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Stigma and Mental Disorders

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1. Introduction

Stigma is recognised as a major obstacle to recovery and integration of people with mental health problems. In this chapter the definitions of cognitive, emotional and social aspects of stigma will be presented, as well as origins, main representations and coping strategies. The research on stigma is presented, beginning with Goffman's work (Chapter History) and followed by contemporary research and critical overview. This work follows the International Study of Discrimination and Stigma Outcomes (INDIGO) led by professor Graham Thornicroft (UK), which was a cross-sectional survey in 27 countries, in centres affiliated to the INDIGO Research Network, by use of face-to-face interviews with 732 participants with schizophrenia. This research was followed by the creation of Antistigma European Network, with further research goals and a strong mission to overcome or at least reduce the consequences of mental disorder stigma in Europe. Each country participated in this projects produced additionally locally specific answers and solutions. Some of them are listed below-these are comments on stigma made by patients with schizophrenia in Slovenia. Each country involved in these research projects also produced locally specific answers and solutions to the stigmatization and particularly to discrimination problems. The intent of this publication is, besides giving an overview of stigma research, to provide some additional insight into real life experience of people with severe mental illness.

2. Definitions

2.1 Stigma

Stigma is a term that applies to labelling certain people as different and inferior. It is a mark of shame, a sign of worthlessness applied to the stigmatized. Its consequence is avoidance and even expulsion from society. It can be described as a form of social monitoring or omission of minorities from certain competitive areas, working as a form of intangible control over groups of people with mental disorders (Goffman, 1963).

Its influence is in proportion to social, economic and political forces that make possible the creation of stereotypes, destruction of reputation, and other forms of discrimination (Link & Phelan, 2001). Stigma is obviously a wide concept, one that binds aspects of labelling, stereotyping, cognitive rejection, emotional reactions and discrimination - therefore, it has cognitive, emotional and social components, whose final result is the loss of social status for the person affected. Social status here refers to an individual's position in society and to an individual's reputation and influence. A high social status guarantees material goods,

freedom, space, comfort, time and the feeling that one is appreciated. The fight for status is a fight to expose our inner wealth.

2.2 Stereotypes

Stereotypes are knowledge acquired by the majority of a social group so that knowledge of other social groups can be categorized. A stereotype is a collective agreement, needed for quick orientation as far as expectations and impressions are concerned. They are dynamic constructs, dependent on social judgment. Having a stereotypical opinion of a patient with mental health disorder would be thinking of him as dangerous and severely behaviourally disturbed. These stereotypes do not fit the facts. A typical patient lives in the community, his behaviour socially managed. A typical person with mental disorder has far less trouble in social adaptation than the usual hospitalised patient. Patients who must be treated regularly throughout their lives are a minority in the mentally ill fringe group. They function according to the severity of the illness, associated disabilities, the level and quality of available support and treatment capabilities. Patients who have recovered are usually invisible to professionals and public, as they generally hide their illness from others, because of stigma. They avoid institutions and social services so that they can pursue their careers, education or other personal goals. A diagnosis only describes the part of a person that the symptoms fit. A person with schizophrenic symptoms is not a schizophrenic, as these symptoms are only a part of his personality at the moment of diagnosis. A diagnosis is used to set treatment goals and methods and to estimate the illness' course. It is only to be referenced correctly in medical classification and professional assessment. Any other use of a psychiatrist's diagnostic terminology is considered to be stereotyping, aimed at discriminating against people with mental health disorders. Psychiatric diagnoses are often carelessly used to discredit political or other opponents, which is hurtful to people who have been diagnosed and have to live with illness and disability.

People do not always agree with stereotypes. Belief in them forms prejudice.

2.3 Prejudice

Prejudice is a wrong conviction, an ideological construct based on stereotyping and oversimplification. It motivates an authoritative bearing, hate and exclusion. In Nastran Ule's (1999) opinion, prejudice is simply a set of evaluations passed by privileged groups. Their main trait is helping repression. She defines repression as dominion of the strong over the weak, with the strong never allowing the weak to question the fairness of this arrangement. People are always very interested in learning how to have more power than others. If prejudice is collective, as those surrounding people with mental disorders are, people adapt to it. The general opinion is that people with mental disorders are less capable and that they require constant monitoring and care, which is followed by disdain and patronizing.

Almost every paper on stigmatization mentions prejudice as hard to change, relatively stable and spontaneous, affecting us no matter our will. This thesis introduced a certain amount of pessimism in all attempts to reduce stigmatization and rationalised poor results of anti-stigmatization campaigns. Social and psychological research, on the other hand, refuses this conclusion and proves that stigmatization is easily manipulated and very changeable in nature, as seen in Jew and women discrimination history (Henriquez et al., 1984) and the quick minimalisation of racial prejudice in the last few decades. It therefore

follows historical experience that prejudice can be changed swiftly and successfully, if appropriate social circumstance and political goodwill exist. Politics can achieve position changes and improve tolerance through media access. But prejudice can not be created or stopped only with conviction. A complex social movement is required, one that provides both moral and financial consequences for those that break the rules. It has been proven repeatedly that the behaviour of people with mental illness even when completely normal is considered »weird« because of prejudice (Link & Cullen, 1986; Link et al., 1987, Link et al., 1999). Their behaviour is not incorrectly interpreted only by the general public, but also by professionals. In 1974 Langer and Abelson made an experiment in which two groups of analytic psychotherapists were shown a video interview with a young man. One group was told that this was a job interview, whereas the other was told that the man was a psychiatric patient. Despite watching the same tape the second group described his behaviour as abnormal, whereas those in the first group didn't see many problems at all (in Corrigan, 2005).

Prejudice means a poor life quality for the affected. It generates strong emotional responses, of which fear is the most important.

2.4 Fear

Most people are afraid of people suffering from mental illness. They fear »infection« despite it being general knowledge that mental illness can't be transmitted. For example, a common effect of fear are complaints from mental health staff about how hard it is to work with psychiatric patients, not because of the workload, but rather because they fear projective identification that could influence a staff member's mental health. This fear originates in prejudice of danger and unpredictability. People with mental health disorders may be dangerous, but only very rarely and always under foreseeable circumstances. Studies show that the percentage of patients with an affinity for violence is less than 10% in men and significantly less among women. Even this small percentage is not dangerous constantly, but only when they're under influence of psychoactive substances like alcohol and alternatively, when their psychotic symptoms are left untreated or poorly treated. Less severe mental disorders like depression and anxiety are not connected to violent behaviour. Research shows that 75% of the population believes that the mentally ill are dangerous, the number of people with this belief doubling over the last 40 years (Corrigan, 2005: 165). The rise of the danger myth can be explained by deinstitutionalization, meaning less access to hospitals and other social institutions; and primarily by media reports (Wahl, 1995). There was a series of papers published in the USA that "proved" psychiatric patients were dangerous. This research is methodologically dubious and its results were interpreted haphazardly at best. It was best refuted by the following statement: Mental illness has little connection to violence. This connection is used for discrimination of people with mental disorders and their families. People with mental disorders must be guaranteed quality treatment. The occurrence rate of criminal acts done with full awareness is much higher than of those who are motivated by illness.

Today, 6% to 15% of the American prison population are people with mental disorders. This number saw a 150% increase over the last 10 years. The reasons for this fact can be found in poor service accessibility, public fear, legislation that prevents hospitalization and lack of education. In the USA, officers of the law seem to have a role of doormen to the medical system, for which they are not educated. Furthermore, in the US, the number of psychiatric hospital beds is evidently over reduced.

Any behaviour that is caused by prejudice is discrimination (Corrigan & Watson, 2002, Corrigan et al., 2003).

2.5 Discrimination

The behavioural manifestation of “applied prejudice” is discrimination. Affected people are discriminated against by being marginalised, avoided and being victims of violence. Even though discrimination can be an upfront protest against the mentally ill, it more often takes the form of avoidance. Openly ridiculing patients is no longer acceptable due to rising awareness. Hostility or (at least) ambivalence is nowadays expressed more subtly.

But, many patients report feeling lonely, losing friends, not being in contact with their families, losing their jobs and being delegated to lower positions in their workplace. Discrimination is not authoritarian and directly aggressive anymore (Corrigan et al., 2001), most likely due to anti-stigmatization movements, which managed to influence the way discrimination is exhibited, but not what it's about. An Australian study researching nurses' relationships with their patients (Happel et al., 2002) showed that most of nurses agree with anti-stigmatization programs, yet wouldn't allow a mentally ill individual to be part of a job screening procedure in their workplace. 40% of them were found to believe that even though a users' view on mental illness is important, lectures on this topics should be given by nurses.

Social distance raises the levels of disability amongst the mentally ill and significantly worsens the illness. Stereotyping, prejudice and discrimination can thus stop people from realising their ambitions and life goals.

3. History of stigma

Any discussion of mental illness is accompanied by strong emotion. Psychiatrists are still considered to be modern witches, capable of both help and harm. The general population's view of psychiatry and psychiatrists is coloured by emotions such as fear, shame, guilt, hostility, admiration and ultimately, confusion. It is for this reason that most mental health disorders are only discussed and treated in a close circle of friends, family and acquaintances and professional help only being sought in extreme circumstances.

Throughout history, society constantly changed its treatment of people with mental disorders. Rejection, punishment and avoidance was replaced, in certain times, by relative tolerance and attempts at integration, but this trend was never exclusive, as different viewpoints coexisted, sometimes obviously in mutual opposition. The general consensus is that the more the group was removed into specific institutions and the edge of society, the more negative society's attitudes were. In Europe, the relationship between marginalised groups and public opinion had been primarily defined by the church, its own attitudes subject to change from acceptance to rejection. For instance, when the predominant belief was that people with mental disorders were possessed by demons, they were either jailed or banished from society, whereas when mental illness was seen as a gift from god, they were protected and respected. In 1486, the book *Malleus Maleficarum* (The hammer of the witches) was published, ushering in 150 years of persecution of people with mental illness. Women with hysterical or psychotic symptoms were labelled as witches and torture was used for making them admit their guilt. The subsequent executions and other extreme violence were not put to a stop until 1656, when, under the influence of more tolerant ideas, asylums were first opened in the French monarchy. During the next century, people with

mental illness were joined in these buildings by orphans, prostitutes, homosexuals, the chronically ill and the elderly. The same century saw the first attempts to classify mental illnesses and understand them as medical disorders. There were attempts to improve the quality of care by the reformists Vincenzo Chiarugi (1759-1820) in Firenze, William Tuke (1732-1822) in York, and finally Jean Baptiste Pussin (1745-1826) and Philippe Pinel (1745-1826) in France. The removal of shackles from the Parisian hospital Bicêtre marks the start of moral treatment. Pinel classified mental illnesses as being melancholy, mania, idiocy or dementia and claimed they were caused by both environmental and hereditary factors. He used education and persuasion as his methods and provided a comfortable environment for patients to heal in, but it wasn't until the 19th century that psychiatry became a branch of medicine, which brought about significant advances. In England, Tuke influenced the removal of restraints from hospitals. America saw a reform of psychiatric institutions, initiated by Benjamin Rush. The Kraepelin classification of mental disorders provided an accurate enough description of psychiatric symptoms. In 1920 electroconvulsive therapy was introduced.

Sigmund Freud (1856-1939), the founder of psychological interpretation of mental disorders, initiated the development of psychotherapeutic treatment through his personality, dream interpretation, sexuality and other theories. Social psychiatry began to evolve, using as its tools both clinical and social theory knowledge. It dealt with the problems of poverty, racial prejudice, war and mass migration, even if it was apparent that no profession can solve them. The anti-psychiatry movement originated within social psychiatry, explaining mental disorders through social and family influences.

From 1954 to 1956, Ervin Goffman, the author of the famous *Asylums* (1961), was doing research in psychiatric hospitals and other institutions, precisely describing life in these »total institutions« (hospitals, prisons, homes for the elderly etc.) meant to hold patients away from society. He reasoned that any »total institution« has the same characteristics: the presence of a large number of people, group management and a clear structure of activities meant to institutionalise. In its essence a »total institution« was about controlling a large population with a bureaucratic institutional organisation, in which obedience was expected from both the population and the staff that oversaw it. A rift between the staff managing the asylum and the patients using it became apparent. The social distance between the superior, displeased staff and the weak, inferior patients was immense, with most of the staff's energy being directed at stopping patient to doctor (or any other staff member with more responsibility) communication. The simple effect of this was that patients were excluded from deciding their own fate. The secondary effects ranged from extreme boredom, the cause of which was that the patients were not trusted with anything, to post-treatment social exclusion. Upon leaving the hospital most patients had no established contacts with the outside world, as being institutionalized severed their bonds with the world. The mere entry into a psychiatric hospital was highly indicative of permanent loss: washing, disinfection, hair cut off, a personal search, listing of personal belongings and receiving instructions. In this way, a patient's life story became nothing more than property of a group of experts treating him, his actions only seen and evaluated through his diagnosis. The whole admission process could, in this light, be termed »programming« for an institutionalised life. A patient thus had no right to personal possessions and could have no space that could not be searched by anyone. Electroshocks were administered to patients in plain view of the rest of the patient population. Patients were only allowed spoons to eat their meals with. One way of ensuring obedience in the patient population was to demand humility, in any

way deemed important by the staff, mainly by acknowledging the staff's superiority. The patients were talked about in their presence, and constantly asked to participate in sessions that forced them to acknowledge that their situation was their fault. These »*mea culpa*« sessions were but one form of mental torture, another example being that they were forced to discuss the conflicts within the patient population. In the name of behavioural therapy, patients were accorded material possessions that were part of normal life in the outside world: clothes, cigarettes, etc. Physical examinations were performed in common rooms, forcing the patients to be exposed to everyone. The hygienic standards were non-existent. Any and every action that was not in accordance with hospital regime was strictly sanctioned, no matter the triviality. Patients lived in a state of constant fear, starting to accept their "moral" careers as psychiatric patients, living their role as social outcasts.

The year 1952 brought about the first antipsychotic medication, which made a significant difference in severe mental disorder prognosis. Public opinion shifted, and under its influence many hospitals were closed. The deinstitutionalisation process and anti-psychiatrist movement were present in every country that had some form of institutional care, leading to thousands of patients ending up on the streets.

There is no clear answer to the question of choosing institutional or not-institutional care. Should the patients be treated in institutions or outside is not even a valid question, as they need versatile care. There seem to be two prevailing types of public opinion concerning this - the public should be protected from the mentally ill and on the other hand, they need to be liberated of any institutional control. Both viewpoints are stigmatizing as they take away both the power to decide one's own treatment and disregard the patient's specific needs. We need to note, however, that Goffman's *Asylums* and the subsequent debates about stigma brought about significant changes in psychiatry. Hospitals were renovated, the number of the personnel employed increased and their education was improved. Patient's human rights are now vigorously protected, through legislation, certain in-hospital rules and advocates and lawyers who take part in the treatment process.

The World Health Organisation and the World Psychiatric Association began a far reaching public campaign in 1996 aimed at reducing stigmatization. Interest in stigmatization prevention reached its zenith in 2001 when the media actively advertised stopping any kind of biased behaviour toward the mentally ill. This message appeared in every important document in the international mental health community. Yet, the perceivable effect was low. There is no evident decrease of stigmatization of people with mental disorders. The prejudice against people with severe mental illness can even be, according to some authors, proven to be rising, mostly because of mass media (Stier & Hinshaw, 2007).

4. Causes of stigma

Stigmatization is grounded in a narcissistic emotional satisfaction that crosses the boundaries of rational self-criticism. One who stigmatizes others finds validation in discrediting another. This discreditation enables him to join the majority; he finds himself stronger and agreed with. Regardless of whether this is the real majority or simply a privileged group, the stigmatised represent a "problem" which needs to be solved. For Jews, this was the »final solution of the Jewish question«, for African Americans it was open disdain and disrespect of their basic human rights. The mentally ill face the same sort of persecution, in the form of avoidance and isolation. In the 1950's, Adorno's study showed that any kind of hate directed towards the different is rooted in early childhood repression

and loss, which is directed towards others in later life. These others are selected by criteria of social acceptability, meaning that those whom society shuns will be selected most often.

Understanding the problem of discrimination, does not, however, help in moderating it.

Social categorization plays a great part in the formation of prejudice, social categorization here meaning simply dividing people into two classes - us and them. Revulsion and violence directed toward stigmatized groups is only possible when personal prejudice finds either political or ideological backing (Nastran Ule, 1999: 305). Being affiliated with a certain group incites favouritism for that group, as is evident in families and work environments. A positive group identity is the motive for stereotyping others, which leads to a better self-image. Stereotypes are thus born from negative self-image, or rather a person's inability to create one. Identity is built on being accepted as separate from »the others«. For the stigmatizing, this is a natural and effective means of countering a potential threat. For the stigmatized it is simply suffering (Yang et al., 2007).

Negative attitude towards the mentally ill is being taught to people from their birth to their deathbed. The place we go to gather information is, for most of us, the media. Information is a market commodity and is being treated as such by the media, which consequently tailors the information to generate income. Reports from many different countries show that any event connected with mental illness is prone to be reported in manner that exaggerates danger and unpredictability of the mentally ill and shows specific behaviour as bizarre and incompetent. The mentally ill are often presented as unpredictable murderers, women with split personalities or homeless people having conversations with themselves. Anyone with a mental disorder is 10 times as likely to be labelled dangerous; additionally, three quarters of such reports graded this danger as extreme. Only six percent of TV shows discussing mental illness included mentally ill people or recovered patients in their panels. Those included were commented on in a stigmatizing fashion (Wahl., 1999; Wahl et al., 2002). These representations have little in common with objective reality.

These claims hold true for American and British media especially. There are few reports of negative media coverage from other countries, with the exception of Australia. Public disdain and branding not only significantly affect ill individuals, but also the services provided to them, which is the reason for numerous educational programs aimed at



Newspaper headings in US journals

reporters. One of them was an international warrant for stigmatizing media reports (<http://www.mentalhealthstigma.com/cinemia.html>), aimed at identifying stereotype and media violence.

A close examination of media responses shows that there was no significant change in less stigmatizing way (Wahl et al., 2002).

Media, however, is the most important tool in fighting discrimination and stigmatization, which was proven in several countries, i.e. Australia, Slovenia etc.

5. Signs of stigma

A significant change can be observed in how prejudice shows itself. It is not shown aggressively and openly, but rather as exclusion in the form of avoidance, passive refusal and ignoring. Fringe groups are not the focus of clear negative beliefs, be it to their advantage or not. Simply put, stigmatization is moving into the subconscious (Nastran Ule, 1998: 323).

Mental illness stigma is strongly linked with prejudice against patients with mental disorders: of danger, incompetence and irresponsibility. The World Health Organization (WHO), aware of this problem, issued a statement in 2001 that described the most common myths concerning mental illness and, of course, demystified them with scientific evidence, summarized below.

“Mental disorders are not imaginary, they are real diseases that cause suffering and reduce capabilities. It is not true that people with mental disorders or brain damage can not be helped. They can be treated and mental health can be restored, which is true of all mental disorders. Patients' suffering can be eased, their symptoms can be managed, and many make a complete recovery. Mental illness has nothing to do with a person's character, as it is always a consequence of biological, psychological and social causes. Furthermore, the correlation between genetics, lifestyle, environment and illness is as well established as with physical illness. Managing mental illness requires not only a serious effort on the patient's side, but also professional help. The WHO emphasized avoiding moralizing and projecting guilt onto patients and their families. People with mental health problems should not be treated exclusively in hospitals and asylums, as they have the same rights regarding special care and intimacy as other people do. They should be provided with specialized treatment plans and be treated at home, clinics and at psychiatric wards. Rehabilitation can be organised in housing communities, employment programs and in support groups. Only 20% of patients are unable to handle regular employment.”

Signs of stigma are myths. One of the most persistent myths concerning the mentally ill is the myth of danger. The WHO emphasized that the vast majority of patients with mental disorders is not in any way a danger to others. When a mentally ill person actually becomes dangerous it is mostly for the same reasons other people do, namely, drug and alcohol abuse. The risk that a mentally ill person could be dangerous is compounded if the person in question exhibited violent behaviour before the illness, if they have delusions and hallucinations, if their psychosis is left untreated and if they abuse alcohol and drugs. This was confirmed by numerous studies. These risk factors are moderate and comparable to risk factors in groups without mental disorders, such as those with a lower education, teenagers, those excluded on the grounds of gender and those who have previously exhibited violent behaviour (Corrigan, 2005). Moreover, this risk factor is significantly lowered by the fact that violent behaviour among the mentally ill is correlated with a specific set of psychotic

symptoms which can be immediately recognised by a professional. Mentally ill people are two and a half times more likely to be victims of violence than other social groups (Chapple et al., 2004).

People with mental disorders are employable and they do the same work as others. Any conviction to the contrary is simply wrong. Their career potential is the same as with others, dependent entirely on their talents, capabilities, cleverness, experience, motivation and health. Any myth about mental disorders decreases the life quality of the stigmatized and significantly hampers their treatment and recovery.

6. Types of discrimination

6.1 Overprotection and patronizing

Feelings of anger, compassion, sadness and uncertainty often fortify discriminatory behaviour in families and experts. The most common defensive behaviour when having these feelings is patronizing. The term can be explained as behaviour that denies a person his remaining capabilities because of his mental wound. Patients often report patronizing language and feel as they are being talked to as if they were children instead of adults. Another common behaviour being the previous' opposite is that the illness and related problems are not talked about at all.

Discussing the disease with nothing but well-meant advice is considered patronizing, if there is no personal experience involved. On the other hand, not talking about the illness spawns feelings of isolation and loneliness, whereas talking about it too much leads to stress, one of the main causes of relapse. Patronizing is a sign of under appreciating the role of the patient in treating and coping with the illness. The main reasons for this type of behaviour amongst professionals are a lack of knowledge, apathy and inertia (Sartorius, 2002).

6.2 Violent behaviour toward the mentally ill

Despite the persistence of the myth that the mentally ill are dangerous, the fact is that they are far more likely to be on the receiving end of violent behaviour. This is supported by research that states, for instance, that 97% of homeless women in the USA have reported being victims of violent behaviour. Studies report that 16% of all psychiatric patients are victims of abuse (Walsh et al., 2003).

An Australian study (Chapple et al., 2004) reported that 18% of psychiatric patients had been abused in the year preceding the study, three times more than in any other population group. A Finnish study (Honokonen et. al., 2004) reported a lower percentage, yet the group researched was far less exposed to such behaviour. Still, it was felt that the number was too high and steps were taken in order to protect this vulnerable group of patients. The mentally ill are also far more likely to be victims of false promises and religious fraud. Their already poor resources are ruthlessly exploited by shamans, charlatans and nonprofessional psychotherapists (Goffman, 1963).

6.3 Courtesy stigma

Stigma spreads from the individual to his loved ones (Goffman, 1963) and to all people close to the stigmatized person. Goffman's term "courtesy stigma", i.e. stigma by association, applies to those who are in contact with mental illness but not ill themselves. Research

proves that it contributes to the low level of interest for psychiatry exhibited by medical students. Further examples include denying a psychiatrists' medical professionalism by other physicians and specialists and consequent neglect of physical illness in psychiatric patients. The most common effect of courtesy stigma is family burden because of prejudice and discrimination.

A family's reaction to mental illness, at least in the beginning, bears all the traits of loss and grief. Mental illness exceeds all normal deviant behaviour. Surprise and outrage of family members expresses itself first through denial, then through attempts at re-education of the affected family member and finally through anger and/or overprotection. The diagnosis itself provides some answers and solutions, but it is only the beginning of the process. Acceptance and the realization that life needs to adjust to these new circumstances are usually a long way off. We now know that professional help often comes too late on this path and that there is too little of it (Stier & Hinshaw, 2007). Numerous studies have shown that family care causes stress, financial difficulties and depression (Wancata et al., 2006). Families often feel that discrimination directed toward the patient is also directed at them (Gonzales Torres et al., 2007).

Most patients with mental illness receive as much care from their families as they can provide. The feelings of guilt that the family experiences are correlated to false beliefs which claim that the reason for mental illness is most often connected to the family or to psychological traits of the patient's parents. In the 20th century a prevailing belief amongst experts was that most psychological problems can be attributed to patients' family situations. These theories have been refuted, but they still caused damage that is very hard to repair. The damage is obvious in families that are unable to help patients due to feelings of guilt.

Families face objective burdens of responsibility and subjective feelings of social exclusion. They are embarrassed by how the affected individual behaves, are under continuous psychological and financial stress which affects their physical and mental health. Guilt can foster either overprotection or hatred, either denial or attempts at correcting »the mistake«. This, of course, leads to stress in a patient's life and can jeopardize treatment and recovery. Families often try to hide that their loved ones got ill. Research reports that the family of a patient with a severe mental disorder often experience the same social exclusion and loss of their social network as the patient does. There is proof to the fact that relatives of these patients experience physical illness, depression, anxiety and other consequences of prolonged stress (Awad & Voruganti, 2008).

Relatives find it hardest to accept structural stigma, namely unfair and unbalanced treatment and rehabilitation in medical and social services, inadequate legislation and thoughtless political decisions that lead to financial crisis and family deprivation. Their most often voiced complaint is poor care quality. They describe being left on their own as far as patient care is concerned and being sent from one institution to another without any apparent concern for their problems. A lack of cooperation between institutions and exclusion of families from the treatment process seem to be two of the more pressing issues (Angermayer et al., 2003). Legislation that protects patients' rights often stops relatives from being informed, even though they need to be. Information can only be distributed by the doctor and only if the patient agrees to it, which can be a problem where mental problems are concerned. Most families try to get the necessary professional help as soon as possible and adjust their lifestyle so that symptoms and disability can be managed.

- *My mom was very concerned about my education, she wondered if I'll manage when I grow up.*
- *I live with my parents; they tolerate much more from me than they did before the disease. They don't bother me with their problems.*
- *My family supported me all the way.*
- *No one in the family treated me differently. Not my parents, not my husband. There was no pity.*

Mental illness scares the family, leading to overprotection, which hampers the patient's self-reliance. Before the patient's family reaches a balance that allows adequate help, too much time passes.

- *When I got sick, my family really just didn't understand it at first. They didn't treat me as an equal. It's better now.*
- *Too much care seriously hampers treatment and rehabilitation. It leads to prejudice and hostility.*
- *They treat me differently now. I can't go out Friday and Saturday night, my parents think something'll happen. I'm not allowed to drink or use any drugs...not that I would, but still.*
- *My parents don't think I can take care of myself.*
- *They were embarrassed at first, that I was in the hospital. Mom wouldn't tell her friends or our neighbours. My parents had a lot of trouble accepting things.*
- *My sisters think that I can't be a good parent, so they interfere all the time.*

Families can be counselled and helped to reduce the feelings of exclusion and helplessness. Educating the family on how to manage the illness in family groups which share experience and help each other is an invaluable tool in combating stigma. Patients' relatives organised on national and international levels wield considerable political power that is used in creating, developing and overseeing different mental health services, including psychiatry.

6.4 Self respect damage, self-discrimination, internalised stigma

A person's lack of success is considered to be his own fault. Victims of prejudice are forced to hide their disabilities, or at least act in a way that enables them to stay in contact with the dominant culture - one that reinforces the fantasy of a strong, unbreakable self that holds dominion over itself and others (Goffman, 1963, Nastran Ule, 1999).

6.4.1 Hiding the illness

The act of hiding a mental disorder strengthens the vicious circle of prejudice. Psychiatric patients most often choose not to talk about their disorder or diagnosis since they are subject to strong feelings of guilt and shame due to the aforementioned prejudice. They lead a double life in fear of exposing themselves, which leads to avoiding other people, as they are a direct threat to their exposure. They become lonely and, in turn, feel insecure, constantly threatened and inferior. Withdrawing from society, fearing ridicule, the stigmatized become more and more alone (Goffman, 1963). Despite the above stated, patients admitting their disease actually severely limits their chances of being a member of any privileged social groups. Most often admittance means a membership in the vast group of second class citizens and losing the battle for status (Thesen, 2001). Attempts to hide and obscure their condition are a source of continuous stress, which forces patients to expend enormous amounts of energy on their disguises. When it was suggested by professionals that psychiatric hospitals should be established in city and town centres, the patients' wish to be

unrecognized was overlooked. Being in the centre is not the interest of the majority of them. The following statements were made by patients who feel that this is the case.

- *I really want people not to know that I've been diagnosed. When somebody asks me how I'm doing, I never tell the truth- that I'm ill and I'm not doing well. Most wouldn't even understand, if I told them that I have schizophrenia.*
- *I don't say to people: I'm sick. I don't say that I'm going to the hospital. It seems smarter to not say anything.*
- *He asked me if I was in the hospital. So I lied.*
- *I'm ashamed of my diagnosis. I must keep it to myself. If it's important I tell people, but not all the time. It's better to stay quiet.*
- *I don't advertise that I'm being treated.*
- *I can't tell people that I've been diagnosed.*
- *When I meet somebody new, I don't say a thing.*
- *I only go to the library, but they noticed and now they look at me different.*
- *I'm not sick, but those who think that I am, avoid me.*

Despite everything, some have decided to admit their illness and risk unforeseeable consequences:

- *My friend said that I'm living in my own world, one that others can't understand. But I think that she's the sick one - always nervous and stressed. On the other hand, my friends at college don't even understand why I've been sent to the hospital. It depends on the person, I guess.*
- *When I was first in the hospital I felt stigmatized, but only because my mom told me all about that. I had trouble fitting in. I noticed later that people don't care much about whether you're in the hospital or not. I told my classmates that I'm being treated. The more you hide it, the harder it gets. It just gets to be another burden. I now tell everyone, because if I don't, I keep having to think about what I told to who. I have lots of friends, so now it's not a problem anymore.*

6.4.2 Anticipated discrimination

What they have been taught in their childhood and adult lives makes many patients with mental disorders expect discrimination. The general belief, that the mentally ill are dangerous and incompetent, turns on a patient in the moment of his diagnosis. Becoming a part of an inferior group makes him expect discrimination which leads to demoralization.

Negative cultural concepts start to be felt on a personal level. Prejudice works as a self-fulfilling prophecy, which means that expectations of discrimination come true sooner or later. The actual identity of an individual is replaced by a »virtual« social identity, one defined by others through stereotyping (Goffman, 1963).

The general social opinion of the mentally ill is largely created by the media. In movies and reports, a negative outcome of treatment, low quality of life and dangerous and incompetent behaviour are attributed to the mentally ill. These myths endanger self-respect and demoralize patients to an extent that doesn't allow them to fight for a better life. The affected individual is taught society's expectations of him and re-identifies himself; starts controlling his own expectations and avoids any confrontation, thus missing almost every opportunity (Angermeyer et al., 2004). Their social networks shrink, leading to poverty and unemployment, which in turn leads to social exclusion (Kroska & Harkness, 2006). Oversensitivity to any communication involving stigma emerges, presenting itself as

embarrassment on both sides, meaning not only with those who expect to be stigmatized but also those who try to cover up their worry for the affected.

- *The opinion of others affects me a lot. I can't talk about that.*
- *Sometimes people say that I would be better if I don't get married and have kids. I agree with them now.*
- *I don't try to make friends.*

Patients believe that expected discrimination is far worse than the smaller number of options they actually have. Still, some do not allow themselves to expect discrimination.

- *I went back to work and back to school. It was a little uncomfortable at first, but now it's OK, I almost never feel that way. I still have trouble meeting people, but I don't give up. Sometimes it works out, sometimes it doesn't.*
- *People had trouble accepting me, but it wasn't me who had a problem, it was them.*
- *I never went back to my old job. My doctor advised me against continuing in this profession, so I changed careers and finished a course. I didn't want to retire.*

6.4.3 Self-stigma

The psychological cause for self-loathing is internalization of prejudice. Some people accept disdain to be justified and legitimate. They start to act passively, dependently and helplessly as is expected of them. A social quarantine devoid of encouragement and responsibility is formed around the individual. Expectations are reduced (Lysaker et al., 2007). One withdraws and gives up hope and wishes, making himself less emotionally dependent and less likely to speak out – which are all recognised as »negative« symptoms of mental illness. It was proven that people, who identified themselves as being stigmatized, compare poorly to others, who do not feel stigmatized regarding their intellectual capacity. This means that a stigmatized social group actually functions below their intellectual potential, stigma being the reason for their impairment and not only their illness. They feel incapable of functioning as rational, competent and functional individuals, have lower self-esteem and are often depressed, anxious and hostile (Quinn et al., 2004).

Being a part of a stigmatized group is a barrier to one's success and often means a loss of life opportunities. People with mental disorders are often isolated, unemployed, poor, single and alone (Thessen, 2001). Recognising their situation many in turn disdain and even hate their fellow patients – a group of people with mental illness. They may exhibit the same or even worse stigmatizing behaviour as those outside of the group towards their fellow, more stigmatized patients (Zalar, Strbad & Švab, 2007). The individual does not want to be a part of the disadvantaged group (Goffman, 1963).

The anger and outrage directed towards the barriers keeping them out of social life is turned on themselves. Self-stigma is exhibited in feelings of shame, exclusion and loss of importance. Still, the consequences of self loathing do not stop there. Patients in its grasp do not argue their rights or interests, thus maintaining the vicious circle of stigma and legitimizing the fact that non-stigmatized people avoid and exclude them (Goffman, 1963).

It must be noted at this point that mental illness does not necessarily mean a loss in effectiveness and self-esteem. People react differently to disease and possible disability. Some fight discrimination and abuse and some are indifferent, depending on an individual's personality and the situation. People who refuse to accept the stereotype feel angry and

strong, and justifiably so. Sometimes, as members of a marginalized group which has been wronged, they feel even stronger and more assertive than before. Similar to the reaction of the Afro-American culture, they say that anger is the fair response to stigma. This expression of just anger is more likely to happen if the stigmatized individuals connect in a group focusing on improving the situation. People who fail to identify with a group more often treat discriminatory practices with indifference, regardless of their personal experience (Corrigan, 2005).

The only way to resist self loathing is to stand up to discrimination and resist abuse.

- They avoid me a lot. I don't care. There is difference between being stupid and mad. I don't think I'm stupid.

- I broke it off with some of my friends. Not just because of the diagnosis. Though I'm ok with those that I kept being friends with. If I manage to sort myself out, find a job and my family is fine, then nobody can say I'm schizophrenic, I know that.

- I think of being diagnosed as an advantage. Me and my family figured it out, what being ill means and we know exactly what to do when I start acting differently, it is the illness that gets worse.

6.5 Structural discrimination

Structural discrimination happens on a systematic level, in a way that automatically stops any attempts to acquire a different social status. The mentally ill are pushed to the edge of society, drastically reducing their life options. Being of the edge of society means that any group can be forced into humility, anonymity and silence. Any discussion of equal rights, respecting diversity and understanding is futile if discrimination is built by the general society and the state itself as the ultimate defence against intrusion of marginalized groups, dreamers and the unadjusted into any decision making system. Some countries include special mental illness clauses in their visa application forms. There are countries or states that deny their mentally ill citizens the right to vote, not considering if an individual can manage the illness or not. But the most generally present effect of structural stigma is poor quality of mental health services and their inaccessibility (Angermeyer et al., 2003), basically denying patients their right to treatment and care in an apparently accidental way. The reasons for this can be found in social service management, political decisions and poor legislation. In a cultural environment with strong values on work and income, a patient is stigmatized and cornered. He is unemployed because of not being able to reach the required production norms. As unemployed individual he is labelled twice: being mentally ill and unproductive or even lazy, unable to achieve the socially required criteria to be considered a productive member of the community. The only possible way out of this situation is belonging to a wider community of people who also feel wronged by the prejudice directed towards the mentally ill. Patients who are able to find a way to belong to such a group and identify with it have more self-esteem and are significantly stronger (Corrigan et al., 1999, 2004).

Stronger individuals report better recovery (Anthony, 2000). Those who are politically connected influence the quality of mental health services.

Poor care for the patients' physical health is one of the more serious problems that mental health care faces. People with mental disorders have the same somatic diseases as other people do, yet the standard for hospital care drops severely whenever a mental problem appears. The risk for physical problems such as diabetes, high blood pressure and cardiovascular disease is far greater amongst people with mental disorders than in other

groups. Cardiovascular disease is the main cause of death in this group. The paradox here is that with severe physical health problem good mental health is not possible. All physical illness is strongly connected with depression, anxiety and other mental health problems. It follows logically that every physician should be trained in identifying and treating mental health problems, yet psychiatry is mostly treated as unimportant at most medical schools, by the teaching staff and students alike. The average medical student is likely to have the same opinion of mental health problems as the general public. They mostly feel that psychiatry as a branch of medical science is ineffective and unscientific (Feldmann, 2005). The basis for improving the life and treatment quality of patients with mental disorders is improving the education on all levels of the educational system, including lessons on needs, rights and the reality of life in fringe groups.

7. Areas of discrimination

7.1 Friendship

Compared to others, people with mental disorders have scarce social networks and are more strongly linked to their families and more dependent on them (Thorncroft, 2006:27). A small social network can be a consequence of stigmatization and the mental disorder itself. Loneliness is a risk factor for poor recovery. Most patients try to hide their illness from their friends, as they believe hiding is essential for their social survival. They believe that mental illness makes them social lepers and rarely see it as an opportunity to improve on the quality of their existing relationships and, perhaps, finding new ones.

- *True friends stay by your side. You can check who your friends really are and start all over again, or even improve them.*
- *We're better friends than before I got ill.*
- *My friends listen more, stand by my side and encourage me.*
- *My friends stuck around, mostly. Those who didn't, weren't my friends, were they?*
- *I didn't exactly have a lot of friends. I met new people when I was admitted to the hospital. They're my friends now.*

But there seems to be much more negative experience. Friends disappear, flat out decline to see the patient and avoid him. Every friendship lost strengthens feelings of loneliness and despair.

- *I had one friend. I went to visit him once. He told me to leave. He avoided me after that, so I did the same.*
- *When they say: »she's the crazy one«, I know they're making fun of me. Nobody can stop it from happening.*
- *Some of my friends, when I told them I was in, didn't come to see me. I don't trust them anymore.*
- *I feel distant. People don't know what to say when I'm around.*
- *People that know treat me differently. If they don't, everything is much easier.*
- *I didn't make any new friends after I was admitted.*
- *I feel they don't want to be around me. It takes a lot of time for anyone to get through to me, I know that.*
- *Nobody ever comes to visit, nobody ever calls me.*
- *I called my friend and wished her happy holidays, She said she'd come, but she didn't. I think her husband doesn't let her.*

- *When I still had a job, I lost my best friend when he found out. He never called me again, so I didn't want to call him.*
- *My childhood friend was shocked, when she found out. She was scared of visiting me, so she never did. I'm sad because I lost my best friend.*
- *They think they're better than me.*
- *My friends were shocked. They avoided me.*

7.2 Partnership

People with mental disorders are much less likely to be in a committed relationship. There are many reasons for this, the most common being low self-esteem and lack of opportunities. Many existing relationships are discontinued due to the severity of the disease, stigma and financial difficulties. On the other hand many couples manage the illness and find new challenges and qualities in their relationships.

- *For me, it's an advantage. She's great.*

Divorce is one of the most stressful events in an average person's life. Most people need to be helped when faced with divorce, the mentally ill especially so. Several cases of patient's being used and manipulated during the separation process have been reported.

- *My boyfriend dumped me the second I was admitted to hospital. He didn't want to be with me anymore.*
- *I was married. My husband left me when I got ill. I had no relationships since.*
- *My husband left me because of my diagnosis.*
- *Once people know you're ill, it's hard to find somebody who's willing to share your life. You can't have kids when you're taking medication.*
- *My husband isn't understating. He had all the power so he had me hospitalized.*
- *He met somebody else, fell in love and that was that.*
- *Nobody wants to have a physical relationship with you once they know you're ill. People are afraid.*
- *Who am I going to get? People see a cripple when they look at me.*
- *When I went to see my girlfriend her mother wouldn't leave us alone. She couldn't trust someone who was in the hospital.*

7.3 Parenting

Nurturing and caring for a child after giving birth is one of the hardest physical and mental tests for mothers. Sleeplessness, hormonal imbalance, physical stress, financial difficulties, breastfeeding and relationship difficulties can shake even the strongest of women. Those who are sensitive to psychiatric disorders often experience a relapse in the year following birth. Admitting this, there is little evidence to suggest that schizophrenic mothers are unable to take care of their children. Women with mental disorders often lose their children, despite all the facts. This can be attributed to not receiving any assistance when it is most needed. Mothers don't have access to counselling, education or family therapy (Thornicroft, 2006: 38).

Most parents who have some form of mental disorder provide excellent care to their children and are considered good parents, if sufficient support is provided for possible overloads.

- *When I was hospitalised, I was handicapped, had no energy. When I went to pick my son up from kindergarten everybody was very correct. I didn't have any bad experiences, none good too; they just treated me like everyone else.*
- *There was some doubt at home, but I went through with it anyway. I'm really happy I had a baby.*
- *My ex-husband tells me I'm not strict enough when the kids are with me. I don't think so, I think he's too strict and they have to let of some steam when they're with me. It's a very small flat and there are five of us when they come over, but they like being here.*

People with severe mental disorders like schizophrenia want children the same as everybody else.

- *We tried to adopt a child with my wife, but we couldn't.*

7.4 Sexuality

People with mental health disorders often exhibit radical sexual behaviour, the outstanding group being those with mania. Women with mental health disorders are far more likely to be sexually abused. Research states that there are a lot of cases when a patient should be treated both for sexual abuse and illness (Thornicroft, 2006).

Several drugs used in psychiatric treatment have a negative effect on libido, erection and ejaculation, which is one of the leading reasons for avoiding use.

- *I have no libido...It's just gone.*
- *It's true I don't have any desire to be sexually active since it got sick.*
- *I can't get a woman pregnant. The medicine would harm the kid.*
- *When I got ill, I couldn't perform. My wife cheated on me a lot, she wasn't happy with me.*
- *Sexual disorders are another cause of slow self-esteem.*

Intercourse is, because of the above mentioned, less likely to happen in psychiatric institution than in other institutions, but it does occur and not rarely. Prohibiting sexual activity is discrimination, yet it must be implemented sometimes in order to stop people acting on basis of their reduced reasoning because of the illness. People with low self-esteem who agree to intercourse they would otherwise reject also need to be protected. Effects of these dilemmas presented themselves through hospital management decisions conflicting over gender separation. In the name of normalization, England implemented mixed wards for a couple of decades, which are being separated again. The reasons for this are numerous reports of abuse and women's dissatisfaction due to a lack of privacy. Closed wards fared the worst in this experiment of gender mixing, as the patients there have a problem controlling their behaviour. Women who experienced abuse before admission often demand their right for privacy very strictly. The number of women being treated because of traumatic sexual experiences in psychiatric hospitals is not low (Thornicroft, 2006).

A patient's right to sexual expression needs to be balanced with the reasonable demand for protection. In clinical practice, this means that in closed wards sexual intercourse is usually prohibited, even though it is a breach of their basic human rights.

7.5 Employment

Employment discrimination is one of the most often encountered forms of stigma.

- I rarely got a reply to my work applications and I was never accepted. I wrote about my diagnosis in these applications.

Work is known to improve mental health, helps manage an individual's life and makes a person feel appreciated. Unemployment deprives people of social interaction, reduces their self-esteem, intensifies feelings of incompetence and pushes people into poverty. Research proves that most people with mental disorders possess work capabilities and desire to employ them (Brohan & Thornicroft, 2010). The low employment rate of people with mental disorders can be blamed on discrimination.

- I want to work, but I am locked up at home. I have nothing to do
- They told me to find another job, when they found about my medication.

Employers expect mentally ill workers to be unproductive and frequently absent. They fear unpredictability and damage to the workplace or the company. Physically disabled people are twice as likely to be employed compared to the mentally disabled. If people with mental disorders get employed, they can expect a lower and less lucrative position, their experience and education not taken into account.

- This is a big obstacle and big stress. Employer looks at me very carefully, what I speak and what I do.
- I was moved to a lower paid work position, and then finally to some unimportant office. Then I quit.
- From team leader to worker and finally a cleaner.

Given time, a lot of them give up on finding employment and accept their social status (Wahl, 1999; Link, 1982). Half of available and appropriate positions are terminated or changed to the mentally ill worker's disadvantage because of poor workplace relations (Becker et al., 1998). The most commonly asked question when discussing possible employment with a patient is whether the individual should reveal his diagnosis to his employer. There is no simple answer to that question. It depends on the employer's prejudice and on whether the position is more or less stressful. Hiding the diagnosis might lead to difficulties. If the individual can not perform set tasks or can not handle the stress, the most common response is inefficiency.

- There was too much overload, I collapsed and had to go away.

Honesty, on the other hand, might expose the individual to rejection and victimisation.

- Nobody said I won't get the job because I was sick, they never say "You are schizophrenic and we don't want you", but it's obvious.

The most common solution seems to be denying the illness and covering up problems (Stuart, 2004).

Experts who try to lower their patients' or clients' expectations and try to get them to accept social aids or pensions are also an issue.

Adjusting the work to the needs of people with mental health disorders improves their job performance (Waghorn, 2011). This means making the workplace a little more serene, employing people to work from their homes, adjusting the work hours or just making sure

that individuals work in a tolerant environment where they are entitled to support when needed. There are clear guidelines how to organize work for people with mental health disabilities (Corrigan & McCracken, 2005). People with mental disorders need adjusted work hours and support at the work place (Crowther et al., 2001). An organizational culture which respects mental health, diversity and offers support is therefore necessary, as job performance can be significantly improved even with the most severe mental disorders (Thornicroft & Brohan, 2008). Legislation can speed up the process of employing people with mental disorders, but only slightly as employers still see them as a threat, despite the financial stimulation the government offers for their employment. Productivity is the cornerstone of respect in many cultural environments. To get and keep a job is the best path to recovery, on walked also by many people with severe mental illness. There are many examples of people who received enough support to recover in this way.

7.6 Education

A student with a mental disorder can experience significant difficulties. Their reduced capabilities show themselves as problems with studying, communicating, memory, thinking and sleep which significantly affects their studies. Such students are hard to recognise as most student difficulties are attributed to a lack of motivation and poor working habits. Research of their special needs is very scarce. The astounding diversity of mental disorders and their varied symptoms further complicate the problem. Student may suffer from depression, anxiety, addiction, psychotic disorders or personality disorders. Each and every of these problems requires a different treatment and different types of support. The diagnosis, however, should not be the reason for program adjustment, it should rather be the reduced capabilities caused by the illness and its other effects - including stigmatization. Obstacles that prevent the student from reaching optimal results need to be removed. Specific social skills, for example, in obtaining information can be improved upon by an appropriate mentor. Additional rights can be provided for a student who just finished recovering from a mental illness, such as additional timelines, additional flexibility, adjustment of class attendance requirements, providing additional mentors and tutors, additional lectures arranged for specific problem areas and the option of at-home studying. Counselling, stress control classes, study planning classes and social skill classes should also be considered. Adjusting the study process should not jeopardise its quality, only change its difficulty. It is not expensive to adjust educational programs, the difficulty lies in combating discrimination against the mentally ill in all stages of the educational system (Rickerson et al., 2004). Rights and needs awareness need to be raised among the staff working in education.

Students who have received sufficient support have proved that education can help control a mental disorder.

- Learning helps me get through the day.

Students with mental disorders have reported that some teachers try to help them manage their duties, which depends on the sensibility of the teachers themselves, not on school rules.

- In college my professors became lenient when they found out about my illness, with homework or even tests. One even gave me a solved test and just told me to copy it.

- I got special treatment in high school.

They frequently experience discrimination and avoidance.

- *When I was doing my requalification everybody looked at me funny.*
- *Teachers, professors-they all underestimated me.*

Some further guidelines for educational adjustment can be found here:
(<http://www.bu.edu/cpr/jobschool>).

7.7 Accommodation, communities

Different social and cultural environments mean different types of care for people with mental disorders. The Slovenian social environment, for instance, sees most patients living in primary families, similar to the Mediterranean countries. In northern and western countries, most patients live on their own (Thornicroft, 2006).

Today numerous patients live in sheltered living arrangements. This form of accommodation offers diverse levels of care and is an alternative to living with relatives. Patients mostly choose to live in such a community when their domestic situation offers no advantage to recovery, when they feel they have no chance of living on their own and when they require help with everyday obligations. These alternative living choices can only work when competent staff is available, one that can recognise and answer the many different needs that people in such a community have. In Slovenia, social institutions are still one of the most common types of long-term accommodation, and however far they are developed, they still seem to face the same problems - an often reported high risk of neglect and inadequate treatment.

- *Looking for an apartment when mentally ill isn't easy. When I did it, I never told anyone I was ill. People don't like people who are...different. It's best to stay unnoticed.*

- *My landlord knows that I'm ill, she's a bit more careful now. I think it's because I didn't tell her much, but she still tries to make conversation and understand me. I know it's a bit awkward for the both of us, but I feel it's ok, it's her house.*

- *My parents think I'm not mature enough to have my own flat, even though I have one. I can cook for myself. Ironing and washing up are still problems, but I'll get help from a therapist so I can look after myself after I'm discharged.*

7.8 Social relations, finances, civil rights

A person's social life outside the bonds of family and the workplace depend on his social skills, opportunities, rights, resources and his perceived worth in society. The mentally ill can be discriminated against by having no means for day to day recreation, quality time and simple pleasures. The most common reason for this is financial deprivation, usually caused by unemployment and poor pension or social aid, sufficient only for the bare necessities. Most patients desire employment that would improve their financial status. Even if they do manage to find some form of employment they have to deal with management that is not always tolerant. Furthermore, they are most often not sufficiently informed of their rights and subsequently do not enforce them. Others do not want to enforce their rights because they want to enter any relationship on equal grounds. Some accept their inferior status because of their low expectations.

People with severe mental disorders are poorer than the general population and suffer from disrespectful behaviour, sometimes physical violence and underestimation. It should be noted however, that there are numerous reports of tolerance, cooperation and equal treatment.

- They encouraged me. In the library, the staff knew what I'm interested in and they helped me.

7.9 Neighbours

Reports from Great Britain and the US claim that people with severe mental disorders are being avoided and excluded by in their communities. When the non-government organization ŠENT in Slovenia was establishing group homes, we believed that people who were living in the neighbourhood should not be given prior information concerning the possible (absence of) danger to help them accept the newcomers. We have firmly stated, however, that any event out of the ordinary, even if it's just an unscheduled visit by an ambulance, should be explained to everyone affected. The recommendation (Thornicroft, 2006: 15) that in the earliest stage of creating the community, residents should be notified carries weight, which might be relativised by the right to confidentiality and the fact that half of the world's adult population will be affected by a mental disorder at some point in their life and that three quarters of this population know somebody who suffers from one. Reports given by interviewed people with schizophrenia in INIGO differ significantly. Often the neighbours are those who notice that an individual requires help. The individual affected may perceive this as an intrusion into his autonomy that damages his self-respect.

- Of course, my neighbours called the ambulance. It's annoying if your neighbours know they can out you away. They just call the ambulance and tell them to take me. When I bought this flat, my own little place, I locked myself in for 14 days straight - I wanted to put it in order. It was my first apartment! In the ghetto, really small, doesn't matter. Then suddenly, cops came to take me away. And I was so happy to get my own flat. It's unpleasant to say the least, when somebody can send you to the hospital anonymously. They just come, handcuff me and take me away.

- The neighbours know when I'm in the hospital. My blinds are down. It bothers me, a little.

- I live in a small village; my mom-she's the village gossip. She always cares most about what the neighbours will say. I think that's the source of a lot of problems. If I lived alone, there would be none of that. People in my village are always watching me.

People in a community most often help one another.

- I was elected house president twice. I told nobody in the building that I was in the hospital. That's why they listened to me.

- My neighbours didn't know I was ill for a long time. They know now, they understand.

7.10 Professionals

Patients with mental disorders are most stigmatized by professionals (Lauber et al., 2006, Nordt et al., 2006). Stigma in professional services is one of the main causes of treatment discontinuation amongst patients (Tehrani et al., 1996). Professionals stigmatize the mentally ill for the following reasons. They are pessimistic about their recovery, despite all the scientific evidence to the contrary. The prognosis for most mental disorders is far better than for most recurring physical illnesses. Experts rarely meet recovered patients, only those

in grave need of assistance. Another reason is the need for distance and superiority, in short, power, which can be easily satisfied in any type of institution. Most professionals claim that they do not stigmatize, that problems arise from patients' oversensitivity to what they say. This anticipated discrimination contributes to patient stress. Stigma directed against the professionals themselves is also very much a reality- people often perceive professionals as arrogant and uncomprehending and therefore don't trust. This leads to procrastination in seeking assistance. Research shows that most people with mental disorders never seek treatment (Wittchen et al., 2005). The most stigmatized diagnoses are alcohol addiction, eating disorders, personality disorders, self-harm and schizophrenia. The most stigmatized patient groups are men with financial problems and the homeless. Discriminatory behaviour of staff increases in case it is decided that the mental problem is the patient's own fault, if the patient is admitted frequently, if violent or criminal behaviour is assumed, if it is believed the patient has little chance of recovery or, finally, if the patient is believed to be dishonest. Besides patronizing, double standards are a common type of stigmatization - every act is judged according to the patient's diagnosis even when there is no objective reason to do so. For example, a patient being upset with the quality of his treatment could be interpreted as agitated because of the illness, even if his complaints are legitimate. People with mental disorders encounter the same discrimination in every institution, not just the hospital. Professionals' attitude towards the mentally ill has a large influence on others' behaviour. Psychiatrists and nurses who see their profession as stressful, hard and unsatisfying lead the public to see apathy, ignorance and poor patient treatment as the way to behave toward people with mental disorders. On the other hand, committed experts who appreciate their choice of profession set an example of respect, hope and the need to cooperate.

- *Social services are like that: they decide instead of you, they treat you differently.*
- *The court doesn't take me seriously. He raped me long ago, I was in the hospital and I am still here, and he, the criminal, is out.*
- *I feel the gap between staff and patients, between "healthy" and "mad". Outside the hospital, I'm worried my professors will find out about me, because we are a very small study group.*
- *My tooth was extracted in spite of my resistance to do that. The dentist just did it. I'm not in control of my life.*
- *They didn't tell me about the effects and side effects of drugs, and also about the length of my hospitalization. They didn't tell me anything.*

Others don't experience such problems.

- *My gynecologist knew about my illness, but she didn't treat me differently. She encourages me to have children, but we decided against it, with my husband, since it's a genetic disease.*

7.11 Privacy

New legislation demands that a patient be accorded his right to privacy. This can not always be done due to current hospital conditions. Living conditions depend on many factors, chief amongst them the budget available and the level of structural stigmatization. Respect for the right to privacy depends on the staff also - some might see the patients' need to be alone as important, others not. Obviously, a closed ward is needed for patients who need to be observed for their and others' safety.

- *There is no privacy in the hospital. For any of us, none has it better.*
- *It's hard to say. There's not a lot of freedom, but they expect you to cooperate with everyone, the doctors, parents. No inner peace.*
- *Patients in psychiatric hospitals don't have privacy. You can't do anything on your own, just what they tell you.*
- *I had to sleep on a „temp“, in the living room. People were coming to look at me all night long, made noise. I cried all night.*
- *They were always ok with it, when I wanted to be alone.*

8. Coping with stigma

8.1 Protest

Protest is the most used strategy to fight injustice, as unsuccessful as it is. People who discriminate are prone to responding with more discrimination when subject to outrage and opposition. They are less likely to cease their behaviour when other opinions are forced on them. Protest can only positively affect media coverage, specifically those reporters who have failed to form a clear opinion on the matter at hand. Protest is a reactive strategy; it attempts to diminish negative attitudes about mental illness, but fails to promote more positive attitudes that are supported by facts (Corrigan & Watson, 2002).

8.2 Education

The belief that prejudice is irrational inevitably leads to the logical conclusion that it can be fought with reason. If we were only able to understand the whole truth of mental disorders, the people it affects and ourselves we would be able to overcome prejudice and weaken their connection with our emotions easily. This thesis is the ground on which all anti-stigmatization educational programs are founded, including those that promote meetings between the non-discriminated and the discriminated. Promoting mental illness awareness is by far the most accepted method of combating stigmatization and discrimination. The same method was used in intercultural dialogue campaigns, aimed at reducing racism and homophobia. It was assumed that people could rationally »delete« their prejudice. It was proven that although short educational programs improve relationships and awareness (Roman & Floyd, 1981, Link et al, 1987, Brockington et al., 1993), they only have short-term effects. Their effect on discriminatory behaviour is unproven and there is some doubt as to whether they influence the behaviour itself or merely change the understanding of a problem (Corrigan et al., 2005, Pinfold et al., 2005, Shulze et al., 2003). People understanding more about mental disorders, however, doesn't mean much to stigmatized individuals. The main problem of educational programs seems to be that discussion is always focused on the stigmatized group, not on the group that stigmatizes. Instead of paying attention to prejudiced individuals, objects of their prejudice are being focused on, as Henriques noted in 1984 in his book »Changing the subject«. Following years showed that more than convictions, actual discriminatory behaviour needed to be stopped, which required knowledge of history, institutions, legislation and the cultural traits of the affected environment (Gonzales Torres et al., 2007).

8.3 Contact

Establishing direct contact with those who recovered from mental illness is another way to educate. Stories and reports by empowered individuals are a strong weapon against

stigmatization. (Brockington et al., 1993; Wolf et al., 1996, Corrigan et al., 2001; Happel et al., 2002, Pinfold et al., 2005). They were proven more successful than educational campaigns, especially in combating fear (Angemayer et al., 2003), yet even these programs only managed to fight stereotyping (Wolf et al, 1996; Thompson et al., 2002), not social distance. Relating to an individual with mental disorder experience does not affect the social nature of stigma. But, even direct contact effects can be relativised, as individuals can consider the one they are talking to, an exception. An informed and competent individual does not affect the reputation of his whole group, except when he is a recognised representative (Oakes et al., 1994). People with mental health problem experience know where to expect stigma in day to day life. Professional representatives of the mentally ill that give speeches at conventions and seminars aren't typical representatives of the group. Similar to professionals, they require frequent public appearances to maintain their status. Their posture is consequently militant, disdainful and they are constantly trying to find mistakes in their healthy colleagues' communication. They demand »appropriate« behaviour, in keeping with the marginalised group's code. Their expectations differ significantly from the bulk of the population's, who try to be polite and careful in order not to jeopardize their position. Most individuals with mental disorders try to demonstrate that they are well adjusted, behaving similar to others. At the same time, they try to convey that they are not the same; that they are at a disadvantage that needs to be accepted as a fact (Goffman, 1963). Most of the discriminated have developed careful and artful forms of communication, which enables them to be at least partially accepted and prevents severe problems.

9. Research on stigma

Already in 1999 US research on stigma argued that socio-psychological research of ethnic minorities and other group stereotypes should be considered when implementing anti-stigma strategies. It indicates that (a) attempts to suppress stereotypes through protest can result in a rebound effect; (b) education programs may have limited effectiveness because many stereotypes are resilient to change; (c) contact is enhanced by a variety of factors, including equal status, cooperative interaction, and institutional support (Corrigan & Penn, 1999).

In 2004, Link and others identified a variety of mechanisms allowing observation and measurements of key components present in a stigmatization process. These are: labelling, stereotyping, cognitive separating, emotional reactions, status loss, discrimination experiences and discrimination expectations, structural discrimination and behavioural responses to stigma. Structural discrimination was found not to be adequately researched. Strong proof of prevalence of expected discrimination over actual, experienced discrimination was found. Most studies show that older people, individuals with a relatively poor education and persons who have never known anyone with a mental illness are more likely to desire social distance than their younger, more educated counterparts who have had more contact with the mentally ill. The main limitation of majority of research by then was found to be social desirability bias. People do not want to state openly that they are reluctant to accept people with mental disorders. Opinion measuring scales and Community Attitudes Toward the Mentally ill scales showed major improvement after contact with people with mental disorders (Crisp et al., 2005), which produced incentive to further anti-stigma strategies. The positive influence of contact was also proved by measuring emotional reactions to people with mental disorders (Angermeyer & Matschinger, 1996) and opened a path to research on stigmatizers.

The stigmatized were, from 1987 onward, repeatedly assessed on rejection, perceived rejection and anticipation. Some measures on coping orientations were taken as well. The stigma on the affected' carers and relatives was measured with different scales from the one of the last developed in Germany (Wancata et al., 2006).

The biggest stigmatization control project was »Open the Doors«, a study and a campaign under the World Psychiatric Association, which got underway in 1996 in 20 different countries around the globe (Thompson et al., 2002; Sartorius & Schulze, 2005). It was meant to combat prejudice and discrimination against schizophrenia. The first phase consisted of public polls in 6 different countries, the second a wave of social service public education programs. The project enjoyed some success, achieving, for example, a reduction in social exclusion in Germany (Gaebel, 2004). The following years showed that more than convictions, actual discriminatory behaviour needed to be stopped, which required knowledge of history, institutions, legislation and the cultural traits of the affected environment (Gonzales Torres in dr., 2007). One of the larger anti-stigmatization campaigns »Moving People« proved this as during the campaign, from 2002 to 2005, of 30 million British reached, 17% more started believing that mental illness and violence are correlated, whereas in Scotland the exact opposite was true- the number of people convinced that the mentally ill are prone to violence dropped by 17% . Before the campaign started 40% more people in Scotland believed in this stereotype than in Wales and England. This result proves that campaigns need to be adjusted to social and cultural environments.

The media research gaps were identified by Stout and others (2004). It was nevertheless clear that those who watch a lot of television hold more negative views of individuals with mental illness than those who watch it less (Granello & Pauley 2000). Most of the articles on media influence on stigma share the same conclusion - this is outrage on media reports. A lack of differentiation among different media channels and the scarcity of research on children perception is nevertheless obvious. Additional problems include non-representative results - the people studied are primarily college students. A link between media depiction and individuals' perceptions is thus still theoretical at this point. Replication and expansion of research in this area is required, and particular emphasis should be given to identifying links between exposure to media images and subsequent perception impact. Simply stated, more precise research is needed.

A major improvement in research was applying qualitative methods , being essential for appreciating the subtle, damaging effects of stigma, for example structural discrimination. The Goffman work described above was the first and still most influential qualitative research on stigma. Major gaps in stigma research still remained: lack of results on structural discrimination, emotional responses of patients and cross cultural approaches.

The importance of understanding the social context of the stigma is presented in research about attitudinal and structural barriers that prevent people with mental disabilities from becoming active participants in the competitive labour market (Stuart, 2006).

The connection between mental disorder and physical illness researched proved that the increased frequency of physical diseases in schizophrenia might be on account of factors related to schizophrenia and its treatment, but undoubtedly also results from the unsatisfactory organization of health services, from the attitudes of medical doctors, and the social stigma ascribed to the schizophrenic patients (Leucht et al., 2007). One of the major approaches to overcome low service use, poor adherence rates, and stigma was defining mental disorders as neurobiological medical disease. The 10-year comparison of public endorsement of treatment and prejudice proved that this approach translates into support

for services but not into a decrease in stigma. Reconfiguring stigma reduction strategies may require providers and advocates to shift to an emphasis on competence and inclusion of patients with mental disorders (Pescosolido et al., 2010).

In Pinfold et al. a review (2005) of relevant literature and the results of the recent Mental Health Awareness in Action (MHAA) programme in England was published to discuss the current evidence base on the active ingredients in effective anti-stigma interventions in mental health. The key active ingredient identified by all intervention groups and workshop facilitators were the testimonies of service users. The statements of service users (consumers) about their experience of mental health problems and of their contact with a range of services had the greatest and most lasting impact on the target audiences in terms of reducing mental health stigma.

Research on stigma and mental disorders has faced several problems: it has made few connections with clinical practice or health policy (for example in relation to help-seeking and access to care); it has been largely descriptive in its use of public attitude surveys or portrayal of mental illness and violence by the media. Few systematic assessments of user experience have been made. The research has been focused on hypothetical rather than real situations, out of context, addressed stigma indirectly rather than directly and has not provided a clear answer on how to intervene to reduce social rejection (Thornicroft et al., 2009). The review of self-stigma research shows lack of longitudinal research in this area and the need for greater attention on disentangling the true nature of the relationship between internalized stigma and other psychosocial variables (Livingston & Boyd, 2010). Public campaigns' efforts to reduce stigma have not been convincing and the field suffers from a lack of applicable solutions (Thornicroft, 2006; Angermeyer et al. 2009; Gaebel et al., 2008)]. The process of destigmatization appears to be a slow one. Data on the economic impact of anti-stigma campaigns is scarce and evaluation is intrinsically difficult (Sharac et al., 2010).

The overall conclusion of research gave some premises that the best course of action to support people with mental illness is empowerment, including a connection with supported employment and job coaching, national policy changes, development of quality services and anti-stigma education of mental health workers. The strongest evidence at present for active ingredients to reduce stigma pertains to direct social contact with people with mental illness and social marketing on the population level (Thornicroft & Brohan, 2008). The research should focus on measures directed at personal stigma of mental illness as it is increasingly being used as a key factor in anti-stigma interventions.

The need to schedule research from public to the affected persons was followed with the introduction of the INDIGO study aimed to describe the nature, direction, and severity of anticipated and experienced discrimination reported by people with schizophrenia. A cross-sectional survey in 27 countries was made, in centres affiliated to the INDIGO Research Network, by use of face-to-face interviews with 732 participants with schizophrenia. Discrimination was measured with the newly validated discrimination and stigma scale (DISC), which produces three subscores: positive experienced discrimination; negative experienced discrimination and anticipated discrimination. Rates of both anticipated and experienced discrimination were found to be consistently high among people with schizophrenia, mostly in establishing and keeping friendship, in family relationships and in work places. Almost three thirds of the participants were found to want to conceal their diagnosis (Thornicroft et al., 2009). The theory that contact with mentally ill people reduces stigma and discrimination is not fully supported by latest qualitative INDIGO results (Rose et al., 2011).

The INDIGO study is followed by the ASPEN project which is currently underway (2009-11) in 27 countries of the EU. It's goals are ambitious and include the creation of stigma and discrimination assessment scales, creation of detailed analytical European profile of stigma and discrimination as experienced by young people and adults with depression, including both anticipated and expected discrimination and self-stigma. The focus groups research, literature search and interviews were applied to identify best-practice, relevant problems in local environments and presentations of structural stigma and social exclusion (ASPEN, retrieved 7.7.2011 on webpage <http://mdac.info/aspen>).

INDIGO and ASPEN projects are seen as a step forward towards improvement of research on attitudes, systems, personal testimonies and discriminative behaviours.

10. Conclusion

Prejudice can be fought by associating it with the political and social environment. Stigma can not be removed by open protest, explanations or examples - the only solution is a complex social movement aimed toward the better investment in the position of the mentally ill. All stigma reducing interventions need to be adjusted according to local experience and founded on daily observation of problems individuals face. Prejudice that affects the areas of life important to the affected individual needs to be determined (Yang et al., 2007). A set of social and institutional measures needs to be taken, one that encourages tolerance of illness, patients, treatment and symptoms. The anti-stigma movement should be connected with big mental service planning issues- those of psychiatric rehabilitation and community mental health that give some promise to improve the social position and access to care and treatment of people with mental disorders. Community care for people with mental disorders is important, since it provides multi-sectoral programmes of action to promote the social inclusion of people with mental illness.

The only way we as individuals can affect stigma is by leading by example, openly opposing derogatory terms and stereotypes. In basic education, schools and teachers should provide also mental health education, care for mental health and wellbeing of pupils and teachers alike. An inclusive school, promoted, can foster tolerance and make possible early recognition of mental disorders. Every educational level needs to prohibit derogatory language directed at the people with mental disorders and consistently view them as individuals, not diagnoses. Changes in educational curricula should include involving mental health service users and their carers at all educational levels as experts and teachers in mental health issues.

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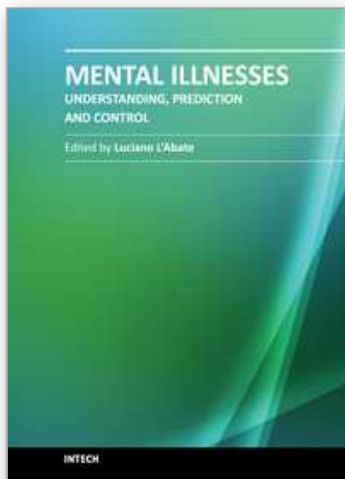
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In the book "Mental Illnesses - Understanding, Prediction and Control" attention is devoted to the many background factors that are present in understanding public attitudes, immigration, stigma, and competencies surrounding mental illness. Various etiological and pathogenic factors, starting with adhesion molecules at one level and ending with abuse and maltreatment in childhood and youth at another level that are related to mental illness, include personality disorders that sit between mental health and illness. If we really understand the nature of mental illness then we should be able to not only predict but perhaps even to control it irrespective of the type of mental illness in question but also the degree of severity of the illness in order to allow us to predict their long-term outcome and begin to reduce its influence and costs to society. How can we integrate theory, research evidence, and specific ways to deal with mental illness? An attempt will be made in the last conclusive chapter of this volume.

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