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Internalizing stigma associated with mental illness: findings from a general population survey in Jamaica

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ABSTRACT

Objectives. *The culture of stigma associated with mental illness is particularly intense when persons who are normally victims of that stigmatization (mentally ill persons and their family members) themselves act negatively toward others whom they associate with mental illness. We attempt to determine the extent of this internalization and assimilation of stigmatizing attitudes, cognitions, and behaviors in persons who are at risk for such stigmatization in Jamaica.*

Methods. *Data from a 2006 national survey on mental health were analyzed. Demographic variables, the presence or absence of mental illness in respondents and in their family members, and responses pertaining to behaviors and attitudes toward mentally ill persons were examined. Subsamples (respondents with mental illness, respondents with a family member with mental illness, respondents with neither) were compared using the chi-square test.*

Results. *Respondents with family members with mental illness were less likely to demonstrate a number of different manifestations of stigmatization than others (P = 0.009–0.019). Respondents with mental illness showed no difference in the demonstration of a number of different manifestations of stigmatization from other respondents (P = 0.069–0.515).*

Conclusions. *The small number of mentally ill respondents resulted in low statistical power for demonstrating differences between that subgroup and other respondents. The significantly more positive attitudes and behavior of respondents with family members with mental illness suggest that some benefit may be gained by creating more opportunities for the general public to interact with persons with mental illness.*

Key words Mental health, prejudice, Jamaica.

The term "stigma" originates from the ancient Greek practice of branding criminals so that they were left with a mark (a stigma), which allowed them to be easily identified. Persons with a stigma were devalued and rejected by society (1). Today, stigma refers not only to a physical mark but to any characteristic that sets an individual or group apart from mainstream society and "justifies" their disqualification from social acceptance (2). Neuberg et al. (1) noted that, in a broad conceptualization of stigma, it refers to both the characteristic that is seen as disqualifying and the beliefs about individuals with such characteristics. That definition is used in this paper.

Stigmatization has two important elements: the recognition of a differ-

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ence (a mark or stigma) and consequent devaluation of the individual or group because of this characteristic (1). The process has a number of predictable cognitive, affective, and behavioral consequences (1), including aversion, depersonalization into stereotypes, condescension, and prejudice. Not uncommonly, some "positive" reactions like sympathy may also occur (2). Goffman (2) noted that the consequences of stigmatization may be ameliorated by the support of "wise" "normals" who, having intimate knowledge of stigmatized individuals or groups, challenge the validity of the stigma. Such persons may be relatives of potential targets of stigmatization and are also at risk of being stigmatized by association (2).

Persons who have been identified or "marked" as mentally ill often experience stigmatizing reactions from "normal" society, and their family members have been shown to experience stigmatization by association (3–5). The phenomenon of stigmatization of mentally ill persons is more common in areas where knowledge of mental health issues is poor (6); therefore, it is more likely to occur in lower-income countries, like Jamaica, where there are fewer resources for public education on these matters. Stigma has deleterious effects on the self-esteem of the affected individual (7). It is also associated with a reluctance to seek appropriate professional help because of the fear of being negatively labeled (8, 9) as well as with difficulty in maintaining employment (10) and close personal relationships (11).

Goffman (2) observed that stigmatization may result in stigmatized individuals experiencing shame and agreement with their devaluation by society. He also noted that persons at risk of being stigmatized may attempt to "pass" as "normal" and that may require them to demonstrate stigmatizing attitudes, cognitions, and behaviors. These reactions to real and potential stigmatization represent an internalization or assimilation of the attitudes, cognitions, and behaviors associated with stigmatization. Phillips et al. (12) noted that this type of internalization occurs in mentally ill persons and their family members, all of whom are potential targets of stigmatization.

We have already noted that one would expect more stigmatization of the mentally ill and their family members in less-developed countries. We also expect countries with high levels of stigmatization to have high levels of internalization. Internalization would be particularly severe if, beyond the passive acceptance of society's stigmatizing values, potential targets of stigmatization also demonstrated explicit stigmatization of others with the same kind of stigma.

We hypothesize that, in the developing country of Jamaica, owing to high levels of stigmatization, and consequently internalization of stigmatization, the following behavior will be observed:

1. Family members of mentally ill persons, who are themselves potential targets of stigmatization by association, will stigmatize mentally ill persons to the same extent as the general population.
2. The stigmatization mentioned under item 1 will be directed toward both family members with mental illness and other persons identified as having a mental illness.
3. Persons with mental illness will exhibit a high prevalence of stigmatization of other mentally ill persons.

The stigmatization of mentally ill persons by their family members has already been explored in the literature (11). However, the exploration of stigmatization of mentally ill persons by other mentally ill persons represents a new area of research.

MATERIALS AND METHODS

In 2006, Jamaica's Ministry of Health commissioned the services of one of the authors of this paper to conduct a household survey to examine the knowledge, attitudes, and practices of the general public on issues related to mental health and illness. The intention was to obtain some guidance for the development of a comprehensive and culturally relevant mental health promotion program that would improve public awareness and ultimately enhance the country's quality of mental health care. The survey was carried out in 2006 and the areas explored in this study depend on the examination of some of the findings of that survey.

Sampling

The sampling procedure was developed by the Statistical Institute of Jamaica (STATIN) and was in accordance with its usual practice for obtaining nationally representative samples of the general population. Of the country's 5 300 enumeration districts, 137 were randomly selected; within each of these districts, 12 households were randomly selected. The head of each of these households was invited to participate provided that he or she was between the ages of 15 and 65 years. If the head of the household was not present or did not meet the age criteria, other persons in the household who were present and within the required age category were identified and a suitable respondent was randomly selected. All participants were interviewed in their homes.

The instrument

The survey instrument was a semistructured interviewer-administered questionnaire. It consisted of 42 questions designed to explore sociodemographic variables and various elements of knowledge, attitudes, and practice regarding mental health and illness. The questions were devised by a panel of mental health professionals and were informed by their knowledge of the literature on stigma associated with mental illness and by their culturally relevant clinical and research experiences in Jamaica. Sociodemographic variables included age, gender, educational level, and urbanicity.

Areas of interest for this study included the presence or absence of a diagnosis of mental illness in respondents and in their family members; respondents' feelings about mentally ill family members, of which there were seven non-mutually exclusive options encompassing both negative and positive feelings; and actions taken by respondents when in the presence of someone perceived to be mentally ill, for which there were six non-mutually exclusive options encompassing both negative and positive actions. Because the basis for stigma lies in the perception of a difference or "defect" and not necessarily in nosological systems for determining normality or abnormality, respondents were not given operational definitions of mental illness. Their responses to questions about mental illness or mentally ill persons depended entirely on their own conceptualizations of those entities. One question asked respondents if they or their family members had ever been diagnosed with or treated for mental illness. Responses to this question formed the basis for categorizing respondents as "mentally ill" or being the relative of a "mentally ill" person. Two examples of questions from the instrument are given below:

- Question 29: Have you or family member(s) ever been diagnosed or treated for mental illness? [Options given for responding about self and about family member(s): Yes, No, Not stated.]
- Question 31: If you have a family member who has been diagnosed or treated for mental illness, how do you feel about him/her? (Circle all that apply): Angry, Compassionate, Caring, Loving, Afraid, Concerned, Disgusted. [Options given for each question: Agree, Disagree.]

The instrument was piloted in four enumeration districts (two urban and two rural) and then minor adjustments were incorporated. The instrument, however, did not undergo formal standardization, validity, or reliability testing. An interviewer's instruction manual was developed for the questionnaire and outlined how each question should be asked and answered. This manual was then used as a resource in face-to-face training of all fieldworkers and supervisors involved in data collection.

Data collection

Of the 1 644 households selected by the randomization process, persons from 1 306 agreed to participate. The overall response rate was 79.6%. It was not higher because many potential respondents, particularly those from violent inner cities as well as affluent communities, were skeptical of the survey process and refused to participate. For similar reasons, many persons agreed to participate but refused to answer all questions. Consequently, questions of interest had data missing for 23.6% to 28.5% of respondents.

Data analysis

Frequencies, means, and proportions were calculated as appropriate. Variables of interest were examined using the chi-square and *t*-tests. Where indicated, further analyses were conducted using logistic regression. Statistical significance was taken at the 5% level.

RESULTS

The age and urbanicity of the survey sample and subsamples closely resembled the characteristics of Jamaica's general population (Table 1). However, they differed in a number of other respects. Significantly fewer males were surveyed (29.2%) than the national proportion of males for the targeted age group (49.9%). Also, the educational level of persons surveyed was higher than that of the general population, although population data on education were available only

TABLE 1. Selected sociodemographic characteristics of participants in a national survey on knowledge, attitudes, and practice related to mental health and illness, Jamaica, 2006

	General population (15–64 years of age; *n* = 1 564 586)[a]	Survey sample (*n* = 1 306)	Subsample with mental illness (*n* = 42)	Subsample with family member with mental illness (*n* = 285)
Male (%)	49.9	29.2	31.0	23.2
Age (years): mean ± standard deviation (range)	32.4 ± 12.9 (15–64)	38.6 ± 13.4 (15–65)	37.7 ± 13.1 (18–65)	37.8 ± 12.3 (16–65)
20–44 years of age (%)	60.8	60.7	54.6	65.4
Urban dwellers (%)	48.9	47.9	54.1	51.0
With education level at grade 6 or lower (%)	26.3[b]	15.6	12.8	14.0

[a] Source: Statistical Institute of Jamaica: population census 2001.
[b] This is for the general population 15–98+ years of age.

TABLE 2. Comparisons of sociodemographic characteristics between mentally ill and non-mentally ill respondents and between persons with and without mentally ill relatives in a national survey, Jamaica, 2006

	Mental illness in respondent				Mental illness in relative of respondent			
	Mental illness present (n = 42)[a]	Mental illness absent (n = 1 264)[a]	Chi-square or t-test	P	Mental illness present (n = 285)[a]	Mental illness absent (n = 1 021)[a]	Chi-square or t-test	P
Male gender	13 (31.0%)	324 (29.8%)	0.027[b]	0.870	66 (23.2%)	270 (32.1%)	8.076[b]	0.004[c]
Age (years)	37.7 ± 13.1	38.6 ± 13.4	–0.44[d]	0.664	37.8 ± 12.3	38.7 ± 13.6	–0.99[d]	0.344
Urbanicity	20 (54.1%)	442 (44.6%)	1.301[b]	0.254	132 (51.0%)	343 (44.4%)	3.394[b]	0.065
Educational level at grade 6 or lower	5 (11.9%)	144 (13.2%)	0.060[b]	0.806	36 (12.6%)	109 (12.9%)	0.015[b]	0.902

[a] Data in these columns are expressed as numbers and percentages, except age, which is expressed as mean ± standard deviation.
[b] Chi-square value.
[c] Statistically significant difference.
[d] t-test value.

TABLE 3. Behaviors and attitudes toward persons perceived to have mental illnesses by respondents with mentally ill family members versus respondents without mentally ill family members in a national survey, Jamaica, 2006

	Respondents with mentally ill family members (n = 285[a])		Respondents without mentally ill family members (n = 1 021[a])			
	Yes	No	Yes	No	Chi square	P
Avoids mentally ill persons	134 (57.0%)	101 (43.0%)	491 (66.4%)	249 (33.6%)	6.747	0.009[b]
Physically assaults mentally ill persons	20 (8.5%)	216 (91.5%)	53 (7.3%)	669 (92.7%)	0.325	0.569
Verbally abuses mentally ill persons	15 (6.5%)	215 (93.5%)	53 (7.5%)	650 (92.5%)	0.265	0.606
Treats mentally ill persons kindly	204 (82.6%)	43 (17.4%)	547 (72.8%)	204 (27.2%)	9.497	0.002[b]
Socializes with mentally ill persons	131 (55.5%)	105 (44.5%)	314 (44.2%)	396 (55.8%)	9.052	0.003[b]
Feels comfortable with mentally ill persons	75 (33.3%)	150 (66.7%)	180 (25.3%)	531 (74.7%)	5.542	0.019[b]

[a] Overall number; actual numbers of respondents to questions vary.
[b] Statistically significant difference between groups compared.

for the age range of 15–98+ years compared with the 15- to 65-year age range of survey respondents. Chi-square analyses and t-tests demonstrated no differences in age, urbanicity, or educational level between mentally ill and non-mentally ill respondents or between persons with and persons without mentally ill relatives. However, significantly more females were represented among persons who had family members with mental illness compared with those who did not. No gender differences were found when mentally ill and non-mentally ill respondents were compared (Table 2).

Persons who had family members who were mentally ill were less likely (57.0%) than other persons (66.4%) to avoid persons perceived to be mentally ill. They were also more likely to treat such persons kindly (82.6% versus 72.8%), to socialize with such persons (55.5% versus 44.2%), and to feel comfortable with such persons (33.3% versus 25.3%). All these findings were statistically significant (Table 3). Respondents with and without mentally ill family members were equally unlikely to report verbally abusing or physically assaulting persons believed to be mentally ill (Table 3).

The findings from Table 2 suggest that, apart from the presence or absence of a family member with mental illness, the observed differences in Table 3 could also be attributable to the confounding effect of gender. Logistic regression analyses were used to determine the extent to which that might be the case. The results of these analyses are presented in Table 4.

TABLE 4. Logistic regression analyses of selected behaviors and attitudes versus respondents' gender and presence or absence of a family member with mental illness in a national survey, Jamaica, 2006

	Factor	Odds ratio	95% confidence interval	*P*
Avoidance of persons perceived	Gender	1.254	0.943–1.667	0.119
as mentally ill	Mentally ill relative	0.662	0.490–0.895	0.007
Kind treatment of persons perceived	Gender	0.931	0.679–1.276	0.655
as mentally ill	Mentally ill relative	1.763	1.211–2.545	0.002
Socialization with persons perceived	Gender	0.884	0.669–1.167	0.384
as mentally ill	Mentally ill relative	1.583	1.175–2.132	0.002
Feeling comfortable with persons	Gender	0.783	0.573–1.070	0.125
perceived as mentally ill	Mentally ill relative	1.501	1.083–2.080	0.015

TABLE 5. Attitudes of respondents toward mentally ill family members (*n* = 285) in a national survey, Jamaica, 2006

	Yes (%)	No (%)
Compassion	79.5	20.5
Care	81.2	18.8
Love	83.1	16.9
Concern	82.4	17.6
Anger	36.9	63.1
Fear	43.8	56.2
Disgust	43.1	56.9

They indicate that, controlling for the presence or absence of a mentally ill family member, gender was not associated with any significant differences in the attitudes and behaviors in question.

Respondents with mentally ill family members had overall positive attitudes toward their mentally ill relatives (Table 5). However, a sizeable proportion felt afraid of (43.8%), disgusted by (43.1%), or angry at (36.9%) their ill relatives.

The number of mentally ill respondents was small (n = 42) and there were no statistically significant differences between these respondents and others with respect to behaviors and attitudes toward those perceived to be mentally ill. Of borderline statistical significance was the greater prevalence of socializing with persons with mental illness among mentally ill re-

TABLE 6. Behaviors and attitudes toward persons perceived to have mental illnesses by mentally ill respondents versus non-mentally ill respondents in a national survey, Jamaica, 2006

	Respondents with mental illnesses (*n* = 42[a])		Respondents without mental illness (*n* = 1 264[a])				
	Yes	No	Yes	No	Chi square	*P*	Power[b]
Avoids mentally ill persons	22 (57.9%)	16 (42.1%)	615 (65.2%)	328 (38.4%)	0.860	0.354	18.3%
Physically assaults mentally ill persons	1 (2.7%)	36 (97.3%)	72 (7.8%)	846 (92.2%)	1.331	0.249	9.9%
Verbally abuses mentally ill persons	1 (2.9%)	34 (97.1%)	66 (7.4%)	828 (92.6%)	1.031	0.310	7.3%
Treats mentally ill persons kindly	33 (84.6%)	6 (15.4%)	711 (74.6%)	242 (25.4%)	2.002	0.157	30.1%
Socializes with mentally ill persons	23 (60.5%)	15 (39.5%)	409 (45.2%)	496 (54.8%)	3.454	0.069	51.8%
Feels comfortable with mentally ill persons	11 (31.4%)	24 (68.6%)	238 (26.5%)	661 (73.5%)	0.423	0.515	12.7%

[a] Overall number; actual numbers of respondents to questions vary.
[b] Statistical power calculated online at http://www.stat.uiowa.edu/~rlenth/Power. Accessed 28 October 2007.

spondents (60.5%) compared with other respondents (45.2%). Statistical power was calculated for each of the chi-square tests and was low (7.3%–51.8%) in all cases (Table 6).

DISCUSSION

The persons interviewed did not constitute a sample entirely representative of Jamaicans. Age and urbanicity were reasonably representative, but gender was overrepresented by females, which may reflect the matrifocal structure of households in the country. Additionally, women are more likely to remain at home than men, given their traditional role of taking care of the home. This would have made women more likely than men to be encountered by the survey team, since the survey was dwelling based. The sample was more educated than the general population but that may be partly because the general population statistic that was used for comparison took into account persons between the ages of 65 and 98+ years. Persons in this age range would have been automatically excluded from the survey and would also have been less likely to have had an advanced education, taking into account that their schooling would have occurred in an era when the country, including its educational system, was much less developed.

Other potential limitations of the study are related to the fact that heads of households were preferentially selected for participation, which may have meant that, of the female participants, those who were unmarried, and therefore heads of households, were more likely to be selected. The preferential selection of heads of households may also have contributed to the small number of mentally ill respondents, since persons with mental illnesses are less likely to be identified as heads of households. The failure of participants to respond to some questions may also have introduced some bias into the findings. On the other hand, one strength of the study is that a combination of chi-square analyses, *t*-tests, and logistic regression analyses (Tables 2 and 4) failed to demonstrate any confounding effects of sociodemographic variables.

In contradiction to our hypothesis, family members of mentally ill persons, although not devoid of stigmatizing attitudes or behavior, demonstrated those phenomena far less than persons without family members who had mental illnesses. Lee et al. (11) described a high rate of stigmatizing attitudes in the relatives of mentally ill persons and suggested that being a family member of a mentally ill person may not necessarily be protective against the demonstration of stigmatization. Our study indicates otherwise and the findings allude to some benefit to be gained from having members of the general population engage and interact more with persons with mental illnesses as family members of mentally ill persons, even if only because of obligation, currently do. This concept is one of the often cited benefits of community approaches to psychiatry. As noted in the United States Surgeon General's 1999 report on mental health (13), many advocates of deinstitutionalization believe that taking patients out of asylums and treating them in their communities should force greater acceptance and normalization of persons with mental illnesses. Deinstitutionalization in Jamaica began in the 1960s and has been quite successful. There has been a decline in mental hospital patients from 3 094 in 1960 to approximately 900 today; most (60%) are over the age of 65 years (14, 15).

Heginbotham (16), however, noted that deinstitutionalization is a double-edged sword, as apart from releasing persons from the isolation of asylums and reintegrating them into society, it also brings into sharp focus the behaviors of mentally ill persons that set them apart from mainstream society. Byrne (17) observed that, catalyzed by media bias and sensationalism, these behaviors are often converted into unfair and enduring stereotypes, which perpetuate stigma. It is worth noting, however, that, in Jamaica, representations of mental health issues by the local media tend to be positive (18). The media as a catalyst for stigma is therefore likely to be less significant than in other countries. Nevertheless, foreign television programming is heavily consumed by the Jamaican public (19) and could be expected to have some impact on perceptions, attitudes, and behavior.

One common stereotype of mentally ill persons is that of the dangerous and unpredictable lunatic (20–22). Both Crisp et al. (20) and Angermeyer and Matschinger (21) showed that this combination of features is commonly ascribed to mentally ill persons, especially those with schizophrenia. In our survey, 43.8% of respondents stated that they were afraid of their mentally ill relatives. That would be in keeping with a perception of dangerousness or unpredictability. However, the finding is somewhat surprising given the fairly well-established concept in the mental health literature that, although persons with major mental disorders are more likely than others to commit violent crimes (23), in reality, only a small percentage of mentally ill persons exhibit dangerous behavior (20). Our finding suggests that even family members of mentally ill persons exhibit a fearful bias toward their ill relatives. An alternative explanation for our finding is that the label of "mental illness" was reserved for relatives who exhibited the most disruptive, and therefore potentially dangerous, behavior. In other words, mental illness may have been underreported in cases in which it was easier to conceal its presence. If that did occur, it would have been in keeping with the presence of stigma and a desire to avoid being stigmatized.

Apart from being afraid of their mentally ill relatives, respondents had generally positive attitudes toward them. The only other negative attitudes were those of disgust, which was found in 43.1% of respondents, and anger, which was found in 36.9%. Despite fairly high levels of fear, disgust, and anger, respondents with mentally ill family members demonstrated significantly less stigmatizing attitudes and behavior toward persons with mental illnesses than did the gen-

eral public. This reinforces the concept that much may be gained by increasing opportunities for members of the public to interact with persons with mental illnesses. Increasing contact of the general public with persons with mental illnesses has been shown elsewhere to decrease stigmatizing attitudes (24). The challenge is to identify and implement creative strategies that go beyond providing mental health services in the community to achieve this goal of increased contact. As an example, one such strategy may be to provide employment opportunities specifically for persons diagnosed with mental illnesses. This would increase the exposure between potential stigmatizers and those who are potential targets of stigmatization, with the desired end result being a normalization of mentally ill persons and a decrease in their stigmatization. Publicity campaigns that attempt to portray mentally ill persons as "normal" individuals may also be useful and have been shown to be successful elsewhere (25).

No statistically significant differences were found when respondents with mental illnesses were compared with respondents without mental illnesses on issues pertaining to attitudes and behavior toward persons perceived as having mental illnesses (Table 6). On the surface, this appears to confirm our hypothesis that persons with mental illnesses have internalized and assimilated stigmatizing attitudes and behavior to the extreme extent that they also stigmatize other persons perceived as being mentally ill. The small number of mentally ill respondents, however, makes it very difficult to draw such a conclusion. The lack of any significant differences is likely to reflect low statistical power as opposed to the absence of any real differences between groups.

Our findings do not support the concept that stigmatizing attitudes toward mental illness have become deeply entrenched and internalized in individuals who themselves are at high risk of stigmatization. Many of these individuals (family members of mentally ill persons) exhibited less stigmatizing attitudes and behavior than other persons. Greater opportunities for exposure of the general public to persons with mental illnesses may therefore be an important strategy to ameliorate stigmatization.

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RESUMEN

Interiorización del estigma asociado con las enfermedades mentales: resultados de una encuesta en población general en Jamaica

Objetivos. La cultura del estigma asociado con las enfermedades mentales es especialmente intensa cuando las mismas personas que normalmente son víctimas de la estigmatización (personas con enfermedades mentales y los miembros de su familia) actúan de forma negativa hacia otras personas a las que asocian con enfermedades mentales. El objetivo de este trabajo fue determinar el grado de esta interiorización y la asimilación de actitudes, juicios y comportamientos estigmatizadores en personas en riesgo de sufrir este tipo de estigmatización en Jamaica.
Métodos. Se analizaron los datos de la encuesta nacional sobre salud mental de 2006. Se examinaron las variables demográficas, la presencia o ausencia de enfermedades mentales en los encuestados y los miembros de su familia y las respuestas relacionadas con el comportamiento y las actitudes hacia las personas que sufren enfermedades mentales. Se compararon tres submuestras (encuestados con enfermedades mentales, encuestados que tenían familiares con enfermedades mentales y encuestados sin ninguna de las características anteriores) mediante la prueba de la ji al cuadrado.
Resultados. Los encuestados que tenían familiares con enfermedades mentales presentaron menos probabilidad de mostrar diversas manifestaciones de estigmatización que los otros subgrupos (P = 0,009–0,019). No se encontraron diferencias significativas entre los encuestados con alguna enfermedad mental y los otros subgrupos en cuanto a la demostración de diversas manifestaciones de estigmatización (P = 0,069–0,515).
Conclusiones. El pequeño número de encuestados con enfermedades mentales dio como resultado un bajo poder estadístico para mostrar diferencias entre ese subgrupo y los otros. Las actitudes y el comportamiento significativamente más positivos observados en los encuestados que tenían miembros de su familia con enfermedades mentales indican que se pueden obtener beneficios si se crean más oportunidades para que la población general se relacione con personas que sufren enfermedades mentales.

Palabras clave Salud mental, prejuicio, Jamaica.