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

Stigma: The Attitudes, Experiences, and Coping Mechanisms of People Attending Public Mental Health Clinics

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Executive Summary

1. Background and Introduction

People with psychiatric illnesses may be adversely affected in their physical, psychological, cognitive, emotional, or social functioning. However, the damage is not limited to distress and internal symptoms. People with psychiatric illnesses have to cope not only with symptoms and limitations caused by their illness, but also with stigma stereotypes and prejudices that derive from erroneous perceptions about mental illness.[1] They are thus deprived of certain elements of quality of life, such as suitable employment, appropriate treatment and medical care, and the possibility of associating with various groups of people.

One of the areas where the impact of stigma is evident is the domain of seeking mental health care. Due to the stigma against persons with psychiatric problems, a considerable proportion of those in need of mental health care (whether or not they have been diagnosed with a psychiatric illness) prefer not to seek help. Stigma is a factor that deters people from seeking and receiving treatment, which may lead to an unwarranted deterioration in the person's condition and, subsequently, to the need for more "intense" treatment, which might have been prevented had the problem been addressed at an earlier stage.

This study, which is a joint initiative of the Mental Health Services at the Ministry of Health and Myers-JDC-Brookdale Institute, is one of three studies examining stigma associated with mental health in Israel, in order to identify possible directions of intervention. It focuses on the perceptions and experiences of people attending public mental health clinics, some of whom have been diagnosed with psychiatric illnesses, while others have not. The second in the series focuses on the general public and its attitude to mental health care and to people with psychiatric illnesses. The third focuses on stigma as experienced by parents of people with psychiatric illnesses.

2. Goals and Research Methodology

The goal of the study was to examine stigma, emphasizing stigma as experienced by persons attending a clinic for help with a psychiatric illness and/or for another reason, as well as by persons who have been hospitalized in psychiatric hospitals and now come to the clinic for treatment and/or monitoring. The ultimate goal was to suggest directions for possible methods of intervention in the future.

[1] The pre-test revealed that the use in the questionnaire of politically correct terms would likely distort the study and its findings. We therefore often used the terms "mental illness" and "mentally ill" in the questionnaire, as these terms are familiar to the public. We use the terms "psychiatric illness" and "a person with a psychiatric illness" throughout this report, except when referring to the terms used by respondents, in which case we quote their use of "mental illness" and "mentally ill."

The study was based on interviews with people attending three government mental health clinics in the Jerusalem district. It included 167 participants, 109 of whom had been admitted to hospital, at some point in their lives, for psychiatric reasons. The age range was from 18 to 70. Approximately two-thirds of the respondents were men. Face-to-face interviews (lasting 30–45 minutes) were conducted at the clinics.

We focused on three components associated with stigma as experienced by the respondents: (1) Fear of rejection; (2) Experience of rejection; and (3) Attempts to cope with stigma.

Regardless of whether or not the respondents have been diagnosed as suffering from an illness, these three factors limit the options of treatment and discourage people from seeking help. They contribute to social isolation, create a fear of exposure and rejection by society, and may harm the person's clinical condition and his/her attempts at rehabilitation.

3. Findings

This section begins with a description of the characteristics of the utilization of mental health services and other services.

Fear of Rejection

As part of the process of socialization, people internalize society's approach toward different groups, including negative perceptions and the rejection of people with psychiatric illnesses. Consequently, when seeking help, people may label themselves in such a category and attribute these perceptions to themselves, possibly reducing their self-esteem or causing them to fear rejection by others. These responses might affect their psychological as well as social functioning. The study found that most of the respondents (whether or not they had been hospitalized) did not fear rejection in their immediate surroundings – i.e., by their GP, friends, and family. However, a considerable number of them did fear rejection – approximately 45% feared that friends would not want to be with them, and about half were afraid that others would think they were not good at their jobs. Over a third feared rejection by their families.

Experience of Rejection and Stigma

Being labeled negatively does not only cause the person to fear or expect rejection. Rather, he or she may actually experience this rejection, not only by strangers, but also by friends, members of the family, and even by professionals in the mental health care system. Over a period of time, the experience of social rejection is liable to result in low self-esteem. With regard to actual rejection in their immediate surroundings, we found that 23% had had the experience of their GP attributing physical problems to their psychiatric problem, 35% of respondents had experienced rejection by their family, and approximately 40% reported that their friends had rejected them. Thirty-nine percent of respondents felt that they were not considered good at their jobs.

We asked the respondents who had in the past been hospitalized about how people reacted to them in an assortment of places (mental health rehabilitation, the National Insurance Institute [NII], the local social service department, the municipality, the police, the supermarket, and the

bank). At least half felt they were treated in the same way as other people. Among those who sensed discrimination, some reported positive discrimination and others, negative discrimination. Twenty-eight percent of those who had been hospitalized in the past reported that landlords had refused to rent them accommodation following their hospitalization.

What happens when people in the immediate surroundings are aware that a person is receiving mental health care or has been hospitalized? We found that 40% of respondents who had been hospitalized and 35% of those who had not felt that attitudes toward them were different (not normal) when people heard they were receiving treatment.

The care framework itself could lead to stigma. We expected that the stigma following hospitalization would be greater than stigma following ambulatory treatment. In fact, we found people who had been hospitalized experienced stigma in a similar way in both situations (when those around them learned that had been hospitalized and when they learned they were receiving ambulatory treatment). Respondents who had not been hospitalized reported similar discrimination (different from the attitude toward "normal" people – 35%). This may testify to the intensity of stigma against mental health care and not only against hospitalization.

The respondent's responses to questions about the "mentally ill," reveal they feared that people with psychiatric illnesses would be rejected in various situations: as neighbors (60% and 67% of those who had and had not been hospitalized, respectively) as coworkers (53% and 61%), and as prospective employees (71% and 77%). They also feared that people would reject a "mentally ill" person as their superior at work (69% and 73%), would not allow such a person to drive their children to school (75% and 81% of those who had and had not been hospitalized, respectively), and would not marry one (76%). In other words, a significant proportion, both among those who had been hospitalized and those who had not, expect people with a mental illness to be rejected by society. The level of fear that people coping with psychiatric illnesses would be rejected was similar among those who had been hospitalized and those who had not.

Ways of Coping

Both the fear and the actual experience of rejection prompt people to seek ways of coping. We focus on four of them: Concealment, education, avoidance, and group "positive distinctiveness." Ostensibly, the various ways of coping would appear effective, but each claims a heavy toll. The very strategies people use to cope with their illness for fear of negative responses can themselves produce negative results.

Concealment/secrecy: About two-thirds of the respondents feel that in order to get a job they should hide the fact they are receiving mental health care. Furthermore, over half of the respondents tend to conceal the fact that they are receiving help. However, over a third had not asked their families to hide the fact that they had been hospitalized /were receiving care and over half of the respondents did not think that they should conceal these issues in order to protect their families. No difference was found between those who had been hospitalized and those who had not, apart from the issue regarding need to hide psychiatric treatment in order to get a job: the

proportion of respondents who believed there was a need to conceal these facts was higher among those who had not been hospitalized. It is possible that this is associated with the difference between being in a normative as opposed to a protected setting.

Education: It seems that this method is used by most of the respondents – over half of them stated that they sometimes explain about hospitalization and mental health care. About half noted that they would be willing to take part in an activity explaining to the public about mental health care.

Avoidance/withdrawal: It is easier for most of the respondents to speak about their problems with someone who is or has received treatment, but they prefer not to associate socially with friends who have been hospitalized or are attending clinics.

Group "positive distinctiveness": Approximately two-thirds of the respondents believe that people who have been hospitalized or are receiving treatment are more sensitive and caring, that they have stronger feelings, and are more understanding about the problems and suffering of others. Perhaps that is the reason that most of the respondents found it easier to talk about their problems with people who are receiving or have received treatment.

Another way of coping is for the person to fight against, rather than internalize, the stigma – to build a positive self-perception and to feel anger against the labeling and the people who do it. About two-thirds of the respondents noted that they are upset when people say offensive things about people in therapy or behave differently with them because they have been hospitalized or are receiving treatment.

Social Support Network

A significant proportion of the respondents felt they receive help from people close to them (78% of respondents who had been hospitalized and 60% of those who had not). However, the fact that 21% of the respondents who had been hospitalized and 39% of those who had not, reported that those close to them did not help them emotionally should not be overlooked – in other words, reports of lack of emotional support were more prevalent among respondents who had not been hospitalized. As noted, 45% feared rejection by friends and 41% had in fact experienced it. About half the respondents sensed a lack of understanding on the part of others. Bearing these findings in mind, the fact that almost half of those who have been hospitalized have difficulty making new friends becomes even more meaningful. There are, then, actual problems and/or fears of both existing contacts and of creating new ones.

Perceived Etiology

The respondents were asked what they believe to be the cause of "mental illness." The main causes mentioned were traumatic events, genetic problems or a chemical-organic problem in the brain, domestic and non-domestic crises, and problems during childhood.

Preference for Location for Treatment

Another sphere where the issue of integration into "normative" society comes up is the type of clinic. As noted, all the respondents were attending government mental health clinics, which are clinics devoted exclusively to the mental health domain. The respondents were asked whether this was their preference or whether they would prefer to go to a general clinic providing both mental health care and general medical care. We found that 24% of respondents who had been hospitalized and 21% of those who had not, did not express a preference. Among those who *did* express a preference, it was found that both those who had been hospitalized and those who had not preferred a clinic devoted exclusively to mental health (54% and 62%, respectively) over a general clinic (46% and 38%, respectively). Respondents who preferred a mental health clinic cited better care and more privacy and confidentiality as the reasons for their choice. Those who preferred a general clinic cited the possibility of seeing other doctors and being in a mentally healthy environment; they also mentioned concealment. Concealment and privacy play a crucial role in both cases – which perhaps expresses the presence of stigma in treatment.

4. Directions for Action

The report indicates several directions for intervention, while emphasizing the need for caution in reaching conclusions due to the fact that the sample is small.

The first direction concerns the people receiving treatment. We propose discussing stigma in the treatment setting itself, i.e., making it a salient issue. An intervention aimed at the people receiving treatment that relates to them as people who may themselves stigmatize people with psychiatric illnesses would be appropriate. It is worth emphasizing and reinforcing the positive sides of the group receiving treatment. The establishment of mutual-support groups may also be encouraged. As noted, people receiving treatment are reluctant to socialize with people who had been hospitalized, or had received treatment in the community, but do appreciate their ability to provide emotional support. Therefore, it is important that these groups should not be proposed as a source of social contact, but as a source of mutual support on the emotional level.

The second direction concerns the treatment setting, i.e., the place where mental health care is provided. The respondents apparently prefer exclusive mental health clinics (as opposed to general specialist clinics). Although this was not a particularly strong trend, it corresponds to a weak trend found in our study among a representative sample of the general population (Struch et al., RR-478-2006). If mental health treatment is brought under the auspices of general health care in the framework of the reform in the health system, it is possible that it will be necessary to do more about stigma both among those receiving treatment as well as among the general population. A campaign will be necessary to reduce fears of a referral to a general clinic for mental health care.

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