm.

As a step towards understanding the factors that affect people's preferred distance from people with psychiatric illnesses or lead to subtle discrimination, we examined models of prediction by employing different variables, such as demographic variables (e.g., age, gender, and education); perceived ability to recover and function; perceived visibility; perceived permeability of boundaries; actual contact with patients; general attitudes towards the "mentally ill"; and emotions of fear and anger. In examining the models, we made several assumptions about the possible order of the effect of these variables. Some variables were found to have a direct effect, some were found to be fully mediated, and some were found to have both a direct and mediated effect.

In both the case of preferred social distance and that of subtle discrimination, we found the two main predictors to be fear of the mentally ill and general attitudes toward them. The perception that an ill person can recover and function, and actual contact with ill people, statistically predict the preferred social distance but do not contribute to the statistical prediction of subtle discrimination. In contrast, the degree of anger felt toward these patients is a significant predictor of the extent of subtle discrimination but is not a significant predictor of the preferred social distance after the fear and general attitudes are taken into account. These findings indicate that despite the strong relationship between subtle discrimination and the preferred social distance, these two measures also have different components.

The general attitudes, which constitute a key factor in predicting the preferred social distance and subtle discrimination, are predicted by fear and anger, the perceived "visibility" of the person with a psychiatric illness, and the respondent's level of education. We tried to predict the extent of fear and anger by age, gender, education, and actual contact with a psychiatric patient. Both were found to be related to actual contact and anger was greater among men. However, the percentage of explained variance we found in both cases was negligible.

The models we examined explained 44% of the variance in the preferred social distance, and 53% of the variance in subtle discrimination.

III. Other Populations

The Ultra-Orthodox

We found less positive attitudes towards seeking mental health care in ultra-Orthodox society than among the non-ultra-Orthodox Jewish population. In particular, there was less willingness to seek treatment openly. The desire to conceal the request for treatment was stronger. A larger percentage of people knew people receiving care, but fewer had considered seeking treatment themselves. They were less familiar with mental-health professionals. Like the rest of the Jewish population, they expressed a preference for a clinic dedicated solely to mental health care rather than a general/integrated clinic and for a general hospital rather than a psychiatric institution. In

the case of a family member in need of a hostel, there was a tendency to prefer one located nearby, but this preference was weaker than in the non-ultra-Orthodox population. The ultra-Orthodox population also had a stronger preference than the non-ultra-Orthodox for private ambulatory care, but this applied to all medical treatment and not only mental health care.

Regarding the approach to people with psychiatric illnesses, the ultra-Orthodox sample is characterized by a wish to maintain a greater social distance from people with psychiatric illnesses, i.e., they are less willing to have contact (as a neighbor, colleague, boss, etc.), but, as an exception to this trend, they expressed a greater willingness to befriend them. The ultra-Orthodox are no different from other Jews in their perception of the ability of people who have had a psychiatric illness and recovered from it, to marry. The perception that the "mentally ill" are violent is more prevalent in the ultra-Orthodox sample. They are fundamentally less willing to rent an apartment to a "mentally ill" person. However, there was a substantial change when a financial guarantee and contact person were provided, such that the percentage of ultra-Orthodox resolutely opposed to renting their apartment became similar to that of the rest of the Jewish population.

Arab Localities

In the sample taken in Arab localities, which we compared with respondents living elsewhere, we found a less positive perception of the benefits of mental health care. The respondents are also somewhat less informed about the existence of psychiatric medications. The respondents in Arab localities are less well acquainted with psychologists and more familiar with social workers and psychiatrists than respondents not living in Arab localities. Although we did not find clear differences as to the wish to conceal treatment, the preference for clinics dedicated solely to mental health care, which was also found in non-Arab localities, was stronger in the Arab localities. The preference for psychiatric hospitalization in a psychiatric ward in a general hospital rather than in a psychiatric hospital, was similar in Arab and non-Arab localities. Should a family member be in need of a hostel, we again found a preference for one nearby. However, we found that, as in the ultra-Orthodox sample, it was weaker than in the rest of the population.

Willingness to have contact with a person with a psychiatric illness was greater in the case of certain forms of contact and smaller in others compared with responses in non-Arab localities. The perception of chances that a person who had had a psychiatric illness and recovered could marry was higher than in non-Arab localities. There was more evidence of subtle discrimination in Arab localities than elsewhere.

Directions for Intervention

The report presents recommended directions for interventions, based both on the findings and on the theoretical principles that underlie behavior and attitude-change interventions. These include adapting the intervention to the problematic dimension (i.e., emotional, cognitive, or behavioral); awareness of resistance to change and the difficulty in bringing about change; and adapting the intervention to the specific population, goals, and subject matter; different modes of intervention,

including the drawbacks and potential of each; protest and legislation, education and information, and contact/exposure.

With regard to seeking mental health care, we consider four directions: (1) Informing the public about mental health clinics and their location; (2) Changing the stigma about seeking treatment; (3) Increasing awareness of the arguments for and against the structural changes to the provision of services in the framework of the mental health reform; and (4) Interventions with family doctors.

With regard to approaches toward people with psychiatric illnesses, we suggest several recommended contents for interventions based on the findings of the study: (1) Reducing the stigma associated with psychiatric hospitalization; (2) Decreasing the perception that people with psychiatric illnesses are violent and deflating the fear of them; (3) Reducing the extent to which people with psychiatric illnesses are blamed for their condition and the anger directed at them; (4) Specific interventions for schizophrenia, including informing the public about the existence of medications and their side effects; (5) Specific interventions for depression, particularly aimed at informing the public about the chemical basis of the illness and the treatments available; and (6) Bolstering empathy. Differential interventions are recommended for specific target groups including the ultra-Orthodox and residents of Arab localities.

In order to address the above, a range of interventions including meetings/contact and the provision of information are required.

We stress the importance of the way that people with psychiatric illnesses are presented: Alongside the emphasis on the normative aspects of the person, the aspects of the illness should not be ignored. Emphasizing the normative is essential if there is to be a process of change; however, over-emphasizing the normative without referring to the deviance/illness may lead to a situation in which the person in question is no longer perceived as representative of a stereotyped group and hence there will be no change in the stereotype. Contact or exposure should preferably not be with a single person, but with a group of people, so that the great variance among them can be recognized.

We present a range of considerations about providing information on the illness and its etiology. Providing information about psychiatric illness helps to reduce stigma against people with psychiatric illnesses in general, but not against a specific person. Information can also refer to the etiology. In the case of some illnesses, such as depression, it is worthwhile considering reducing the perception of responsibility by stressing the physiological causes. This applies to problems and illnesses about which the perception that this is a condition over which the person has no control (as it is controlled by the biochemistry), may be difficult to understand but it does not arouse fear. In contrast, it is doubtful whether this approach is recommended when trying to change one's orientation to, for example, schizophrenia, concerning which the uncertainty is associated with perceived threat.

We also discuss a range of aspects of exposure and contact. One of the most powerful interventions is direct encounter and contact. It is important to be judicious in the choice of conditions so as to prevent ineffective interventions or even harmful ones. Notwithstanding the positive effects of exposure on people with illnesses (such as empowerment), the possibility that exposure may harm them must also be considered. Contact is required with a diverse group of patients in order to reduce sub-typing. Diversity is required, inter alia, in the types of disorders/problems. One should strive for exposure and contact with people at different stages of their illness. In other words, on the one hand it is important for there to be contact with people who are getting better and are in remission. On the other hand, exposure to people only when they are in that condition could create a situation whereby the positive effect of the contact would not be generalized to include patients in more severe stages of the illness. The optimal solution could be exposure to the same person at different stages of his/her illness, i.e., to be exposed to the same patients both during good and less good periods.

Finally, we raise some issues regarding interventions aimed at specific target groups such as current or potential neighbors, and potential employers and landlords.

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