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# Stigmatization of mentally ill people – a contemporary problem

Jakub Gdowski, Krzysztof Szczygieł, Piotr Podwalski, Jerzy Samochowiec

Department of Psychiatry, Pomeranian Medical University

**Summary**

Stigmatization and discrimination of people due to their specific characteristics is a widespread problem, both in Poland and worldwide. Stigmatization of people with mental disorders and diseases is a particular type of it. Although this phenomenon has its roots in Antiquity and the Middle Ages, and was scientifically described several dozen years ago, it is still a current and unsolved problem. Stigmatization can take place on different levels and appear as autostigmatization, community-related stigmatization, and institutional stigmatization. It takes different forms and has varying negative effects. Counteracting this situation and eliminating its effects, that have already arisen, is a vital necessity and an essential activity of the society in order to provide better functioning and treatment for people with mental illness. Challenges in this area are faced both by state institutions responsible for the health care system and by private entities such as NGOs, media corporations, and companies employing people. The individual commitment of each and every person is also important to prevent and respond appropriately to the stigmatization of people affected by mental illness.

**Key words:** stigma, society, funding

## 1. Introduction

### 1.1. The definition of stigmatization throughout history

Stigmatization is a type of punishment that was used in ancient Greece[1], through the Middle Ages and up to the 19th century [2]. It consisted in burning a visible mark (stigma) on the convict's body in a place that was visible and easily recognizable. For that purpose a red-hot metal seal was used and a typical place of leaving a mark was a forehead or a cheek [3]. The stigma was supposed to be a sign of a defect in morality and indicate that the bearer of it was a criminal, traitor or impure person. It was a clear sign for the other members of the society that such people should be avoided [1].

### 1.2. Changes in the understanding of stigmatization

The contemporary concepts of "stigma" and "stigmatization" to some extent refer to the original, historical meaning, but they have gained a new dimension in which the main emphasis is put not on the secondary physical attribute, but on the primary cause that constitutes the stigma [1]. While initially the appearance of a visible stigma was the result of an act of stigmatization, today it is rather a secondary attitude towards the previously stigmatized person, which often arises without the participation of the society or in a way that goes unnoticed by it. Furthermore, the currently used concept of stigmatization usually refers to the phenomenon of so-called social stigmatization, i.e., disapproval or discrimination because of a perceivable trait that makes it possible to distinguish a person from the other members of the society. It often refers to culture, gender, sexual orientation, race, economic status, age, intellect or health state.

### 1.3. The role of historical changes in the approach to treating mental illnesses

A very significant factor contributing to stigmatization are mental illnesses and disorders [4]. The societies have regarded the mentally ill people with a distance and contempt for centuries, not exceptionally treating them equally with the criminals [4]. In the Middle Ages such a disease was perceived as punishment from a God, whereas the manifestation of clinical symptoms – as a result of diabolical possession [5]. However, there were also some cases when the people manifesting such symptoms were deemed mystics possessing the direct connection with Higher Power [6]. Sufferers were often imprisoned or even killed [4]. Only since the times of Luis XIV from the Bourbons dynasty the approach to mental illnesses and disorders have changed. That were the Sun King's times (1656) whereby the public system of mentally ill people care was created. However, the attention should be drawn to the fact that undertakings involved only providing the secure asylum, separating sufferers from the rest of the society, but without offering them any form of treatment [7].

Poland also has played an important role in the development of care and therapeutics towards the people suffering from mental disorders. The year 1609 can be considered as the beginning of organized solution in this regard, when the Brothers Hospitallers of Saint John of God came to Poland and set in Cracow their first fraternal order and a hospital, whose funder was the wealthy Cracovian merchant, Walerian Montelupi. The institution, despite its general profile, admitted mentally people as well, and in the course of its activity was associated mainly with that branch. In the following years the fraternal order opened similar institutions in other towns of the Crown, including Vilnius and Warsaw [8]. It is worth mentioning that because of monastic habit with a pointed hood (in Polish "czubek") worn by the Brothers Hospitallers of Saint John of God, their institutions were colloquially known as "u czubków" ("at spikes"). In the contemporary Polish the remain of that practice is recognized in the word "czubek" ("spike"), which is a pejorative and stigmatizing description of the mentally ill person (Eng. nuthead) [9]. The state legislation in Poland was also related to that issue. As far back as in 1529, 1566, and 1588, the king Sigismund I the Old sanctioned the Statutes

of the Grand Duchy of Lithuania including regulations related to insanity or care of mentally ill people [10].

However, Philippe Pinel, the French doctor of Enlightenment, is considered to be a father of modern psychiatry. In 1792 he introduced the groundbreaking doctrine thanks to which in curing mental diseases the particular attention was brought to humanitarianism and personal treatment of patients [11]. Since then, the dynamic development of psychiatry was observed. However, that period in the 20th century was halted by the establishment of totalitarian countries such as the Soviet Union or Nazi Germany. In 1926, a category of insanity was introduced into the Soviet Criminal Code, which was used so that people who opposed state policies could be considered mentally ill and sent to political wards of psychiatric hospitals [12]. In the 1960s, a new disease entity called "sluggish schizophrenia", sometimes also referred to as asymptomatic schizophrenia [13], was defined by Andrei Snezhevsky at Moscow's Serbsky Institute of Forensic Psychiatry, for the diagnosis of which a change in thinking leading to reformist or critical tendencies was sufficient [14]. The Second World War introduced a significant increase of discrimination and stigmatization of mentally ill people [4]. The Nazi regime in the Third Reich is responsible for killing and castrating hundred thousands of mentally ill people [15]. Examples of this include the mass forced euthanasias carried out as part of Aktion T4, during which between 1939 and 1945 in Germany, Austria, occupied Poland, and the Czech Republic, approximately 200,000 sick, handicapped, and disabled people whose lives were judged "not worth living" (Lebensunwertes Leben), were killed [16, 17]. Among such people were many mentally ill patients. In just one psychiatric hospital located in Warta in 1940, SS soldiers murdered 499 patients [18].

### 1.4. Erving Goffman – a pioneer in the study of stigmatization

The significant relation to the theme of social stigmatization and introducing it into medical nomenclature took place only in the second half of the 20th century. An important role in this process was played by the American sociologist Erving Goffman, who laid the groundwork for the subject of social stigmatization by publishing *Stigma: Notes on the management of spoiled identity* in 1963 [1]. He defined the stigma as "a severely discrediting attribute". Moreover, he provided the description what current social stigmatization is, where it is from, and how the stigmatized people react to it. This way he became the father of the new science which, since then, has been developing dynamically [4, 19].

## 2. Stigma, stigmatizing, and stigmatized ones

### 2.1. The model of stigma understanding according to Erving Goffman

According to Erving Goffman, the stigma bases on two main elements – the trait which enables to recognize the stigmatized person, and the way this trait devaluates the stigmatized person. He divides people experiencing stigmatization into 'discredited',

when the stigma attribute is visible for the majority immediately, and ‘discreditable’, when this attribute is unrecognizable *a priori*, however, there is a possibility it will be denounced [1]. The mentally ill people can belong to both groups.

### 2.2. Types of stigma

In general terms, three main types of stigma are distinguished: related to the physical ugliness, the character defect, and the group one (Figure 1). The first one and the most obvious is associated with physical deformation, the second one is attributed mainly to pathological beliefs, dishonesty or inability to cope with the passions. This group embraces the stigmas related to homosexuality, addictions, suicidal attempts or mental diseases. The third group involves races, nationalities, and religions.

### 2.3. The process of stigmatization and its consequences

All of these stigma types generate the secondary reaction of the society, i.e., stigmatizing. The person, who would be socially accepted easily, because of their stigmatizing attribute becomes not only unacceptable, but their potentially positive traits are devaluated and ignored. The stigma modifies social anticipation of stigmatized people in the holistic way, is not only limited to the reason that constitutes stigmatization. The society learns stereotypes and oversimplifies them, which secondarily allows the specific individuals to possess their own impressions about the stigmatized [20]. It is essential to admit that such individuals not necessarily believe in their own feelings[21], natheless they feel them.

Stigmatization, regardless of its reasons, consists of three components: stereotype, prejudice, and discrimination [22]. Stereotype is a negative belief about the person or about their own in the case of auto-stereotyping (e.g., about weakness, incompetence or aggression). Prejudice is expressed by accepting the stereotype and, as a result, creating negative feeling (it can be fear or anger, but auto-prejudice is characterized by low self-esteem). Discrimination is manifested by secondary behavior towards prejudice such as interaction avoidance, refusal of employment or help. In contrast, auto-discrimination is visible in a form of forbearing from finding a job or own place of living [23]

### 2.4. The uniqueness of stigma associated with mental illness

The particular type of stigmatized people are these stigmatized because of their mental disease. They are subjected to double challenge. On the one hand, they have to cope with the symptoms of their own illness, on the other hand, with the stereotypes and social misunderstanding of the nature of mental diseases [23]. Also of note in this group is the increased risk of dehumanization. People with a diagnosis of mental disorders are more likely to be perceived as less human compared to those with somatic illnesses [24].

Stigmatization of such people can occur on various levels. These include auto-stigmatization, family stigmatization and the one related with other social groups, and institutionalized stigmatization [4]. Notwithstanding the level at which it occurs, it generates various effects.

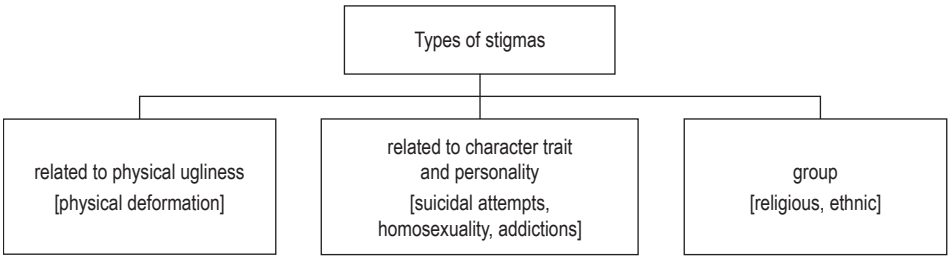


Figure 1. **Types of stigmas [4]**

## 3. Auto-stigmatization

### 3.1. Definition and stages of development of auto-stigmatization

Auto-stigmatization is the state in which a person with a mental illness thinks stereotypically about themselves and is prejudiced and discriminating towards themselves [22]. Auto-stigmatization is done in stages. In the initial phase the person knows that some of their unwanted trait (in this case the illness or mental disorder) triggers the creation of stereotypes in the society (awareness). Subsequently, they concede their validity and treat as truth (acceptance). The final stage involves recognizing that these stereotypes apply specifically to the individual (application) (Figure 2) [22].

### 3.2. "Why-try" effect

Auto-stigmatization is characterized by so-called "why-try" effect [22]. It has an effect on achieving goals or executing tasks – the auto-stigmatized person has a low self-esteem and self-efficacy. It causes the belief of being unworthy of chances that happen and leads to resignation from seizing the opportunity [22]. Such a string of occurrences results in mentally ill people deciding not to engage into opportunities improving their professional life, place of living or fulfilling their personal aspirations [25]. It has been proven that the occurrence of auto-stigmatization depends on the occurrence of social stigmatization [26].

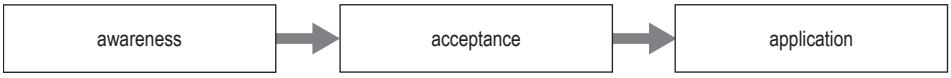


Figure 2. **The stages of auto-stigmatization development**

## 4. Social stigmatization

### 4.1. Mechanisms of stigmatization in the family and society

The society in the general meaning is defined as a group of people sharing common culture, interacting with each other on the particular territory [27]. The basic integrated functional unit of the society is a family [28]. However, the wider circles of people create more extended communities. The stigmatization of mentally ill people can occur in all these groups, and depending on its level, its form varies. The family stigmatization causes the changes in family relations. The members of families express their resentment towards their relatives revealing their afflictions, what is more, they feel ashamed and afraid themselves of other people's reactions after learning about the occurrence of mental disorders in their family [29].

### 4.2. Specific effects of social stigma

Stigmatization of mentally ill people is also widely spread among so-called western societies [23]. The stigmatized person not only anticipates the resentment, but also actually experience it [30]. Mentally ill people experience social stigmatization by avoidance, dismissal from work, refusal in renting a flat or not being provided with other forms of help [23]. The property owners were less likely to admit the flat was for renting to people they knew were psychiatrically hospitalized, in comparison to those about whom they did not have such knowledge [31]. The mentally ill person encounters greater difficulty when applies for a job or wants to be joined in marriage [32]. Among the other stigmatizing activities are resentment to make friends with the mentally ill person or even living in the neighborhood of such a person [33].

The other research have proven that psychiatric medications are claimed to cause heavier side effects than cardiological medicines [34]. Moreover, such attitude is also met among professional medics. The GP doctors display stigmatizing behaviors more often than the psychiatrists, which are manifested by, e.g., in interacting with a patient in a way that lacks compassion [34].

## 5. Institutionalized stigmatization

### 5.1. Manifestations of stigma in healthcare policy

Aforementioned types of stigmatization of mentally ill people are related to the behaviors of particular people or communities of various size. The other and specific form of stigmatization is institutionalized stigmatization, also called as the structural one. The essence is the introduction by governments or private subjects lines of policies which intentionally or unintentionally limit the potentials of mentally ill people [35]. It includes reduced funding of research related to mental illnesses or limitations in psychiatric healthcare services. In Poland, according to *Final plan funded by NFZ for 2023*, in 2023 slightly over 5.3 billion Polish zlotys

was spent on psychiatric healthcare and addiction treatment [36]. It is only 3.36% of total NFZ expenses on healthcare provision, whereas in the countries of Western Europe this ratio is from 6% up to 10% of money allocated to finance healthcare [30]. It is worth perceiving this percentage from the perspective of proliferation of mental disorders in Poland. According to the EZOP research (*Epidemiology of mental disorders and accessibility of psychiatric healthcare*), at least one mental disorder classified in ICD-10 or DSM-IV is recognized in 23.4% of study population (Figure 3) [37]. Such a low level of psychiatric healthcare funding against the background of such a high level of prevalence of mental illnesses and disorders cause restrictions in access to services per se. This is reflected in, among others, relatively limited number of psychiatric care institutions, insufficient number of professional staff or limited access to modern pharmacological treatment [38]. The system's imperfections translate into negative opinions about it among psychiatric patients. They point to inefficiency of psychiatric community care and the necessity to intensify preventive measures [39].

### 5.2. Discrimination in the public and private sectors

Meanwhile, the issue of institutionalized stigmatization of mentally ill people is not only manifested by relatively low funding of psychiatry and subsidy allocated to it, but also by legislation which, in certain areas, discriminates mentally ill people. For example, in Article 12 of the Family and Guardianship Code there is a provision preventing the marriage of people suffering from mental illnesses [40]. Legislator gives the permission only if certain requirements are fulfilled. The structural stigmatization also refers to private sector. The survey carried out among the Polish employers shows that only 4.4% of them have ever employed the mentally ill person, and almost half of them (48%) share the opinion that only 10% of mentally ill people are able to keep a full-time job [41]. These results confirm that employers are commonly prejudiced towards mentally ill people.

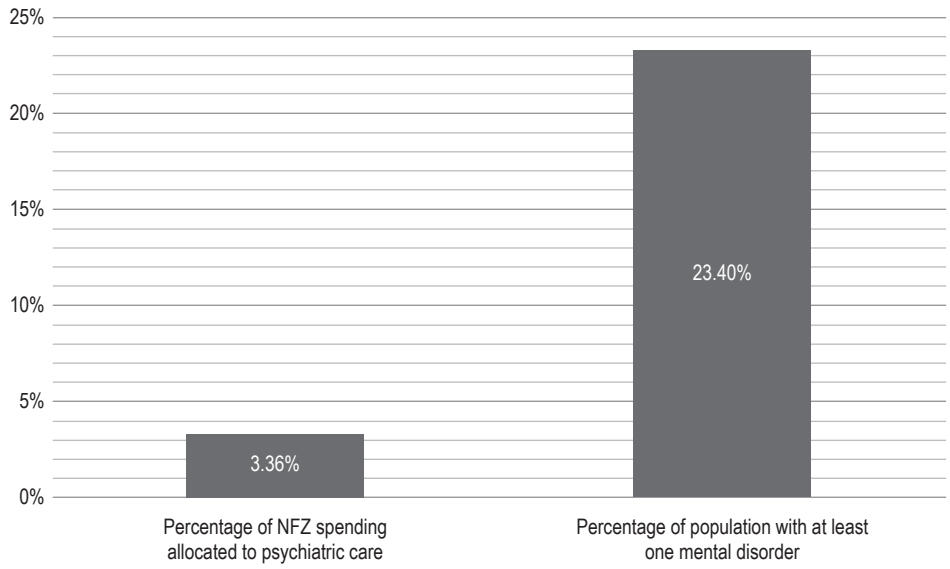


Figure 3. **The percentage of NFZ expenses spent on psychiatric healthcare and the percentage of population suffering from at least one mental disorder**

## 6. The consequences of institutionalized stigmatization

### 6.1. Impact on availability of psychiatric care

Resentment and discrimination towards the psychiatric patients are reflected in the area of the healthcare system. Task achievements control of National Program of Psychiatric Healthcare System (NPOZP) for 2011–2015 carried out by Supreme Audit Office (NIK) showed that the assumed objectives were not achieved. The main objectives of NPOZP were new organization rules and the improvement of psychiatric healthcare efficiency, however, according to NIK, the reason of negative assessment was, among others, failure in securing funds for assumed tasks, lack of engagement of voivodeship governments or lack of district and borough governments' activities aimed to meet these objectives [42]. The audit related to accessibility of psychiatric healthcare for children and adolescents in 2017–2019 carried out by NIK revealed that the system of psychiatric healthcare for children and adolescents does not meet the needs of this population of patients [43]. Not only did the number of institutions decrease, but also in five voivodships there was not any psychiatric outpatient ward [43].

### 6.2. Negative effects of stigma in the healthcare system

Inefficiency of healthcare system with regard to psychiatric treatment leads to insufficiency in benefiting from necessary services by mentally ill or mentally

disordered sufferers. The sufferers meet various barriers that make obtaining help difficult, such as lack of knowledge about the place where the services can be provided, inability to obtain the phone contact or too long waiting time for the appointment [44]. It has disproportionate negative impact on psychiatric healthcare availability [45]. On the other hand, even if the mentally ill person effectively reaches the place providing psychiatric care, the problems are not vanished. It can be sometimes associated with the attitude of psychiatric staff. It has been indicated that medical professionals providing mental health services have a more pessimistic attitude towards the prognosis of people with depression or schizophrenia than the general population [34]. Planning treatment, they can also take into consideration the patients' requests to the limited extent [46]. Dissatisfaction with the applied treatment is the most important single factor contributing to treatment discontinuation at own request among the psychiatric patients [47]. These phenomena may relate to worse prognosis of life expectancy among the patients with mental illnesses and disorders. The fact is that mental disorder itself contributes to shorter life expectancy for at least 10 years in comparison to the general population. When it comes to severe mental illness such as schizophrenia or addiction to psychoactive substances, the difference is more than 20 years [45]. Every year in Poland the number of fatal suicide attempts reaches 5 thousand [48], which means that every 10 years the number of lives lost this way can be compared to the population of towns like Wejherowo, Piaseczno or Starachowice.

## 7. Challenges

### 7.2. The need to remove systemic barriers in healthcare

It is certain that described status quo is undoubtedly pathological, requires intervention and introduction of changes. The task is complex, so it needs consideration and examination in all aspects of this issue. It is necessary to extend funding and efficiency of healthcare system in the field of psychiatric treatment. According to the resolution of the 46$^{th}$ Congress of Polish Psychiatrists approved on 26 June 2021, the Polish Psychiatric Association calls, among other things, for an increase in the level of financing of psychiatric care to 6% of resources allocated to healthcare services covered from public resources in the next 3 years, and to realize objectives of National Program of Psychiatric Healthcare [49]. These objectives embrace providing comprehensive care by popularizing community model of psychiatric care, various forms of help, social and psycho-pedagogical support among students, parents, and teachers [50]. Moreover, the National Program of Psychiatric Healthcare is going to frame the rules related to presenting people with mental disorders on the media, as well as educational activities concerning respect for rights of such people. It is expected to prevent stigmatization and discrimination of people suffering from such disorders [50]. It is important to mention the Report of the Spokesperson of the Polish Psychiatric Association for the term 2016–2019, which sets new communication goals. Their main goals include promoting a positive image of psychiatry as a modern field

of medicine and normalizing the use of psychiatric help, by comparing it to seeking help from doctors of other specialties [51].

### 7.3. A culture of accountability and support to counter stigma

However, not only healthcare system, on all its levels – starting with Cabinet and Minister of Health, through officials of National Health Fund, finishing on employees performing medical activities such as doctors or psychologists – is responsible for changing present inertial conditions. The essential role in preventing stigmatization and its results plays education of society, which takes place mainly in schools. Effective education of children and adolescents preventing stigmatization could take place in classes. Because of seriousness and influence of stigmatization on significant percentage of population, it seems reasonable to introduce on each level of school education the additional subject or at least the course dedicated to psychiatric health, symptoms, and ways of preventing the effects of mental illnesses and disorders. The second aspect is introducing free and public access to psychological support for school students. The introduction of analogous solutions in university education, regardless of fields of study chosen by students, would bring similarly positive results. The described measures belong to solutions of systemic policy, in which the impact of state organs affects the achievement of objectives [52]. Although they play a key role, they cannot remain alone. The resilient development of NGOs is also important as they would actively educate the society, provide and facilitate help in individual care institution. The private media corporations such as press, TV, radio stations or internet websites should also get involved into these actions, mainly in order to totally eliminate all the published content and reach of people who stigmatize, discriminate or deride the mentally ill people or present false picture of coping with such illnesses. The other desirable media activity is production of materials that would draw public attention to the problem of stigmatization and discrimination or offering free places for them on their pages or programs.

Finally, the crucial element of the changes is the activity of the individuals in the society. Helpful in this regard may be the recommendations for non-discriminatory language for people with mental disorders, presented as part of the *Sensitive to Words. Sensitive to People* campaign, which detailed communication practices including refraining from stigmatizing terms (such as “crazy”, “mental”, “lunatic”, “schizophrenic”, “autistic”, and “border”), and encouraged an empathetic view of the situation of people struggling with mental disorders [53]. Everybody, proportionally to their possibilities, should search for knowledge and shape their behaviors in a way as never to be the cause of stigmatization for the sake of mental illness, and in the situation of being a victim or a witness of such bad behaviors, have enough knowledge how to respond appropriately.

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Corresponding author: Piotr Podwalski
e-mail: piotr.podwalski@pum.edu.pl