

Mental Health: Perspectives on Resolving Social Stigma in Employment for Ex-Mental Patients

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ABSTRACT

This paper discusses social stigma in the context of disability in general and mental health in particular, and the impact of stigma on the employment prospects of those who are defined as mentally sick or are ex-mental patients. The roots of stigma, and how stigma can be countered in society in an effort to promote successful rehabilitation, are also discussed.

Introduction

Throughout history, attitudes towards the mentally sick have been unfavourable and those labelled as mentally sick or ex-mental patients might have been unfairly treated because of this. One major obstacle in trying to help the mentally ill and ex-patients lies in the public's negative attitude towards them. Studies have shown that most people, whether young or old, highly educated or with little schooling, feel that the mentally sick are "dangerous, dirty, unpredictable, worthless" (Thio, 1983: 294). It is based on such attitudes that mentally ill ex-patients are discriminated against and denied jobs and any meaningful interaction with other members of society. To change this behaviour on the part of society, societal rehabilitation must be undertaken.

The stigma attached to mental ill-health has decreased greatly as our awareness and understanding of mental illness has increased. However, the mentally ill or former mental patients are still viewed with fear and distrust by the general public, family and friends. There is a general belief that once people receive mental help, their ability to make decisions is impaired. To make matters worse, there is a deep seated belief that there is no recovery from any type of mental illness.

It is a fact that many of the mentally sick who receive proper and adequate treatment get well and prosper at work, and live a satisfactory and productive life. Despite this, it is difficult for society to accept mental illness as being

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comparable to physical illness, and as amenable to treatment and prevention. The public often forgets that mental illness could be cured; that if people seek help this must not be held against them; that everyone has the right to receive help regardless of their social status in life; and that they should not be denied employment or receive negative or differential treatment because they once received help with mental illness. The treatment of, and attitudes towards, patients and ex-patients shows that societies still fear mental illness unreasonably.

In this paper, mental health is defined as adjustment to the world and to each other, with a maximum of effectiveness and happiness (Finkel, 1976).

Stigma

Goffman (1963) refers to stigma as an attribute that is significantly discrediting, and a stigmatised person as one who is thought to be not quite human or normal. Stigma is, therefore (English, 1977:207):

“the negative perceptions and behaviours of so-called normal people to all individuals who are different from themselves.”

The concept of stigma sums up an important social reality that the mental patient or ex-patient faces. The individual is in a situation where he is disqualified from full social acceptance. A stigmatised person is seen as having a ‘spoiled identity’ which may transform him into a faulty interaction. He is viewed as being strange and different and this induces negative reaction. Stigmatised persons, therefore, become discredited individuals who must be avoided so that others will not be polluted or defiled by them.

Stigma may affect people in two ways. First, relatives, associates and friends tend to treat them as inferior and channel them to marginal positions in society, and, second, they are often refused employment. Even when people are willing to live near or work with a former mental patient they do not want to marry one, or have their children marry one for fear that mental illness may be inherited. The stigma attached to mental health is often indicated by questions on the application form for employment, which ask if an applicant has ever had mental illness or been in a mental hospital. Even when one talks about finding jobs for ‘former mental patients’, the stigma is built into the label. There is no such label for former ‘appendectomy patients’.

A concept called ‘societal reactive theory’ (Mervin and Freeman, 1974) contends that once a person is labelled as having been mentally ill, he is channelled into a stereotyped role that forces him to function as an ill person. This is despite the fact that most of them show improved relationships with their families and friends after treatment.

The roots of stigma

The roots of prejudice may be the result of mental health organisational and interpersonal processes. In a mental health facility, the presence of prejudice

is caused by organisational pattern, emphasis upon the differences between patients and staff, and procedures which accentuate the helper-helped polarity. Prejudice is therefore rooted in the social role of the patient, and its attendant attributes of inferiority and inability, in the mental health facility. The patient confronts a closed, self-sufficient subculture with an unfamiliar value system. As patients they have a low level position in the status hierarchy. They are controlled and manipulated by forces over which they have no control. For example, the time, place, type of activity and method of treatment are dictated by the needs of the treatment-rehabilitation process. In effect, choices and decisions are imposed upon them (Gellman, in Stubbins, 1977).

There is also a distinction between patients and staff throughout a mental health facility. In this context, impairment serves as a symbol of exclusion from the dominant group. The patient is viewed as someone to be helped and the professional as the one with the skill and knowledge to do that. The patient is also seen a malleable individual who is to be shaped or educated into health.

Mental health is a personal as well as an interpersonal process which is affected by informal interpersonal relations. English (1977) contends that informally, interpersonal relations between non-disabled and disabled persons tend to follow a superior-inferior model of social interaction. The non-disabled person tends to demonstrate stereotyped, inhibited and over controlled behaviour with the disabled.

Informally, there are words in the language which describe disabled persons in devaluing terms. Words such as 'retarded', 'psycho', and 'dummy', connote stigmatisation. Within formal institutional structures, words exist which contribute to stigmatisation. For example, instead of 'retarded' we talk about 'mentally retarded'. Other words include 'emotionally ill', 'psychologically disturbed' and 'mentally deficient'. Although these words may be professionally valuable because they are descriptive, they often have a stigmatising effect.

One result of the segregation of the disabled is that they feel psychologically apart and inferior to their non-disabled peers.

Stigma and employment

Social stigma, as described above, has serious consequences for the employment of the one being stigmatised. Mental patients and ex-patients do not have the same opportunities as other citizens to obtain and retain employment. This is despite Article 23(1) of the Universal Declaration of 'Human Rights which states:

Everyone has a right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment. Within the context of employment, social stigma refers specifically to those

practices which deny rightful opportunities to people who are labelled mentally sick but could otherwise perform in the labour market. Once someone is labelled mentally sick, regardless of the fact that the person may be already cured, he is shunned by society, including employers. This leads to isolation, which in turn contributes to 'progressive sickness'. Thus, instead of the person feeling better with treatment, his condition may actually get worse. The prevailing societal attitudes, perceptions and beliefs affect the person's social functioning, including employment.

Most people believe that all mental sickness is chronic; that the mental patients and ex-patients are a danger to themselves and society; that they are invariably violent; and that they must be isolated from the rest of society and participation in societal activities, including employment. These societal perceptions and behaviour often lead to the almost permanent institutionalisation of those labelled mentally sick, and, once discharged from the institution, being given the status of fourth rate citizens, fit for nothing.

In terms of the implications of these beliefs, attitudes and behaviour for employment, the situation is extremely disturbing. It does not really matter whether these people were originally employed or not or whether they can still perform their jobs after mental care. As soon as the label is applied, all the doors to employment are closed immediately.

In situations where ex-patients are received back into employment, they have to constantly struggle to re-establish themselves as normal human beings. For most of the time they are carefully watched for any signs or hidden signs of abnormal behaviour. Not only do they have to struggle to keep their job, but even when they perform as expected, they stand very little or no chance of being promoted. In most cases even the so called open minded employers will try to keep the ex-patient in one place as long as is conveniently possible, and for as long as there is no detectable abnormal behaviour. Once they are defined as acting irrationally or abnormally, that will be the end of the employment. Thus, in situations where jobs are scarce and unemployment is very high, and where there are many of the so called 'normal people' who are employable, the stigmatised person stands no chance of being employed. An employer who gives a competitive job to a person with a label is really taking a risk when there are many others without a label.

Stigma and rehabilitation

When a stigmatising agent is manifest, for example mental sickness, one is faced with managing the tension created by the discrepancy between what is expected (a whole normal other person) and what is seen to be (disabled, crippled, ex-mental patient) (Chaiklin and Warfield, in Stubbins, 1977). Available data indicates that the feelings of stigmatised people who are expected to deviate from accepted norms affect their behaviour in significant

ways. Despite this, stigma is often not seriously taken into consideration in rehabilitation and after-care of the mentally sick.

Siller (in Chaiklin and Warfield:104), has emphasised the importance of the psychological components of rehabilitation and states:

"We are grossly negligent in discharging persons without adequate orientation as to reality, problems generated by interaction with family and community."

For example, it is also evident that studies that have used social variables to predict success of rehabilitation have focused on static factors such as age, self, and self concept rather than the dynamics that result during interaction.

The way a person sees himself affects his ability to carry through a successful rehabilitation course. Since being stigmatised affects behaviour, this affects progress in rehabilitation too. It is in this regard that Fishman (in Chaiklin and Warfield) suggests that three sets of variables must be considered in predicting success of rehabilitation. These are:

- (a) the experience and reality problems which the mentally sick or ex-patient must cope with;
- (b) the variety of emotional and behavioural responses with which the person reacts to these experiences;
- (c) identifying the dynamic processes that relate objective experiences and behavioural and emotional responses.

Stigma should therefore be discussed as part of rehabilitation. The people being rehabilitated should be helped to deal with their feelings and work out an effective method of stigma management. In rehabilitation, therefore (English, 1977: 221):

"Work should be regarded a humanising experience which provides individuals with dignity and prestige. Specifically, in work individuals have the opportunity to display competence. Since one of the most prevailing stereotypes of the disabled person is that they are basically incompetent, work can be associated with improving positive attitudes toward the disabled and different."

Remedy for stigma

This paper has emphasised that individuals who bear the label physically handicapped, mentally retarded, or mentally ill are often targets of prejudice and discrimination, which in many instances affect their chances of becoming fully functioning members of society. This discrimination is least evident in relatively impersonal situations and most blatant in either close interpersonal or business situations such as marriage and employment.

The remedy for this problem of stigma, prejudice and discrimination is through societal rehabilitation. Societal rehabilitation refers to efforts to reduce the general public's prejudicial attitudes towards the disabled

individual. This should be distinguished from individual rehabilitation which is designed to restore or reinstate the disabled individual into society.

There are three broad categories of societal rehabilitation. These are contact with the disabled individual; information about the disabled individual; and a combination of both contact and information. It is believed that attitudes of non-disabled persons towards persons with disability can be influenced positively by providing non-disabled individuals with an experience which included contact with disabled persons and information about their disability. Neither alone is believed to be sufficient, significantly and consistently, to have a favourable impact on attitudes towards disabled persons (Anthony in Stubbins, 1977).

The greatest problem with stigma is that it serves as a deterrent to recovery and may enhance the tendency to deny further needed help. To promote their well-being, ex-patients need a bill of rights which includes the following (Herman and Freeman, 1974): businesses and industry must evaluate them not as psychiatric or mental patients but as individuals; community services should be maintained to help them find satisfactory employment; employment application forms should eliminate questions about psychiatric treatment; individual firms should be helped by professionals, perhaps as consultants in the area of mental health, as well as physical health; and accurate public information about mental illness in general, in order to decrease fear and discrimination against the mentally ill.

To assist in the rehabilitation process, employers should re-examine the measures and processes they use to judge suitability for jobs, and make objective evidence the basis for suitability or non-suitability. Objective evidence supposes, for example, that prospective employees will be judged on psychiatric and social workers' reports as well as their own proven capabilities, as indicated by actual performance — rather than basing judgement on a label which, in most cases, is not an adequate measure of capabilities and performance.

In addition, people who fall mentally sick either before employment or during employment should be treated just as those with other diseases. There should be legislation to protect those who fall mentally sick on the job. Just as some people get certain benefits whenever they become sick, injured or handicapped on the job, so should the mentally ill. For example, in many industries, if employees suffer any physical injury on the job they get compensation and may continue working. However, when they fall mentally sick this means almost immediate dismissal or gradual displacement. Often no one will take the trouble to see whether the mental illness is a result of the job. Legislation should seek to remedy this oversight in the employment statutes.

Access to employment for people who have had mental health problems should be improved through a programme of vocational rehabilitation,

training, counselling, societal rehabilitation, and education. Where no appropriate employment opportunities exist, and alternatives must be developed, these should be done in such a way that they do not lead to segregation, stigmatisation and alienation.

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