The Role of Stigma in the Global Mental Health Crisis: A Literature Review

Yvonne I. Larrier

Indiana University South Bend

Monica D. Allen

San Jose State University

Irwin M. Larrier

Capella University

Author Note

Yvonne I. Larrier, Counseling & Human Services Department, Indiana University South Bend; Monica D. Allen, Department of Health Science and Recreation, San Jose State University; Irwin M. Larrier, Harold Abel School of Psychology, Capella University.

Correspondence concerning this article should be addressed to Yvonne Larrier, Counseling & Human Services Department, Indiana University, South Bend, IN 46615. E-mail: ylarrier@gcscored.com

Abstract

"This oppressive darkness is too much for me to bear alone, but my family and community tells me that nothing's wrong with me. They say if I would only pray more, or if I would reach out and help others, then I would be fine." This statement negates the depressive symptoms of the individual and attributes the "oppressive darkness" to the personhood of the individual in a negative light. Underlying those statements are erroneous beliefs, negative attitudes, and discriminatory behaviors related to mental illness. Stigma plays a large role in this. This is prevalent in many Low and Middle Income Countries as well as in High Income Countries. Across the globe, people with mental illness, either common mental health disorders or chronic mental illnesses, are not valued as equally nor treated as respectfully as persons who do not have mental illness. This article addresses the global mental health crisis and the continued need to make it a global health priority.

Keywords: Global mental health, Mental health, Stigma

The Role of Stigma in the Global Mental Health Crisis: A Literature Review

Introduction to the Mental Health Crisis

According to the World Health Organization (World Health Organization [WHO], 2001, para. 1), one in four people worldwide will be affected by mental disorders at some point in their lives. Experts agree on the most common mental health disorders (CMHDs): depression, anxiety, attention deficit hyperactivity disorder, and some behavioral problems. While effective treatments do exist for these, few individuals have access to such treatments. The barriers to access are stigma and discrimination, insufficient financial resources, shortage of mental health care specialists, and treatment gaps (Collins & Saxena, 2016). For example, in High Income Countries (HICs), an estimated two out of ten adults with CMHDs receive care from a mental health specialist in any given year (Patel et al., 2013); whereas in Low and Middle Income Countries (LAMICs), there is one psychiatrist for every 10 million people seeking mental health care (Collins & Saxena, 2016). Mental illness has always been with us, even when we can't see or hear it. For every notable and tragic event related to mental illness, there are numerous individuals around the world who are suffering in silence, shame, and isolation without knowledge, treatment and services, and without the support of peers, family, mental health providers, and their community.

The WHO defines mental health as “a state of well-being in which an individual realizes his or her abilities, is able to cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (Centers for Disease Control [CDC], 2013; University of North Carolina-Charlotte, 2016; WHO, 2001, para. 1).

Mental health is critical for families, communities, and societies to be productive, safe, and competitive, and is fundamental to everyone's ability to be a contributing citizen.

Global Mental Health

Global mental health (GMH) is an area of research and practice within global health that places a high priority on improving mental health and achieving equity in mental health for everyone worldwide (Cohen, 2014). In 2001, David Satcher, then Surgeon General of the United States, introduced the phrase "Global Mental Health" in an article titled "Global Mental Health: Its Time Has Come" (Satcher, 2001). Since the turn of the 21st century, GMH proponents, in collaboration with ministries of health, schools of public health, and other health and development disciplines have intentionally focused on ecologically valid, effective, and sustainable promotion, prevention, intervention, and treatment for all people everywhere in need of mental health care (Verdali, 2016). These concerted endeavors have burgeoned into further awareness and initiatives worldwide that identify global mental health as a public health priority issue.

Global Mental Health is a Global Health Priority

Global mental health is a growing field intricately connected to broader health, violence, and economic issues. Despite the high prevalence and cost of mental health disorders, an estimated 75% of those in lower resource settings with need do not receive intervention (Murray & Jordans, 2016), and 40-60% of people in HICs with mental disorders do not receive the care they need (Collins & Saxena, 2016). This most arresting inequity brings into sharp focus disparities in how care is provided; the lack of respect and human rights for persons living with mental disorders across the globe; persistent personnel shortage; and research, treatment, and

intervention gaps (Baingana, Al'Absi, Becker, & Pringle, 2015; Collins & Saxena, 2016; Patel & Prince, 2010). According to the WHO world health report (World Health Organization, 2014a), 10-20% of children and adolescents experience mental disorders. Half of all mental illnesses begin by the age of 14, three-quarters by the mid-20s and nearly 30% of people globally experience a mood, anxiety, or substance use disorder at some time in their life. Nearly one-third of the US population lacks adequate access to mental health care providers (Collins & Saxena, 2016). The numbers demonstrate that CMHDs are the leading causes of disability worldwide (Collins & Saxena, 2016; Wang et al., 2007). It is estimated that, by the year 2020, depression will be the second leading cause of disability throughout the world, trailing only ischemic heart disease (Murray & Lopez, 1996). The Global Burden of Disease report found that five of the top ten global contributors to years lived with disability are mental disorders (Murray & Lopez, 1996). Mental health disorders include, but are not limited to, early drug or alcohol use, antisocial or aggressive behaviors, and violence. The personal, family, community, economic, and societal costs associated with these and other mental health disorders are enormous. For example, in 2010 the economic cost of such disorders was estimated at $2.5 trillion globally, and by 2030 the cost is projected to reach $6.0 trillion (Bloom et al., 2011). Additionally, mental health disorders among young people impede their ability to achieve culturally appropriate developmental tasks, such as learning healthy intra- and interpersonal skills, succeeding in school, and transitioning to college and career. Also compromised are individuals' abilities to function adequately during their most productive years, when they plan their educational, family, and vocational futures (O'Connell, Boat, & Warner, 2009; Verdali, 2016).

Significance

Central to the WHO Mental Health Action Plan (World Health Organization, 2014b) is the principle that there is no health without mental health. The world has a growing need for mental health care that is culturally responsive and accessible both locally and globally. Personal and societal crises, such as police brutality, school shootings, and the heroin epidemic in the US, combine with the trauma, shame, discrimination, and human rights abuses suffered by millions of refugees fleeing their homes due to conflict and violence.

These personal and societal crises lay the foundation for mental health care to become a GMH priority because the current resources available to address them are inadequate, unequally distributed, inaccessible, inefficiently used, and static (Collins & Saxena, 2016). Unfortunately, according to WHO, for every 100,000 people globally, there are only nine mental health providers; and an extra 1.7 million mental health workers are needed in LAMICs (Collins & Saxena, 2016). Furthermore, the Mental Health Atlas (World Health Organization, 2014c) reported that most countries classified as LAMICs spend less than $2 USD per person; while in the US and other HICs, expenditure is estimated to be over $50 USD per person. Much of this expenditure is allocated for inpatient mental health care and mental health hospitals (WHO, 2014). Given these facts, it is safe to surmise that individuals with CMHDs most likely will not receive mental health care services.

In HICs, the shortage of mental health care providers is such that an estimated 40-60% of individuals with CMHDs do not receive the care they need (Bruckner et al., 2011). In LAMICs, the need is gargantuan; however, their ability to single-handedly bear such a huge disease burden requires help from all individuals, institutions, systems, and countries.

According to Collins and Saxena (2016), when it comes to mental health, all countries can be classified as developing countries.

Stigma as a Barrier to Mental Health

People avoid seeking mental health treatment for many reasons. Stigma is recognized as one of the toughest barriers to overcome, and can significantly complicate the experiences of individuals with a mental illness as well as those of their families (Bathje & Pryor, 2011; Corrigan, 2007). Satcher (1999) and Ben-Porath (2002) suggest that people are afraid to acknowledge that they have a CMHD, and at the same time are afraid to seek and receive treatment. Recognizing, seeking and receiving treatment appear to be stigmatizing. Public stigma can have profound adverse effects (e.g., devaluation, rejection, etc.) on individuals who are diagnosed with a CMHD. The consequences of stigma have the capacity to create more suffering and isolation than the actual mental illness itself (Martinez, Piff, Denton-Mendoza, & Hinshaw, 2011)

Stigma refers to a cluster of negative beliefs, attitudes, and behaviors that motivate societies to fear, reject, avoid, and discriminate against a particular trait, individual, or group of people (Mehta & Thornicroft, 2014). It is about disrespect, shaming, discrediting, and isolating, as well as about labels and language (Braithwaite & Ray, 1993; Centers for Disease Control and Prevention [CDC], 2010; Granello & Gibbs, 2016; Goffman, 1968; ISU Institute of Rural Health, 2011; Link & Phelan, 2001; Thornicroft, Wyllie, Thornicroft, & Mehta, 2014).

The general populace tends to view mental illness through four lenses: psychiatric symptoms, social skills deficits, physical appearance, and labels (Bathje & Pryor, 2011). All of these are negative and have unfavorable outcomes for the individuals with mental illness.

Persons with a CMHD have less value placed on them and are treated differently than people without a CMHD (Mehta & Thornicroft, 2014). For instance, individuals with a CMHD lose out on jobs, housing, supportive relationships, and other opportunities that are commonly enjoyed by individuals without a CMHD (Corrigan, Watson, Byrne, & Davis, 2005). Across the globe, stigma has been found to be common among all socio-demographic groups. Many individuals attributed their attitudes and interactions toward persons with mental illness to a variety of etiologies of CMHDs, including biology, genetics, medical disease models, supernatural forces, drug and alcohol use, social and life events, and psychological trauma (Magaard, Schulz, & Brutt, 2017; Mehta & Farina, 1997; Mehta & Thornicroft, 2014; Phelan, Cruz-Rojas, & Reiff, 2002). Given the varied belief systems at play here, it is no wonder that many individuals do not seek help for CMHDs, which creates unnecessary suffering and missed opportunities.

Numerous programs have been developed and implemented to reduce the effects of mental illness stigma (Griffiths, Carron-Arthur, Parsons, & Reid, 2014; Henderson, O'Hara, Thornicroft, & Webber, 2014; Horgan & Sweeney, 2010; Lloyd-Evans et al., 2015). However, many of these programs only seem to worsen the stigma by reinforcing beliefs of individual differences and defects (Corrigan et al., 2005). It is incumbent upon researchers, practitioners, and other stakeholders to develop models of intervention that take into account factors that impede the use of mental health services (Vogel, Wade, & Hackler, 2007).

The direness of the GMH shortages, treatment gaps, and burden of disease have propelled us to explore and propose the use of social-emotional competencies (SECs) terminology instead of mental health terminology as a stepping stone toward de-stigmatizing mental illness. This alternate use of terminology led the authors to develop an agricultural metaphor to use as a

mental health promotion strategy and as a stigma reducing alternative. Corrigan (2007) suggested that practitioners consider using and understanding diagnosis dimensionally rather than categorically as a solution to the stigma problem. In other words, instead of assigning an individual to a category and giving him or her a label (e.g., conduct disorder), the focus should be on the profile of symptoms, behaviors, or competencies (exhibiting poor self-awareness, relationship management skills, and self-management skills), thus unlinking from the mental health terminology and thereby reducing the stigma (Erreger & Foreman, 2016; Granello & Gibbs, 2016). Therefore, one of the goals of the proposed agricultural metaphor is to be a stepping stone in facilitating the transition from the use of mental health terminology to social-emotional language. The WHO in their *Thinking Healthy Intervention* manual emphasizes the need to employ commonly used terms such as stress and burden instead of depressive disorder or illness to avoid stigma (World Health Organization, 2015).

De-Stigmatization: Labeling and Language Matter

Stigma is presented in many forms, and researchers suggest that one of those forms is the continued use of labels and language associated with mental illness. Language can become a spotlight that highlights certain attributes or qualities of objects or people, making particular aspects of the world more prominent than others (Granello & Gibbs, 2016; Wolff & Holmes, 2011). For instance, the movement toward person-first language emerged from concerns that the use of labels to refer to individuals had the potential to promote bias, devalue others, and express negative attitudes (Granello & Gibbs, 2016). This person-first movement is grounded in the philosophy of linguistic relativity that states that language shapes perceptions of the world and significantly influences cognitive processes (Wolff & Holmes, 2011). In other words, the labels

and language we use to describe persons with mental illnesses shape how they perceive and treat themselves as well as how others perceive and treat them. These perceptions help to influence whether or not they pursue treatment and support.

A study conducted by Granello and Gibbs (2016) emphasized this principle that the terminology used to describe individuals in need of mental health support does matter. Three groups (undergraduate college students in general education courses, community adults, and professional counselors/counselors in training attending a counseling conference) completed the Community Attitudes Toward the Mentally Ill (CAMI) survey. Participants were randomly given a version of the instrument that used the term "the mentally ill" or another version that used the term "people with mental illnesses." The results showed that, in each of the three groups, the participants who received the survey using the term "the mentally ill" had significantly lower tolerance scores than participants who received the survey using the term "people with mental illnesses." People who had the lower tolerance scores perceived "the mentally ill" person as inferior and as a threat to society; these participants had less empathy for clients. The difference in tolerance based on words used was noticeable, meaningful, and real (Granello & Gibbs, 2016).

Full Engagement While Moving Forward (Every Piece Matters)

The fact that 40-60% of people in HICs with severe mental disorders do not receive the treatment they need paints a dismal picture for individuals in LAMICs with CMHDs. Clearly, when it comes to mental health, truly all countries are developing countries (Collins & Saxena, 2016). Stigma has been identified as one of the leading causes of individuals not receiving the care they need. This in turn translates to needless suffering, potentially causing individuals to deny symptoms, delay treatment and refrain from daily activities. Stigma can exclude people

from access to housing, employment, insurance, and appropriate medical care. Thus, stigma can interfere with prevention efforts (CDC, 2010).

De-stigmatizing mental illness requires full engagement globally from stakeholders at every level. No longer can disciplines afford to work in silos and expect this global crisis to be resolved. The global mental health crisis demands trained mental health specialists, concerned and committed lay people, practitioners, researchers, policy-makers, philanthropists, and governmental and non-governmental organizations from HICs and LAMICs to work together with one goal in mind: to increase access to culturally responsive mental health services by any means necessary.

References

Baingana, F., Al'Absi, M., Becker, A. E., & Pringle, B. (2015). Global research challenges and opportunities for mental health and substance-use disorders. *Nature*, *527*(7578), S172-S177.

Bathje, G., & Pryor, J. (2011). The relationships of public and self-stigma to seeking mental health services. *Journal of Mental Health Counseling*, *33*(2).

Ben-Porath, D. D. (2002). Stigmatization of individuals who receive psychotherapy: An interaction between help-seeking behavior and the presence of depression. *Journal of Social and Clinical Psychology*, *21*(4), 400-413.

Bloom, D.E., Cafiero, E.T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L.R., Fathima, S., …Weinstein, C. (2011). The global economic burden of noncommunicable diseases. Geneva: World Economic Forum.

Braithwaite, D. O. (1993). "Isn't it great that people like you get out?": The process of adjusting to disability. In E. B. Ray (Ed.) *Case studies in health communication* (pp. 149-160). Hillsdale, NJ: Lawrence Erlbaum Associates.

Bruckner, T. A., Scheffler, R. M., Shen, G., Yoon, J., Chisholm, D., Morris, J., & Saxena, S. (2011). The mental health workforce gap in low-and middle-income countries: a Needs-based approach. *Bulletin of the World Health Organization*, *89*(3), 184-194. doi:10.2471/BLT.10.082784

Centers for Disease Control. (2013). Mental health basics. Retrieved from http://www.cdc.gov/mentalhealth/basics.htm

Centers for Disease Control and Prevention. (2010). Attitudes toward mental illness: 35 states, District of Columbia, and Puerto Rico, 2007. *Morbidity and Mortality Weekly Report*, *59* (20), 619-625. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5920a3.htm

Cohen, Alex. (2014). A brief history of global mental health. In V. Patel, H. Minas, A. Cohen, & M. J. Prince (Eds.), *Global mental health: principles and practice* (pp. 3-26). New York: Oxford University Press.

Collins, P. Y., & Saxena, S. (2016). Action on mental health needs global cooperation. *Nature*, *532*, 25-27. doi:10.1038/532025a

Corrigan, P. W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work*, *52*(1), 31-39.

Corrigan, P. W., Watson, A. C., Byrne, P., & Davis, K. E. (2005). Mental illness stigma: Problem of public health or social justice? *Social Work*, *50*(4), 363-368. doi:10.1093/sw/50.4.363

Erreger, S., & Foreman, A. (2016). That's so borderline: #Language Matters when talking about Borderline Personality Disorder. Retrieved from http://www.socialworker.com/feature-articles/practice/that-s-so-borderline/

Goffman, E. (1968). *Stigma: Notes on the management of spoiled identity*. New Jersey: Prentice-Hall, Englewood Cliffs.

Granello, D. H., & Gibbs, T. A. (2016). The power of language and labels: The mentally ill versus people with mental illnesses. *Journal of Counseling & Development*, *94*(1), 31-40. doi:10.1002/jcad.12059

Griffiths, K. M., Carron-Arthur, B., Parsons, A., & Reid, R. (2014, June). Effectiveness of programs for reducing the stigma associated with mental disorders: A meta-analysis of randomized controlled trials. *World Psychiatry*, *13*(2), 161-175. doi:10.1002/wps.20129

Henderson, C., O'Hara, S., Thornicroft, G., & Webber, M. (2014). Corporate social responsibility and mental health: The Premier League football Imagine Your Goals programme. *International Review of Psychiatry*, *26*(4), 460-466. doi:10.3109/09540261.2014.924486

Horgan, A., & Sweeney, J. (2010). Young students' use of the internet for mental health information and support. *Journal of Psychiatric and Mental Health Nursing*, *17*(2), 117-123. doi:10.1111/j.1365-2850.2009.01497.x

ISU Institute of Rural Health. (2011). Anti-stigma: Do you know the facts? Retrieved from http://www2.isu.edu/irh/projects/better_todays/B2T2VirtualPacket/AntiStigma/Anti-Stigma%20Do%20You%20Know%20The%20Facts.pdf

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*(1), 363-385.

Lloyd-Evans, B., Sweeney, A., Hinton, M., Morant, N., Pilling, S., Leibowitz, J., & Johnson, S. (2015). Evaluation of a community awareness programme to reduce delays in referrals to early intervention services and enhance early detection of psychosis. *BMC Psychiatry*, *15*(1), 98. doi:10.1186/s12888-015-0485-y.

Magaard, J. L., Schulz, H., & Brutt, A. L. (2017). What do patients think about the cause of their mental disorder? A qualitative and quantitative analysis of causal beliefs of mental

disorder in inpatients in psychosomatic rehabilitation. *PLOS One*, *12*(1), e0169387. doi:10.1371/journal.pone.0169387

Martinez, A. G., Piff, P. K., Denton-Mendoza, R., & Hinshaw, S. P. (2011). The power of a label: Mental illness diagnoses, ascribed humanity, and social rejection. *Journal of Social and Clinical Psychology*, *30*(1), 1-23.

Mehta, N., & Thornicroft, G. (2014). Stigma, discrimination and promoting human rights. In V. Patel, H. Minas, A. Cohen, & M. J. Prince (Eds.), *Global mental health: Principles and practice* (pp. 401-424). New York, New York: Oxford University Press.

Mehta, S., & Farina, A. (1997). Is being "sick" really better? Effect of the disease view of mental disorder on stigma. *Journal of Social and Clinical psychology*, *16*(4), 405-419. doi:10.1521/jscp.1997.16.4.405

Murray, C. J., & Lopez, A. D. (1996). Evidence-based health policy--lessons from the Global Burden of Disease Study. *Science*, *274*(5288), 740.

Murray, L. K., & Jordans, M. J. (2016). Rethinking the service delivery system of psychological interventions in low and middle income countries. *BMC Psychiatry*, *16*(1), 234.

National Research Council and Institute of Medicine. (2009). Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. In O'Connell, M.E., Boat, T., & Warner, K.E. (Eds.). *Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education.* Washington, DC: National Academies Press.

Patel, V., Belkin, G. S., Chockalingam, A., Cooper, J., Saxena, S., & Unutzer, J. (2013). Grand challenges: Integrating mental health services into priority health care platforms. *PLOS Medicine, 10*(5), 1-6. doi:10.1371/journal.pmed.1001448

Patel, V., & Prince, M. (2010). Global mental health: A new global health field comes of age. JAMA : The Journal of the American Medical Association, 303(19), 1976–1977. doi:10.1001/jama.2010.616

Phelan, J. C., Cruz-Rojas, R., & Reiff, M. (2002). Genes and stigma: The connection between perceived genetic etiology and attitudes and beliefs about mental illness. *Psychiatric Rehabilitation Skills*, *6*(2), 159-185. doi:10.1080/10973430208408431

Satcher, D. (1999). Global health at the crossroads: Surgeon General's report on the 50th World Health Assembly. *JAMA*, *281*(10), 942-943.

Satcher, D. (2001). Global mental health: its time has come. *JAMA*, *285*(13), 1697-1697. Retrieved from http://jamanetwork.com/journals/jama/article-abstract/193712

Thornicroft, C., Wyllie, A., Thornicroft, G., & Mehta, N. (2014). Impact of the "Like Minds, Like Mine" anti-stigma and discrimination campaign in New Zealand on anticipated and experienced discrimination. *Australian & New Zealand Journal of Psychiatry*, *48*(4), 360-370. doi:10.1177/0004867413512687

University of North Carolina-Charlotte. (2016). *Mental health.* Retrieved from http://yourhealth.uncc.edu/mental-wellness

Verdali, H. (2016). Global Mental Health: An Introduction. *Journal of Clinical Psychology*, *72*(8), 761-765. doi:10.1002/jclp.22357

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology*, *54*(1), 40-50. doi:10.1037/0022-0167.54.1.4

Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., Bromet, E. J., Wells, J. E. (2007, September 8). Worldwide use of mental health services for anxiety, mood, and substance disorders: Results from 17 Countries in the WHO World Mental Health. *Lancet*, *370*(9590), 841-850. doi:10.1016/S0140-6736(07)61414-7

Wolff, P., & Holmes, K. J. (2011). Linguistic relativity. *Cognitive Science*, *2*(3), 258-265. doi:10.1002/wcs.104

World Health Organization. (2001). Strengthening mental health promotion. Retrieved from https://apps.who.int/inf-fs/en/fact220.html

World Health Organization. (2014a). Child and adolescent mental health. Retrieved from http://www.who.int/mental_health/maternal-child/child_adolescent/en/

World Health Organization. (2014b). Mental Health Action Plan. Retrieved from http://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2014/en/

World Health Organization. (2014c). Mental Health Atlas. Retrieved from http://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2014/en/

World Health Organization. (2015) Thinking healthy: A manual for psychosocial management of perinatal depression (WHO generic field-trial version 1.0). Geneva: WHO.