Stigma

DEFINITION

Stigma refers to the social consequences of negative attributions about a person based upon a stereotype. In the case of people with mental health problems, it is presumed that they lack intelligibility and social competence and that they are dangerous.

KEY POINTS

• The features of stereotyping and stigma are outlined.
• The particular ways in which people with mental health problems are stereotyped and stigmatised are discussed.

Stigmatisation has two main aspects. First, the person stigmatised is perceived stereotypically as an example of a social group (rather than tentatively and respectfully as an individual). Second, this stereotyping or ‘social typing’ has negative connotations. (It happens occasionally that there is positive stereotyping. This does not lead to stigma but it is still illogical.) These two features are associated with emotional reactions in others such as fear, contempt and disgust, though pity and concern may also be evoked. In the case of the stereotyping of people with mental health problems, all of these reactions may be present in different proportions from one situation to another. Thus, stereotyping has both cognitive and emotional aspects.

What then arises from these inner processes of stereotyping is a social reaction, whereby one party rejects that other or reacts towards them in a way that is significantly different. As a result, the stigmatised person is set apart and they suffer the consequences of the social distance created. The person feels depersonalised, rejected and disempowered. As a consequence, they may develop what Goffman (1963) called a ‘spoiled identity’. Pilgrim and Rogers (2005) note that people with mental health problems are stigmatised in a particular way, which refers to three presumed qualities in the target: a lack of intelligibility, a lack of social competence and the presence of violence. The strongest cultural stereotype is the spectre of a
homicidal madman – a deranged being who explodes violently, erratically and inexplicably (Foucault, 1978). This scenario remains a focus of fascination for news-reporting even today, when it is singled out sporadically, against a wider backdrop of completely unreported homicides.

In order to establish that stereotyping is irrational, it is necessary to examine the evidence that may or may not support it. In our case here, do mentally ill people always lack intelligibility? Are they always socially incompetent? Are they always violent?

• The question of intelligibility In most social situations, participants have an obligation, if called upon, to render their speech and conduct intelligible about any rule transgression or role failure (Goffman, 1971). If we break a rule, then we should be able, if called upon, to give an account. If asked, we must be able and willing to provide a persuasive reason or an explanation (Scott and Lyman, 1968). If we do not, then that itself represents a form of rule breaking. With specific regard to madness, then this rule breaking does indeed occur. Lay judgements about the emergence of madness refer primarily to a person’s lack of intelligibility and inability to explain their oddity in an acceptable or persuasive manner (Coulter, 1973). Of critical importance here is that judgements about the social obligation to explain oneself occur in context. Take the example of talking to oneself. Generally, this might be the main piece of behavioural evidence that a person is mad. However, if it happens in church or when the person is holding a mobile telephone to their ear, then madness is much less likely to be attributed. Also, the presence of auditory hallucinations may be considered intelligible in one context but not another.

• Thus, there is some empirical evidence to suggest that the stereotype of people with mental health problems lacking intelligibility is valid. Generally, it is fair to say that mad people act in a way that others do not understand and that they are unable or unwilling to give credible accounts to others of their thoughts and actions. However, there is also evidence that this generalisation (the key to stereotyping) is flawed. First, mad people may be unintelligible sometimes and not others. For example, it is common for psychosis to occur episodically, with periods of recovery and sanity. Another example is in relation to persistent paranoid delusions. In this case, the person may act completely intelligibly all of the time except when the delusional material emerges in conversation. Second, many people with mental health problems (those with a diagnosis of neurosis rather than psychosis) are highly aware of their problems – indeed, they may be preoccupied with giving accounts to others about their feelings and actions. The attribution about unintelligibility only applies to madness, not all mental disorder, and even then, not all of the time.

• The question of social competence Lay judgements about mental health problems and their formal medical codification in psychiatric diagnoses include an
attribution of failed social competence. The mad person loses their credibility because they have lost their reason. Because they are not taken seriously, they are socially disabled – they are not permitted to be competent. The depressed or anxious person is unable to carry out their normal role obligations. As with the previous point about intelligibility, there is evidence to undermine these generalisations about the loss of competence (and its associated credibility). First, some people with mental health problems are disproportionately creative. Second, some symptoms create greater competence at some tasks. For example, those with a diagnosis of obsessive-compulsive disorder or obsessive-compulsive personality disorder are more likely to perform above average on tasks requiring a close attention to detail. Third, religious leaders may enjoy heightened credibility even though they may manifest symptoms of mental illness.

There is therefore some evidence that some people with mental health problems act in an unintelligible way some of the time. There is no evidence that all people with mental health problems are unintelligible all of the time. Likewise, there is some evidence that some people with mental health problems have diminished social competence, some of the time, to warrant diminished social credibility. However, this is not true all of the time for all people with mental health problems. Indeed, some of the time their competence and credibility are actually raised and not diminished. In addition, some patients are at increased risk of being violent to others. However, these are in the minority. The vast majority of people with a psychiatric diagnosis are not more violent than those without a diagnosis. In some cases, for example in anxious people or in psychotic patients with ‘negative symptoms’, the probability of violence is actually lower than would be the case in the general population.

The persistence of these three elements of stigmatisation of those with mental health problems is historically rooted in the generalisations made about madness. Not only were these historically-based stereotypes always questionable on empirical grounds, but also they are now applied inappropriately and unfairly to many patients who are not mad. This is because the jurisdiction of contemporary mental health services extends beyond the management of madness. Solutions offered to reverse stigmatisation include patients demanding citizenship rights and professionals pleading for mental illness to be treated with the same respect as physical illness. (These points are explored further in the entry on Social Exclusion.)

See also: creativity; labelling theory; madness; mental health; social exclusion; the mass media.

REFERENCES