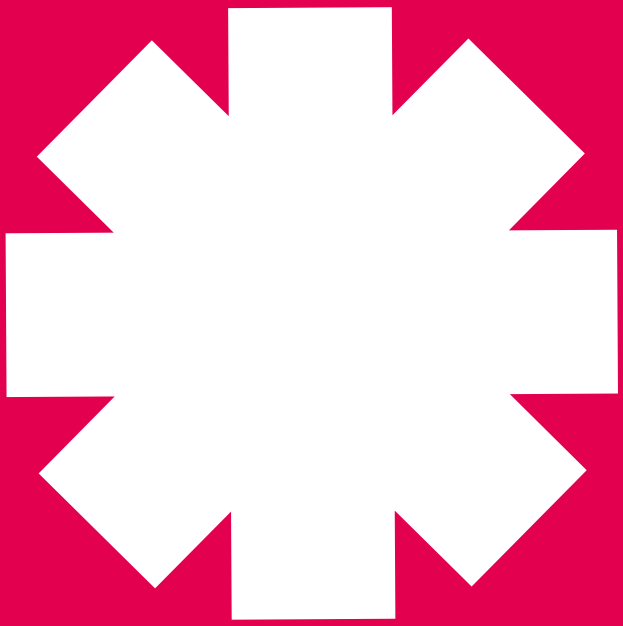
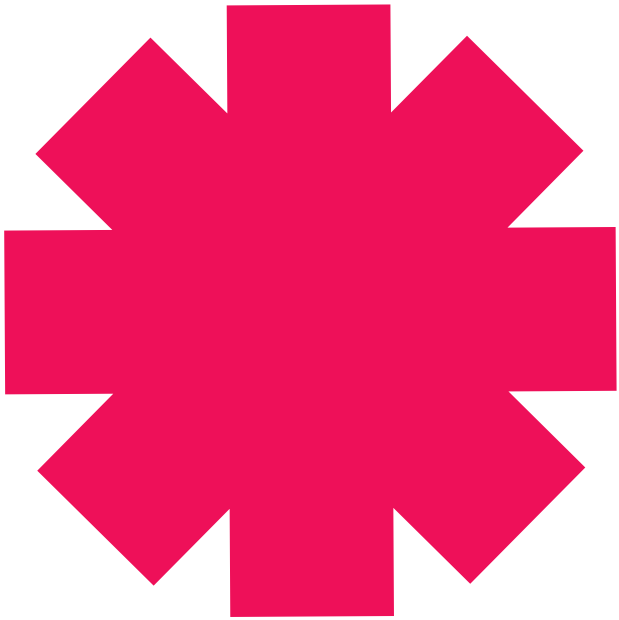


STIGMA AND DISCRIMINATION IN MENTAL HEALTH

in Catalonia, 2016



STIGMA AND DISCRIMINATION IN MENTAL HEALTH in Catalonia, 2016

It is literally impossible for us to personally express our gratitude to everyone who participated in this study or helped to made it possible, since they count in the hundreds and many did so anonymously. We would like to thank all of them.

We would also like to thank all of the organizations that collaborated, offered their facilities, or provided contacts.

Among others, ACFAMES, Activament, AFAMMEBAN, AFEMHOS, Altaia, Ammfeina, AREP, Benito Menni Complex Assistencial en Salut Mental, Centre d'Higiene Mental les Corts, Centre d'Higiene Mental Nou Barris, Centre Educatiu i Terapèutic Carrilet, Centre L'Alba, Centre Mèdic Psicopedagògic d'Osona, Club Social La Muralla, Comissió Mixta de Girona, Consorci de Salut i Social de Catalunya, Cooperativa Aixec, Coordinadora de Salut Mental de Terres de Lleida, Coordinadora de Salut Mental Tarragona-Terres de l'Ebre, CSMA Sant Andreu, CSMIJ NOU BARRIS, Família i Salut Mental de Girona i Comarques, Federació Salut Mental Catalunya, Federació Veus, Fòrum Salut Mental, Fundació DRISSA, Fundació Eulàlia Torras de Beà, Fundació Salut i Comunitat, Fundació Vidal Barraquer, Grup Atra, IMET, Institut d'Assistència Sanitària, Institut Pere Mata, La Unió Catalana d'Hospitals, Ondara Sió, Salut Mental La Noguera, Salut Mental Pla d'Urgell, Salut Mental Ponent, Salut Mental Sabadell, Sant Joan de Déu, Sant Pere Claver, Sol del Solsonès, Suport Castellar and UME Institució Balmes.

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Stigma and discrimination negatively affect many individuals with mental health problems in all different aspects of their lives. In our country, the struggle against stigma and discrimination has long been a part of the daily activities of many individuals and organizations. However, an initiative was still needed that could combine all of the work that had been done, facilitate the task of generating and promoting experiences, and use social marketing and first-person experience to achieve real changes in society's attitudes and behaviour regarding mental health.

With this objective, in 2010 Obertament was born, as the brainchild of the principal agents in the mental health sector in Catalonia. For the first time, individuals who were directly affected by mental health problems, such as family members or service providers, were working together with the different Catalan administrations and with Obra Social "la Caixa" to develop a long-term, ambitious project.

From then until now, Obertament's work has been intense: we have trained more than 170 activists against stigma in six towns in Catalonia; more than 3,500 individuals have been exposed to awareness-raising actions; we've given support to 24 local projects aimed at fighting stigma; we've developed several methodological kits, and we've exposed hundreds of thousands of Catalans to the first-hand experiences of our spokespeople and to our social marketing campaigns.

However, Obertament isn't just acting as a catalyst in the fight against stigma; we're also working to create a body of knowledge. Our desire to achieve results and measure the impact of our actions has driven us to seek the collaboration of the Department of Health in periodically measuring the level of stigma in Catalan society through the Catalan Health Survey (*Enquesta de Salut de Catalunya*). Thanks to this collaboration, we know that the way Catalans treat individuals with mental health problems has changed for the better since Obertament was created.

With this investigation, we've taken a step further. We wanted to understand the kind of discrimination experienced by individuals with mental health problems in Catalonia in order to help us identify how stigma is manifested in different aspects of people's lives. This knowledge can help us to more effectively focus our efforts in the coming years.

We would like to thank the hundreds of individuals and organizations that have participated in this extensive study. Without them, it wouldn't have been possible. This participation clearly shows the commitment of a large part of the population to fighting stigma and discrimination here in our country.

PROLOGUE

This is the framework document for the research project *Stigma and discrimination in mental health in Catalonia*, whose objective is to analyse stigma and discrimination in mental health. More precisely, in this document we analyse the different ways in which the stigma and discrimination suffered by those with mental health problems (MHPs) in Catalonia operate.

This research was carried out by combining quantitative and qualitative methodologies. During the qualitative phase, 14 focus groups were formed consisting of: individuals with mental disorders (5 groups), family members (2 groups), mental health professionals (2 groups), health professionals (1 group), human resources and contracting personnel (1 group), educational professionals (1 group) and young people (2 groups). In all, 112 individuals were interviewed.

In order to apply quantitative methodology, we created a questionnaire using the results obtained from the focus groups and from secondary sources. In all, we obtained 967 valid questionnaires from individuals who have or have had a MHP at some point in their lives. The data obtained provided results with a 95.5% level of reliability (2 sigma) and a maximum admissible error of 3.44% on the basis of maximum variance (p=q=0.5).

Individuals with MHPs have historically suffered from dehumanizing and discriminatory treatment, and as a result society has a debt to them. Today, behaviours that stigmatize and discriminate against them still persist, and need to be overcome. In this context, this research is aimed at identifying the negative aspects

that affect the quality of life and the socioeconomic opportunities of individuals with mental disorders.

It's very important to point out that the objective of this document, as well as all the documents corresponding with *Stigma and discrimination in mental health in Catalonia* is:

To explore and identify aspects related with the stigma and discrimination suffered by individuals with mental disorders.

Although we present a series of behaviours and practices that contribute to the stigmatization and discrimination of this group of individuals, it's worth mentioning that this is not the only kind of relationship that exists between individuals with MHPs and the rest of society.

The aim of this research is not to place the blame on any collective in particular, but to point out a series of key elements that need to be addressed. The fight against stigma requires teamwork and a coordinated effort on the part of different social agents. As a result, this research should help to place the need to change certain practices and socially dominant perceptions regarding mental health on the political agenda.

Finally, *Stigma and discrimination in mental health in Catalonia* has produced a framework document on the perception of mental health, and six specific documents related to the following areas: education, the context of employment, family, couples, the health sector, and social relationships.

INTRODUCTION

"I think that society is afraid, that it has a phobia with the whole mental issue. It's a phobia that's been around for centuries. It's like a taboo for society" (0.a)

According to DSM-5, "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities" (DSM-5, 2014).

The definition offered by the scientific community shows the enormous complexity and diversity of disorders included in this concept. This complexity makes it difficult for society as a whole to understand what mental disorders are, and what individuals with MHPs are like.

In order to face this social complexity, as individuals we tend to rely on a strategy that can save us cognitive effort when we need to analyse each and every one of the social situations we're met with on a daily basis. According to Mary Douglas (1986), there are pre-established, collective ways of classifying the world that we tend not to question, that help us to make generalizations in our everyday lives that save us cognitive effort. By creating categories, we avoid having to analyse each and every one of the situations we're met with. This

STEREOTYPES ARE AN EFFICIENT STRATEGY FOR CLASSIFYING INFORMATION ON DIFFERENT SOCIAL GROUPS

classification of the world is a naturalized "legitimized social grouping," which allows us to interpret the world in a quick and simple manner.

This strategy is known as a **social labelling process** or as **stereotyping**. According to Muñoz (2006) we can define stereotypes as socially-acquired knowledge structures that represent a general consensus on what characterizes a certain group of individuals.

Stereotypes are an efficient strategy for classifying information on different social groups. They are "efficient" inasmuch as they allow us to rapidly generate impressions and expectations on individuals belonging to a certain social category. As a result, attributing certain characteristics to individuals that make up a single social group produces a simplification of reality that allows us to understand it more rapidly. When we meet someone, the stereotypes we've built around whatever category they belong to automatically activate. Obviously, these simplifications include many inaccuracies and generally do not correspond with the reality of the individual being stereotyped. Nevertheless, eliminating stereotypes is a complex task, precisely because of the important role they play when it comes time to interpreting the world around us in an "efficient" way, with as little cognitive effort as possible.

Tajfel (1972) referred to the process we use to organize our surroundings into categories as **social categorization**. This social categorization process involves attributing imagined common traits and characteristics

to all the individuals that make up a certain category. It also causes us to exaggerate the differences perceived between people from different social categories.

In this chapter, we will see which stereotypes society tends to apply to individuals with MHP. In other words, which characteristics, traits, aptitudes or behaviours are attributed to individuals because they have a MHP. We will also see that these generalizations don't just cause certain concepts to become socially hegemonic; they also affect behaviour and how we relate with this social group. The stereotypes we apply to individuals with MHPs tend to be reflected in our behaviour which, as a result, is often discriminatory and stigmatizing.

Finally, we will see how individuals with MHPs tend to take on these stereotypes themselves. Auto-stigma happens when these individuals make socially dominant stereotypes their own and apply negative stereotypes to themselves.

THE STEREOTYPES WE APPLY TO INDIVIDUALS WITH MHPS TEND TO BE REFLECTED IN OUR BEHAVIOUR WHICH, AS A RESULT, IS OFTEN DISCRIMINATORY AND STIGMATIZING

1.
CHARACTERISTICS ATTRIBUTED TO INDIVIDUALS WITH MHPS

The discussion groups created through this project allowed us to create a list of the characteristics or traits that are generally attributed to individuals with MHPs. In order to understand the degree to which these are applied to individuals with MHPs, this list was included in our questionnaire. The graph below shows to what extent individuals with MHPs feel that these characteristics are applied to them.

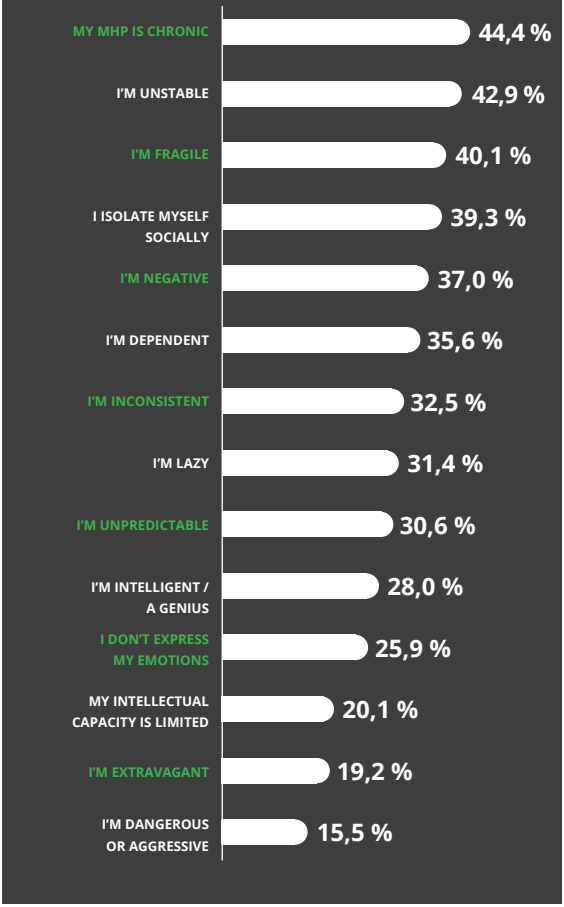
Graph 1.1 shows a series of characteristics that society tends to attribute to individuals with MHPs. 76.6% of those surveyed stated that at least one of these characteristics has often been applied to them because they have a MHP.

Almost half of those with MHPs (44.4%) stated that society has often assumed that their MHP was chronic, meaning that it would not be overcome. Instability (42.9%), fragility (40.1%) and social isolation (39.3%) are other characteristics that society tends to cast on those with MHPs.

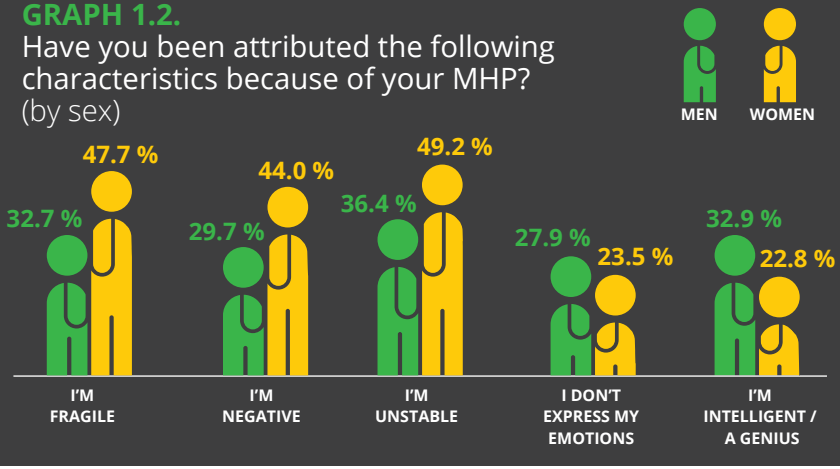
In terms of differences between men and women, the results of our study show that there is a stronger tendency to apply these characteristics to women than to men.

Graph 1.2. only shows characteristics where a significant difference was noted between women and men.

GRAPH 1.1.
Have you been attributed the following characteristics because of your MHP?



GRAPH 1.2.
Have you been attributed the following characteristics because of your MHP?
(by sex)

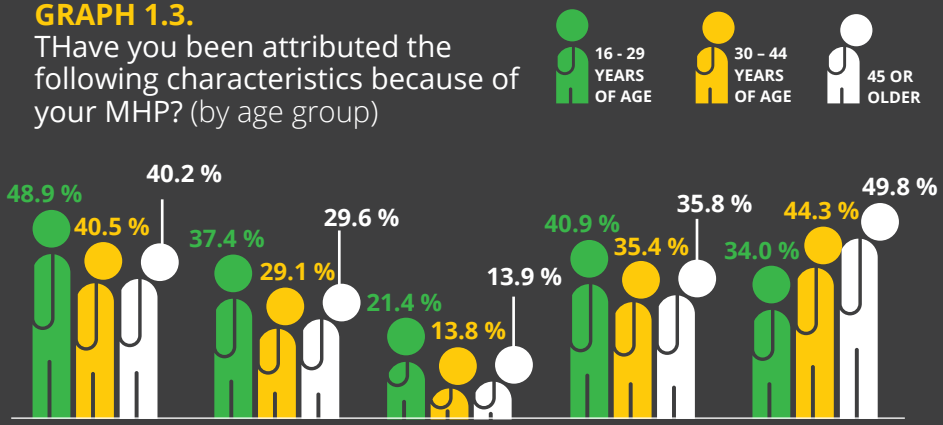


As can be seen in this graph, fragility (with a 15% difference), negativity (with a 14.3% difference) and instability (with a 12.8% difference) are characteristics that are especially attributed to women, while intelligence and genius (10.1% higher in men), as well as the lack of emotional expressiveness (4.4% higher in men) are the only traits that society tends to apply more to men than to women.

The following graph shows traits where differences have been noted between age groups. In general terms, the most significant differences are found between young people (15-29 years of age) and the rest of the adult population.

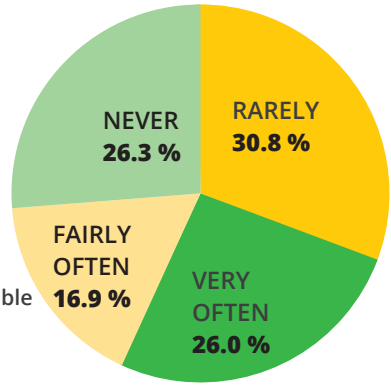
Instability (with a difference of more than 8% between young people and other age groups), laziness (with a difference of more than 7%), dangerousness or aggressiveness (with a difference of more than 7%) and negativity (with a difference of more than 5%) are characteristics applied especially to young people under 30. Only in terms of perception of chronicness do older individuals show significantly higher numbers.

GRAPH 1.3.
THave you been attributed the following characteristics because of your MHP? (by age group)



In the following sections, we analyse the social traits cast on individuals with MHPs in more detail, and we see what explanations emerge in relation to each of these traits.

1.1 PERMANENT INSTABILITY



GRAPH 1.4.
Have you been considered unstable because of your MHP?

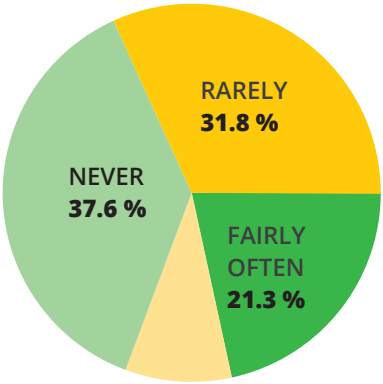
> *"Society doesn't understand that mental illnesses can be treated, just like any other illness. People with mental health problems have times when we're more stable and periods where we're more delicate." (0.a)*

The attribution of instability tends to include the idea that individuals with MHPs are permanently in a crisis situation or suffering from an outbreak. This generalization casts the typical characteristics of an outbreak on all individuals with MHPs and assumes these are constantly present. This idea doesn't take into account periods in which the symptoms of the disorder recede, nor does it contemplate periods of stability. It assumes that individuals with MHPs are permanently divorced from the reality around them, or that their perception of reality is perpetually altered.

The immediate consequence of this assumption is that all individuals with MHPs are viewed as permanently unstable. As we will see, this characteristic is strongly linked to two others: unpredictability and dangerousness. If an individual with a MHP is permanently under the effects of a crisis or an outbreak, then they are unpredictable or even dangerous.

Of those surveyed, 73.7% stated that they have been considered unstable because of their MHP. The frequency with which this assumption appears in the life of individuals with MHPs is, in addition, fairly elevated: 42.9% have been considered unstable *fairly often* or *very often*. These numbers are even higher among young people; almost half (48.9%) stated that this characteristic was often applied to them.

1.2 UNPREDICTABILITY



GRAPH 1.5.
Have you been considered unpredictable because of your MHP?

> *P2: Yeah, because they think you'll lose your head, and...*
> *P8: Right. And that instead of turning right, you'll turn left." (0.a)*

This characteristic refers to the idea that individuals with MHPs might unexpectedly begin to act in a socially unacceptable manner at any moment. This assumption includes certain reactions and behaviours that place those around them at risk and that, in addition, happen at random. According to this explanation, the reactions of people with MHPs don't follow any sort of pattern, they can't be predicted, and they appear unexpectedly. As a result, those around them have no way of predicting their behaviour.

In some cases, people state that this behaviour can also be harmful for individuals with MHP. When this assumption is cast on individuals with MHP, it causes others to fear or avoid them.

As shown in the table above, 62.4% declared that at some point they have been considered unpredictable, even though in most cases the actual presence of this characteristic is rare.

1.3 DANGEROUSNESS / AGGRESSIVENESS

"They think we're aggressive, that we're completely out of control, and that we act randomly." (0.a)

According to this perception, individuals with MHPs tend to be dangerous and aggressive. It's considered that the characteristics of their disorder –voices, negative thoughts, impulsiveness, etc.— cause them to commit violent acts. It's considered, as a result, that individuals with MHPs are potentially more dangerous than others.

The aggressiveness attributed to individuals with MHPs is differentiated from that of others because it's supposedly more irrational and has no motive or rational explanation, since it's a result of their altered perception of reality. In addition, it's believed that the violence exercised by an individual with a MHP would not be checked by social norms and has no limits, since these individuals do not follow normal social behaviour. "Society is afraid that we might have an outbreak" (0.a). This distinction between "violence with a motive" and the "irrational violence" of individuals with MHPs makes it more disturbing, more to be feared.

In our discussion groups, the idea that the media helps to reinforce this idea came up often, especially when murders with no apparent motive are associated with MHPs. As we will see, some cinema, literary or media icons have contributed significantly to creating the association between violent behaviour and MHPs.

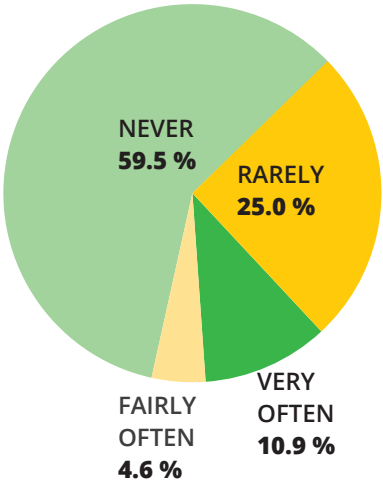
Of all the stereotypes analysed in our questionnaire, dangerousness or aggressiveness is the least present in the lives of individuals with MHP. Nevertheless, the number of individuals who claim to have been affected by this stereotype is quite relevant: 40.5%. This percentage is the sum of those who claimed to have been rarely, fairly often or very often affected by this assumption. However, those who are affected by this very or fairly often are relatively few (15.5%). This percentage increases among the young, 21.4% of whom have been considered dangerous or aggressive.

The combination of the information obtained from our questionnaires and focus groups suggests that this characteristic is more often attributed to MHPs in general than to individuals with MHPs. This phenomenon is also fairly habitual in other types of discrimination, and it responds to the cognitive resistance that makes social categorizations more prevalent even when personal experience refutes them.

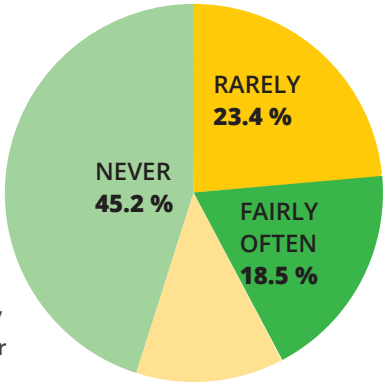
As an example, it's common to attribute certain characteristics to certain social categories (immigrants, homosexuals, etc.) that are modified when referring to concrete individuals. Expressions such as "Latin Americans are very lazy, but Julián is a hard worker" are an example of this. In these cases, the general prejudice against a group is maintained, even though the members of the group with which one has had some sort of a relationship contradict the stereotype society attributes to their social group. These individuals become the exception that proves the rule.

Because of this, even though the percentage of individuals with MHPs that claim to have been considered dangerous or aggressive is relatively low, it seems that the relationship established between aggressiveness and MHPs in general still has a strong social presence.

GRAPH 1.6.
Have you been considered dangerous or aggressive because of your MHP?



1.4 LAZINESS



GRAPH 1.7.
Have you been considered lazy because of your MHP?

> *"If you're in bed because of your medication or whatever, they say 'oh, they're really lazy, and they're in bed because they want to be.'" (0.a)*

Similarly to what happens with other disorders or illnesses, it's often assumed that individuals with MHPs tend to be lazy, and that they don't recover from their illness because they have no desire to do so. This explanation assumes that people with MHPs take advantage of their medical situation so that they don't have to work or manage their lives, etc. Laziness is not considered to be a direct consequence of the disorder, but rather an attitude adopted once the individual is granted leave or is recognized as having a disability.

This attitude is claimed to be the result of the fact that the benefits or the treatment received during this period 'spoils' people and makes them dependent, causing them to stop trying and to give up on their responsibilities.

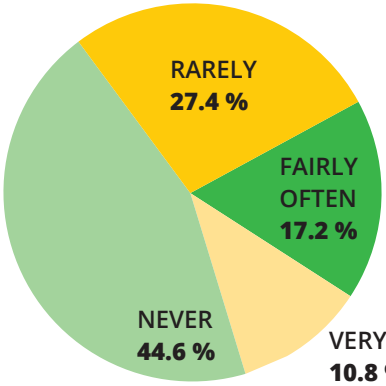
54.8% of individuals with MHPs state that they have been considered lazy by others at some point. As with aggressiveness or dangerousness, younger individuals suffer from this stigma more frequently than others: 37.4% state that they have been considered lazy *fairly often* or *very often.*

1.5
INTELLIGENCE / GENIUS

> *"They're mentally ill, but they're really happy, super intelligent, and they do really awesome things, you know? What do you think they feel like on the inside? Their life is like a video game. And the normal person says: this guy is really surprising— I mean, they don't suffer at all from their illness." (0.a)*

GRAPH 1.8.

Have you been considered intelligent or been attributed a certain genius because of your MHP?



This characteristic is based on the idea that the brains of individuals with MHPs have a different structure. This causes individuals with MHPs to have certain traits or qualities that place them above the rest, and explains why they have superior intelligence or are very creative. This idea is related to the myth of the "mad genius," according to which individuals with MHPs aren't limited by social conventions, and as a result they filter information and stimuli in unexpected, creative and innovative ways. Their MHPs are gifts that allow them to process information in an unconventional manner.

When this characteristic is attributed to individuals with MHPs, they become more attractive, and their "madness" may even be seen as something desirable. This explanation overlooks the suffering that their MHPs may provoke, as well as the MHPs or side effects of the medication that may diminish the creative and cognitive capacity of the individuals that suffer from them. Society considers that they are more creative or intelligent than the rest of the population, while overlooking the suffering that can result from MHPs.

55.45% state that they have been assumed to be especially intelligent or creative because of their MHP. This is one of the few assumptions that is cast with more frequency upon men. 32.9% of men indicate that they have been assumed to have these *attributes often* or *fairly often,* 10% more than in women. Among men 45 years old or older, this assumption is even more prevalent.

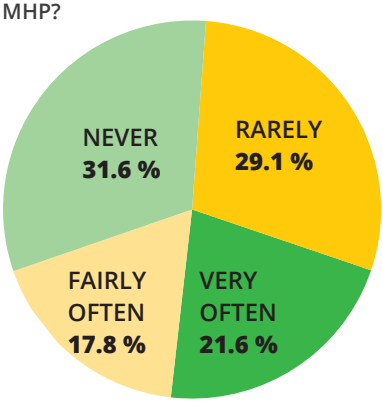
1.6 AFFECTIVE FLATTENING / SOCIAL ISOLATION

"She doesn't feel like she's understood because we don't understand her; and we don't understand her because she can't understand us, because her head works differently." (0.c)

This stereotype assumes that individuals with MHPs suffer from affective flattening, whether because of their medication or because of their mental disorder. In other words, they are absent, they don't express emotions, and they have a lost gaze and little emotional feeling. This trait supposedly prevents others from establishing an empathetic relationship with them, since emotional expression is necessary for quality relationships.

GRAPH 1.9.

Do others feel that you isolate yourself socially because of your MHP?



> *"We'll go to a friend's bar to spend the evening or whatever. He's there, he doesn't talk, he doesn't bother anyone, if you ask him something, he just goes 'good', and that's it." (0.c)*

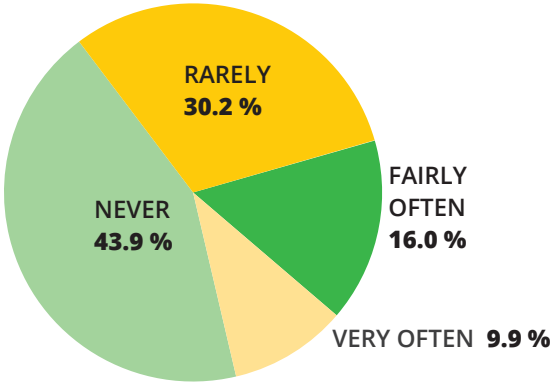
As a result, it's assumed that individuals with MHPs deliberately chose to separate themselves from social life and not to communicate with others. They are supposedly solitary individuals, closed off in their own worlds, who show no interest for their social surroundings and who shut themselves off from others; therefore, it's better not to bother them or interact with them.

This stereotype is very prevalent. More than a third (68.4%) have experienced it to some degree. 39.4% have experienced it *fairly often* or *very often.*

The stereotype of emotional inexpressiveness affects 56.1% of individuals with MHPs. Together with the stereotype of intelligence and genius, this is one of the two stereotypes that is more often associated with men than with women.

GRAPH 1.10.

Do others feel that you don't express your emotions because of your MHP?



1.7 CHRONICNESS

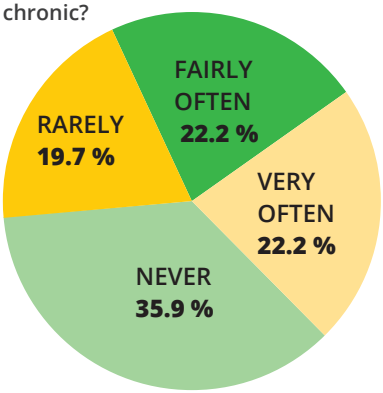
> *"**P3**: Depression can be temporary. If you have schizophrenia once, you just have one outbreak, then you're schizophrenic.*
> ***P2**: Right, you mean you're always schizophrenic.*
> ***P3**: But you can be depressed over a certain situation and then get over it." (0.c)*

According to this stereotype, once MHPs appear they become chronic and do not subside. Chronicness is a characteristic that's principally associated with psychotic disorders and schizophrenia.

As can be seen in the quote above, this assumption strengthens the relationship between MHPs and the identity of the individuals that have them. Instead of *having* them, they *are* them; the individual no longer has a MHP, they *become* a MHP, and instead of *having* schizophrenia, they *are* schizophrenic. As we will see, this totalization of the relationship between the individual and their MHP has negative effects, and strengthens auto-stigma.

The chronicness of MHPs doesn't simply refer to a situation that will remain unchanged throughout the

GRAPH 1.11.
Have others considered your MHP chronic?



individual's life; it also serves to underline the fatality of the future with which the individual is faced. It allows others to assume that if an individual is affected by a MHP, there's nothing they can do to improve their quality of life, and they'll be condemned to suffer from it for their entire lives. To this end, the idea that MHPs are always chronic promotes an irreversible fatality with strong negative connotations.

As we indicated at the beginning of this chapter, chronicness is the characteristic that society most frequently attributes to individuals with MHPs. 64.1% indicated that this stereotype has been applied to them at some point. This tendency is less pronounced in individuals under 30 (49.3%), where the attribution of chronicness seems not to be sufficiently consolidated.

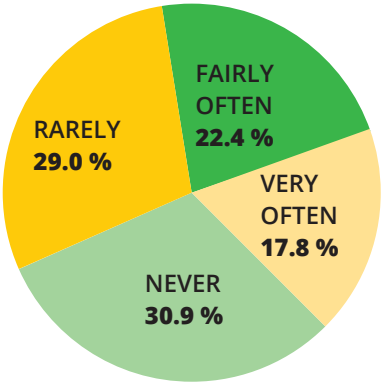
1.8 FRAGILITY

"I think that what he means is that when you talk with these people, you can never tell them that something isn't acceptable. In other words, even if they're doing something completely out of line, you can't tell them not to. Or if they say something, always respond to them; like if they ask something, you have to answer them, pay attention to them, keep them satisfied." (0.c)

This stereotype assumes that individuals with MHPs that don't externally show any imbalance are really in a state of precarious balance. Even though they seem to be fine, the smallest thing might bring them crashing down. In addition, because of the nature of their MHP, it's impossible to know what might provoke the collapse of their state of balance.

This stereotype suggests a cardboard box with "fragile" marked on it. Externally, it doesn't seem fragile, but we've been informed that it is. We don't know what is inside, we don't know if what we're supposed to

GRAPH 1.12.
Have you been considered fragile because of your MHP?



avoid is dropping the box, turning it upside down, or shaking it.

To continue with this analogy, individuals with MHPs are fragile, we don't know what their breaking point is or what might bring them crashing down, and as a result it's preferable not to get close to them or interact with them. We need to avoid doing something in our interactions with them that might spark an outbreak or a crisis. Since we don't know which of our actions might do so, it's better to keep a safe distance. This stereotype, as we will see, contributes significantly to promoting attitudes of fear, avoidance or distance from individuals with MHPs.

Fragility is one of the characteristics that are most often attributed to individuals with MHPs. More than two-thirds claim that they have been qualified or characterized as fragile (69.1%). Of all the stereotypes considered in this project, fragility shows the greatest difference between men and women. Women claim to have been considered fragile 15% more often than men.

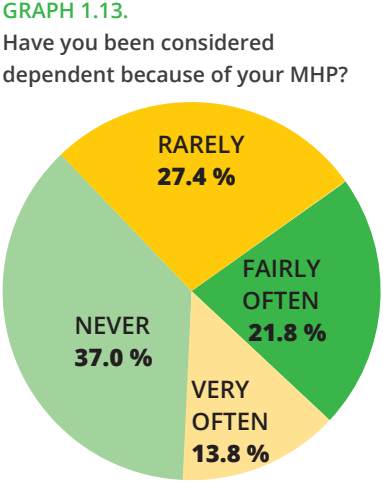
1.9
INABILITY / DEPENDENCE

"I think that people also have the fantasy that people with mental disorders aren't useful or capable, or at least not enough to fulfil their roles." (0.a)

The stereotype of inability refers to a diverse group of activities from everyday life that individuals with MHPs can't correctly execute. As a result, it's assumed that they are dependent on others supervising and managing those activities. It's assumed that individuals with MHPs don't have the abilities they need to manage their finances, they aren't prepared to be parents, or they're not capable of driving.

This idea is based on the fact that, at certain moments, some individuals with MHPs do indeed have difficulty managing certain aspects of their everyday lives. However, this characteristic is generalized and is cast on all individuals with MHPs, who are assumed to be perpetually affected by these difficulties. Therefore, they are all stereotyped as incapable.

GRAPH 1.13.
Have you been considered dependent because of your MHP?



When individuals are stereotyped as incapable and dependent, this idea becomes a self-fulfilling prophecy (Merton, 1968). In other words, if the individual's social surroundings –family and friends, for example— assumes that they are incapable of doing certain things, the way they are treated will coincide with this expectation. This causes the person to doubt themselves, to feel insecure about their abilities, and this ends up confirming the suspicion. The phenomenon of the self-fulfilling prophecy happens, then, when expectations regarding the abilities of an individual influence how they see themselves.

The attribution of dependency or a lack of autonomy is fairly frequent (63%) although this characteristic is attributed *fairly often* or *very often* 36.5% of the time.

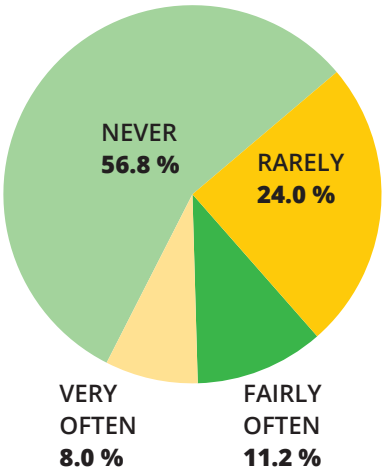
1.10 EXTRAVAGANCE

"I notice that my cousin isn't doing too well when I talk to him and he doesn't look at me. I'm talking with him and he's like that, and I think 'oh, that's it, he's off in his own world', as I say." (0.c)

This stereotype is based on the idea that individuals with MHPs don't follow the social norms and codes that regulate interaction and communication. It's believed that one of the traits of individuals with MHPs is strange behaviour, a non-empathetic communication style or the absence of the ability to connect with others.

When this stereotype is present, anything an individual with a MHP does that doesn't fit with social norms and conventions is explained as a symptom of their MHP. And, on the other hand, behaviours that don't respond to social conventions tend to be associated with MHPs, whether the individual has one or not. This stereotype can result in what is sometimes referred to as a 'false positive', meaning that individuals without a MHP are considered "mentally ill."

GRAPH 1.14.
Have you been considered extravagant because of your MHP?

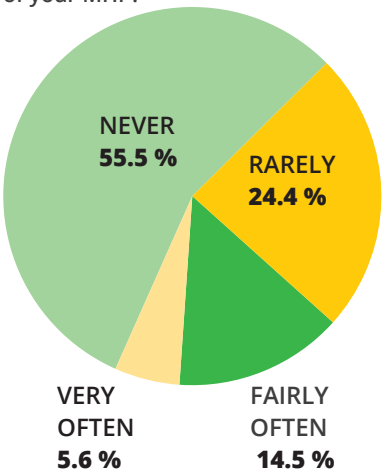


In addition, this characteristic exaggerates the inconvenience of the behaviour by associating it with a discriminated social category, that of individuals with MHPs. As a result, once the behaviour has been associated with the fact that the individual suffers from a MHP, it becomes even more extravagant, unusual or inappropriate. Paradoxically, this stereotype causes those with MHPs to feel more inhibited than others, since anything they do that varies from social conventions will be considered a symptom of their disorder.

Although it appears less than other stereotypes (19.2% claim to have experienced it *fairly often* or *very often*), extravagance has a notable reach: 43.2% indicate that they have felt it at some point.

1.11 COGNITIVE DEFICIT

GRAPH 1.15.
Have others considered you to have a low intellectual capacity because of your MHP?



"What I find is that sometimes terms get mixed up. Like 'mental disorder' and 'mental retardation', you know? You even find it working with the patients themselves, sometimes; they're confused, too: if I have a mental disorder, it means I'm less intelligent or less capable, right?" (0.d)

Since individuals with MHPs are believed to be divorced from reality, this is interpreted as a cognitive deficit. According to this explanation, individuals with MHPs have difficulty with learning, abstract reasoning or correctly understanding aspects of everyday life, since the MHP must significantly reduce their cognitive abilities.

44.5% of individuals with MHPs have been considered to be lacking intellectual capacity at some point in their lives, even though most often this assumption affects them *rarely* (24.4%).

1.12
CONTAGIOUSNESS / SOCIAL CONTAGIOUSNESS

> *"**P1:** As if it were contagious. Keep these people away because they can be inferior or problematic...*
> ***P2:** Because you're afraid you'll be associated with them.*
> ***P3:** Problematic, or you don't want to be seen with this person, or...*
> **P1:** *You don't want trouble." (0.a)*

Even though this aspect was rarely mentioned in our focus groups, it's worth addressing. The idea that a MHP can be contagious appears in two clearly different senses.

Firstly, there's the idea that the probability of developing a MHP is higher among those who interact with individuals with a MHP. This doesn't happen because of physical contact or proximity, but because of being in contact with an individual who lives in a disordered and chaotic reality. Associating and interacting with individuals with MHPs includes the risk of being drawn into this disorganized "other world," and, as a result, of developing a MHP or suffering from some kind of mental disorder.

According to this explanation, contact and interaction with individuals with MHPs draws us into a chaotic, unbalanced universe that places our mental stability at risk. As happens with other characteristics that we mention in this section, this argument justifies an attitude of caution around individuals with MHP.

The second manifestation of the idea of "contagiousness" is on a more symbolic and social level. According to this idea, interacting with individuals with MHPs involves the risk of being socially rejected. Since individuals with MHPs are socially discriminated, those who openly interact with them can also attract discrimination. In this case, what is contagious isn't the MHP itself, but the discrimination and stigma that are associated with it.

1.13
THE FALLACY OF THE SINGLE CAUSE

> *"Everything is related; we can't even get angry. If I get mad and start to yell, they say 'look at how unbalanced you are!' Of course, if someone without a disorder starts yelling, they say 'look how stressed he is'." (0.a)*

As we've seen, stereotypes are assigned indistinctly to all the individuals that make up a certain social category. These traits are seen as permanent, chronic and unchanging. Rarely is reference made to the episodic or occasional character of some of the characteristics attributed to individuals with MHPs.

Because of this, as we have seen, the individual becomes associated with their disorder, and others state that they "*are* schizophrenic" instead of considering, for example, that "they *have had* a schizophrenic episode." This totalization of the person's relationship to their MHP helps to promote the fallacy of the single cause.

This fallacy arises when any attitude or behaviour is seen as a symptom of the individual's disorder, and no other possible factors or variables are taken into account. The MHP becomes the explanation for everything. This simplification of causal reasoning denies the existence of the individual beyond their disorder. The person becomes their MHP.

Because of this, any way the person with a MHP behaves is understood as a symptom of their disorder, which causes them to lose legitimacy when it comes time to express their emotions or express their opinions, which are pathologized and seen with contempt.

2.

SELF-ATTRIBUTION OF CHARACTERISTICS WITH NEGATIVE CONNOTATIONS: SELF-STIGMA

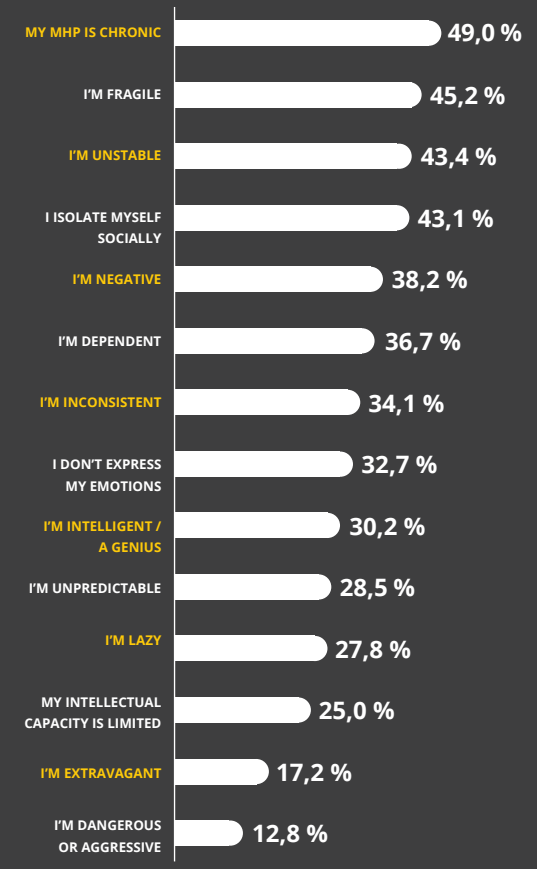
“Even we are embarrassed of ourselves.” (0.a)

Self-stigma happens when individuals with MHPs take on the stereotypes that society attributes to them –those described in the previous section— they make them their own and attribute them to themselves.

This process negatively affects individuals, since they perceive that they are part of a social category that is associated with negative traits. They become part of a deteriorated (Goffman, 1963) or negative (Tajfel, 1972) social identity. When individuals with MHPs self-stigmatize themselves, they are affected by the psychological effects of the loss of self-esteem and the self-attribution of characteristics with negative connotations.

Graph 1.16 shows the degree to which individuals with MHPs interiorize and self-attribute the characteristics that society casts on them because of their MHP.

GRAPH 1.16.
Have you attributed the following characteristics to yourself because of your MHP?



The self-attribution of chronicness (49.0%) is the most frequent. Fragility (45.2%), instability (43.4%) or social isolation (43.1%) are other stereotypes that individuals frequently cast upon themselves.

In general, those who participated in the study referred to two key processes that consolidate self-stigma among individuals with MHP.

2.1 DIAGNOSTIC LABELS AS A BASIS FOR SELF-PERCEPTION

"We're a little violent, and the truth is that we tend to break or hit things, and stuff like that. So of course, our families and society in general tend to get scared..." (0.a)

The social vision of MHPs, as we saw in the previous section, tends to attribute a series of negative traits and characteristics to individuals with MHPs. Because of this, the application of a diagnostic category not only medically identifies the problem affecting the individual, but it simultaneously becomes a category or label that becomes so assimilated that it permeates every aspect of the individual's concept of themselves.

The diagnostic category becomes the individual's image of themselves. They construct this image around the idea that they belong to a certain social category: that of individuals with MHPs. As a result, their self-image is rebuilt according to their self-categorization. In other words, it's based principally on their belonging to a certain social group or category. When the individual classifies themselves as part of this social group, they take on the negative traits and characteristics that society casts on individuals with MHPs.

This self-stigmatization process causes individuals to self-evaluate themselves with the expectation that they will fulfil the stereotypes assigned to them by society. When individuals with MHPs are aware of these stereotypes, they interiorize them and make them

their own, which increases the possibility that they will see themselves through these stereotypes. Since the person expects to fulfil the characteristics that society attributes to them, they tend to over-interpret their behaviour and actions as empirical proof that they are indeed 'playing the part'.

As a result, it's likely that the individual with a MHP will behave in ways that are common for the general populace, but they will reinterpret them as the result of the symptoms of their disorder and analyse them according to socially predominant stereotypes. As a result, their behaviour becomes abject, the exceptional and negative result of their disorder.

One example of this effect is when the individual considers that some of the reactions that are the result of ill humour, such as breaking things or slamming doors, are violent actions provoked by their illness, or that changing their opinion on a certain topic is irrevocable proof of the instability that results from their disorder. Put simply, self-stigma causes the person to pathologize some of their behaviours by considering them exceptional or anomic (beyond the bounds of social norms).

2.2
THE PERCEPTIONS OF THE INDIVIDUAL'S CLOSE SOCIAL CIRCLE AS THE BASIS FOR SELF-PERCEPTION

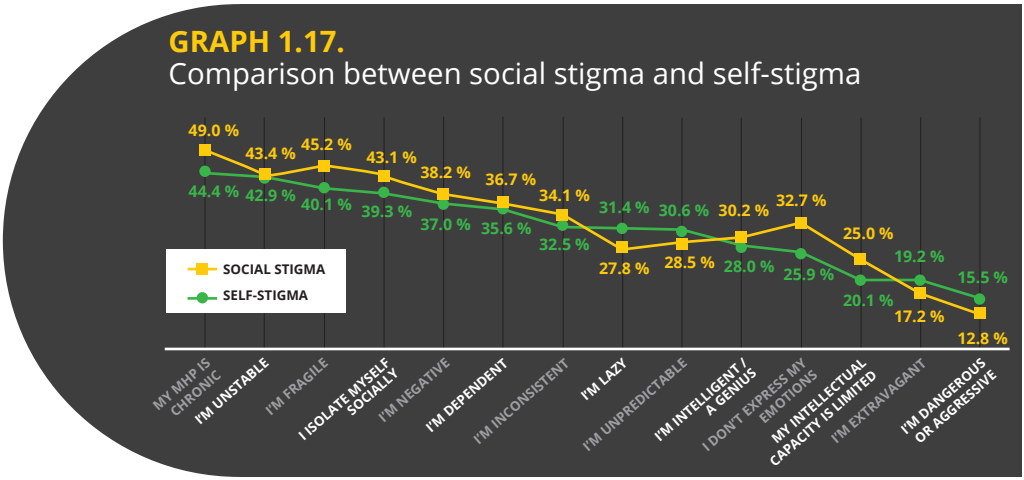
*"**P6:** We're capable. We're not incapable just because we have an illness. We can do it. What happens is that even our families hurt us sometimes. They make us believe that we aren't capable. Then, sometimes, even we believe it. Even we do...*
***P1:** With the way they treat us...*
***P6:** And it affects us...*
***P2:** Yeah, we're ashamed, too.*
***P6:** And we're ashamed of ourselves.*
***P4:** Sometimes we hear it so much...*
***P6:** That we just collapse." (0.a)*

Self-stigma is strengthened and consolidated by the repeated actions of the individual's closest social circle, which reminds them of the negative traits and characteristics associated with their MHP.

Since our self-image depends on the feedback provided by our social surroundings, when certain traits are repeatedly cast on us we end up interiorizing them. As we will explain below, the actions of our families, friends, etc., play a key role when it comes time to consolidate our self-esteem. It's worthwhile mentioning that some of the traits associated with individuals with MHPs, such as incapacity or dependence, are assimilated and interiorized when the individual's immediate social circle reinforces them.

2.3
COMPARISON BETWEEN SOCIAL STIGMA AND SELF-ESTEEM

GRAPH 1.17.
Comparison between social stigma and self-stigma



The following graph summarized the comparison between social stigma and self-stigma as related to the different characteristics analysed in our survey.

In general terms, for most of the characteristics analysed, self-stigma is slightly higher than social stigma. This indicates that individuals with MHPs interiorize the stereotypes society attributes to them in a significant manner. This difference between stigma and self-stigma causes individuals with MHPs to see themselves more negatively than those around them, which clearly indicates the importance of the opinions of others in the construction of one's own self-image. The importance of the opinion of one's social surroundings causes individuals with MHPs to "over-incorporate" the stigma and discrimination that society applies to them.

Even though the differences observed between stigma and auto-stigma aren't very wide, those in which the difference is largest are: a "lack of emotional expression" (6.8% difference), "fragility" (5.1%), "lack of intellectual capacity" (4.9%) and "chronicness" of the MHP (4.6%).

3.

DISCRIMINATORY TREATMENT

As we explained, the social attribution of certain characteristics and negative traits to individuals with MHPs predetermines our attitude towards them. This predisposition towards the social group, which is fundamentally negative, is manifested in the way we treat and interact with these individuals.

Discrimination consists of the actions or behaviours that affect individuals to whom prejudice is applied. In fact, the relationship between the perception of individuals with MHPs (stereotypes), the predisposition or behaviour that we have towards them (prejudice) and the manifestation of these ideas as negative actions and behaviours (discrimination) follow a circular, self-sustaining pattern. Discriminatory treatment of individuals with MHPs feeds and reinforces the stereotypes we apply to them.

In this section, we'll explain which attitudes and behaviours generally exist around individuals with

MHPs, and we'll show the relationship with the stereotypes reviewed in the previous section.

In the specific documents pertaining to *The Perception of Mental Health in Catalonia*, we will present the kind of treatment received by friends, family members, partners, in educational contexts or in the context of employment. This framework document will only focus in a general manner on the behaviours that result from prejudice against individuals with MHPs.

As an introduction, it's worthwhile mentioning that 80.1% of those interviewed claimed to have been treated unjustly in some area of their lives (personal, social, in the workplace, or socio-sanitary) because of their MHP. It's also worth noting that 54.9% claimed that, either in one of these areas or on the part of a specific person, this negative treatment was fairly or very frequent.

3.1 FEAR

The most immediate consequence derived from the stereotypes attributed to individuals with a MHP seems to be the adoption of a fearful attitude that defines the way we treat the individual. Below, we present the two principal motives that explain this fearful attitude.

FEAR AS A RESULT OF IGNORANCE

> *"She already mentioned the whole 'fear as a result of ignorance' issue, and I think that's a big issue. Human beings need some kind of a solid foundation we can build our lives on, to put it one way. And when you see that someone doesn't have that solid foundation, or that they might be a little unstable or that you can't really explain why... If you break a leg, you've got a broken leg; but mental issues are much harder to explain. Sometimes you can't even explain why you're faced with a certain situation. How can someone know if they can't get inside your head? Then, I guess what that person does from the outside is (...) –consciously or unconsciously, I don't know— generate that prejudice as a way of protecting themselves from something they don't understand." (0.c)*

When a discussion emerges on why it's common to react fearfully to individuals with MHP, people often cite ignorance regarding mental health disorders and how they affect individuals. Since MHP are still relegated to the private sphere and they are phenomenons that generally aren't openly addressed means that they are still an unknown for individuals who haven't been closely affected by them.

In discussion groups, the idea that mental health is a little-known subject often comes up. It's often mentioned that most people have little information about this

topic, and that it's often confused with other questions (intellectual disabilities, Alzheimer's or senile dementia).

The lack of knowledge regarding MHP causes people to be seriously afraid of establishing contact with it. This fear is manifested in behaviours and ways of interacting with individuals with MHPs based on mistrust. As we will see, the most common reactions to fear of MHPs are either avoidance and rejection, or condescending treatment and overprotection. Either way, when the principal reaction to MHPs is fear, the way people interact with those with MHPs rarely takes place on an equal footing.

FEAR OF THE MIRROR EFFECT OF MHPS

"Sometimes you hear opinions from people who are really scared about the whole craziness thing, you know? I guess it's because it connects with... well, with that part of each of us that's a little bit scary." (0.d)

Individuals who don't have MHPs are often afraid of individuals who do because they represent another potential version of them. As Bauman (1998) explains, rejection and discrimination against these "different ones" happens because they represent the "flip side," the other side of the mirror. This mirror relationship with MHPs makes it evident that the separation between those with MHPs and "healthy" individuals isn't clear-cut, but rather nebulous. It's easy to cross over to the other side without realizing it. Individuals with MHPs become a threat and provoke fear, because their presence reminds us that, in the words of Bauman, the distance between humans who are "healthy and normal" and those who are "monstrous and abhorrent" is very small.

Because of this, treating individuals with MHPs as unpleasant, abominable or repugnant individuals is nothing more than a fearful reaction to the possibility of becoming one of them. At the same time, by identifying the "abominable other," we place ourselves firmly in the group of "normal and healthy" individuals.

3.2 ABUSE

One of the most common forms of discrimination involves the abuse or negative treatment of individuals with MHPs. These practices are presented below.

USE OF DISCRIMINATORY LANGUAGE

Individuals with MHPs don't just feel that they are negatively treated when they are the victims of direct discrimination. Traces of the stigma associated with mental health can be found in everyday language, in the use of certain common turns of phrase.

Individuals who have MHPs state that, when they hear these expressions on the street, on television, etc., they feel mistreated, even when the expressions are used generally and do not refer to them. The abuse caused by mockery or jokes can't be reduced to direct attacks against individuals with MHPs, but is also present in expressions used in everyday language as turns of phrase or part of jokes.

SOME EXAMPLES OF THESE EXPRESSIONS ARE:

Mockery that uses MHPs humorously:
"You're a little off today, did you take your medication?"
"They belong in an institution!"

Using a mental disorder as an adjective:
"I'm depressed."
"My mum's bipolar, she's always changing her mind."
"That girl is totally schizophrenic."

MISTREATMENT AIMED AT THOSE WITH MHPS

> *"His friends dragged him wherever they wanted, and I saw it all from the window. They'd buy him a drink and then ask him for money." (0.b)*

Evidently, those with MHPs also face direct negative treatment.

Almost half of those with MHPs (47.4%) stated that they have at some point suffered from contempt, mockery, insults, coercion or blaming in some area of their lives because of their MHP.

Some examples that were mentioned in our discussion groups were:

- **Mockery:** some examples of mockery those with MHPs claim to have experienced personally are inquisitive looks, people averting their gaze, people laughing at them or humiliating them publicly.

- **Economic mistreatment:** asking the individual with a MHP for money, taking advantage of the individual's emotional dependence towards the person asking.

Relating strange or inappropriate behaviour with a MHP:
"The driver that sped through that red light is a nutcase."
"You didn't study for the test? You're crazy!"

Using MHPs as an insult:
"You're mental!"
"You're crazy!"

PHYSICAL OR SEXUAL AGGRESSION

Even though, as we expressed in the previous section, one of the characteristics most often associated with individuals with MHPs is aggressiveness or violence, the truth is that these individuals (along with all of those belonging to minority or discriminated social groups) are more at risk of suffering physical or sexual aggression than the rest of the population.

Some of the individuals that participated in our discussion groups recounted episodes of physical or sexual abuse, principally on the part of their partners.

11.9% of those surveyed claim to have suffered from physical or sexual aggression at some point in some area of their lives (personal, social, in the workplace or socio-sanitary) because of their MHP.

AVOIDANCE / REJECTION

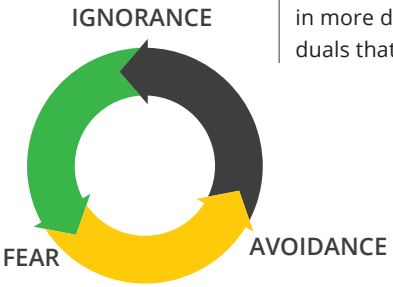
> *"If I see someone on the street I can't tell what kind of illness they have, but I can see that they have some sort of mental health disorder, that they have some kind of a problem. The prejudice just activates suddenly, and I don't even get close to the sidewalk. I mean, I don't even look at them; if I see that they're acting weird, I don't even get close." (0.c)*

The behaviour that was most often mentioned in our discussion groups was the avoidance or rejection of individuals with MHPs. 50.7% of individuals with MHPs have suffered from avoidance or rejection, or state that the individuals around them have distanced themselves in some aspect of their lives because of their MHP.

As we have seen, it's common for people to react fearfully to a mental disorder. The most normal reaction to fear is to distance oneself from whatever provokes it. Avoidance of mental disorders and the individuals that experience them contribute to the perpetuation of ignorance about this phenomenon, which reinforces the sense of fear. The circle of "ignorance-fear-avoidance-ignorance" results, fuelling stigma and discrimination against those with MHPs.

Even though the most habitual response is to avoid individuals with MHPs by distancing oneself from them, when this is not possible, rejection results: by not speaking to them, not making eye contact, acting as if the individual wasn't there, or not inviting individuals with MHPs to participate in social activities.

In the specific documents for *The Perception of Mental Health in Catalonia*, **the different forms of rejection suffered by individuals with MHPs** will be addressed in more detail, according to the context or the individuals that reject them.



CONDESCENDENCE, OVERPROTECTION AND CONTROL

"In my case, people are condescending. They say 'hey, how are you feeling?' 'Are you all right?' 'Are you OK?' 'Aren't you feeling good?' And it's a little bit condescending." (0.a)

In keeping with some of the stereotypes we addressed, one common way of interacting with individuals with MHPs is to treat them in a condescending or infantile manner. In this case, the emotion provoked by those with MHPs is pity or affliction.

This way of interacting with those with MHPs creates a hierarchy between the two individuals. The relationship is based on the dissymmetry between the individual with a series of shortcomings and the other person, who is in a position of superiority. When this attitude is adopted, the interaction ceases to be between equals, and it places both individuals in clearly pre-determined roles. The individual in a situation of superiority treats the person with a MHP in an infantile manner, they feel pity for them, and they feel that it's impossible to establish the same sort of relationship as they have with others.

"It's happened to me. I've taken chronically psychotic patients from the hospital to go eat paella in Cambrils, and the women at the restaurant says 'poor things', you know? 'The coffee's on the house'." (0.d)

Once these roles are established, certain forms of interaction cease to be possible (such as sharing our concerns with the individual with a MHP) while others become "natural" (such as giving the person with a MHP advice on how to behave, what decisions to make, what's good for them and what isn't, etc.).

This form of discrimination is not seen as such by many of those who exercise it, nor by many who suffer from it. However, this behaviour contributes to placing the individual in a situation of weakness and inability.

51.6% of individuals with MHPs state that they have

51.6% OF INDIVIDUALS WITH MHPS STATE THAT THEY HAVE BEEN OVERPROTECTED OR CONTROLLED IN SOME ASPECT OF THEIR LIVES BECAUSE OF THEIR MHP

been overprotected or controlled (suffering from condescending or infantilizing treatment, or interference in personal matters) in some aspect of their lives because of their MHP.

It's worth mentioning that the quantitative data obtained in relationship to this type of treatment indicates that some individuals don't view condescending treatment, control or overprotection as discrimination. In the specific chapters for each context, the prevalence of these phenomenons will be analysed.

This seems to indicate that a significant percentage of those with MHPs don't interpret overprotection or control as discrimination. This tendency is especially pronounced in individuals under 30 (29.6%), while in individuals 45 or older, it isn't so prevalent (18.6%).

Those who know or have a close relationship with an individual with a MHP may manifest a tendency to exercise control or to overprotect them. This behaviour especially emerges when these individuals are viewed as being unable to manage their own lives. If they are seen as weak, fragile, or lacking personal abilities, they tend to be shielded, separated from surroundings that may affect them negatively, or to be viewed as needing intermediation with a hostile environment.

As we have seen, this treatment contributes to weakening the individual and making them dependent, hurting their self-image, making it difficult for them to make decisions on their own and reducing their resiliency. Overprotection tends to make them "learn" that they need to look for the protection of others, and to reduce their autonomy as a result.

3.3 ANTICIPATED STIGMA

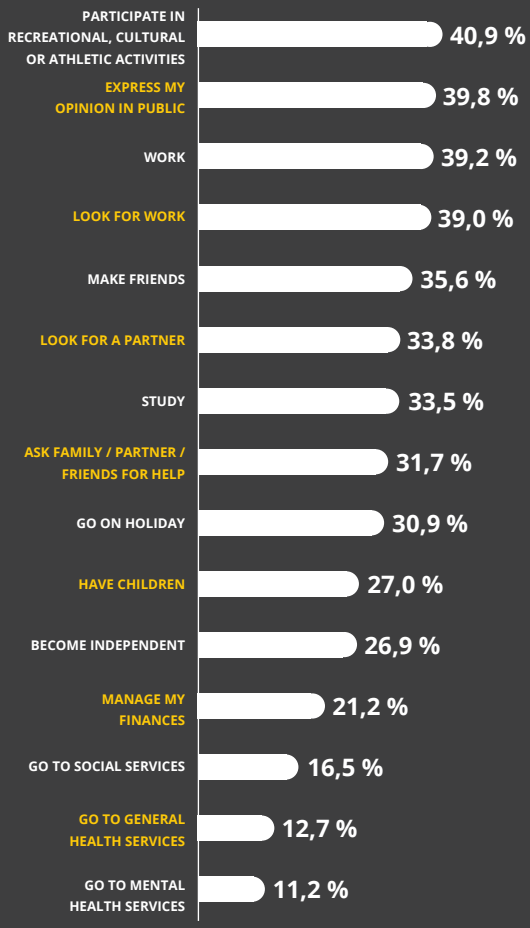
Anticipated stigma is the concept used to explain the rejection or discrimination the individual with MHPs expects to receive before it actually happens. This anticipation corresponds with the expectation that they will be under-valuated or discriminated against because they have a MHP. This phenomenon is different from experienced stigma, or real experiences.

The following graph shows the relationship between anticipated stigma and the individual ceasing to realize basic activities in the development of their lives.

This graph clearly shows that anticipated stigma is a significant obstacle when it comes time for the individual to interact with others and to develop themselves as a human being. 40.9% state that they have often ceased to participate in recreational, cultural or athletic activities in order to avoid being treated unfairly because of their MHP, and 29.8% claim that they have ceased to express their opinion in public. The consequences of anticipated stigma also affect their lives in the context of employment, with individuals ceasing to work (39.2%), or ceasing to look for work (39%), which significantly affects their personal independence.

It's worth stating that 88.8% of those surveyed has ceased to do one of the activities indicated because of their MHP.

GRAPH 1.18.
Have you ceased to do one of the following to avoid being treated unjustly because of your MHP?



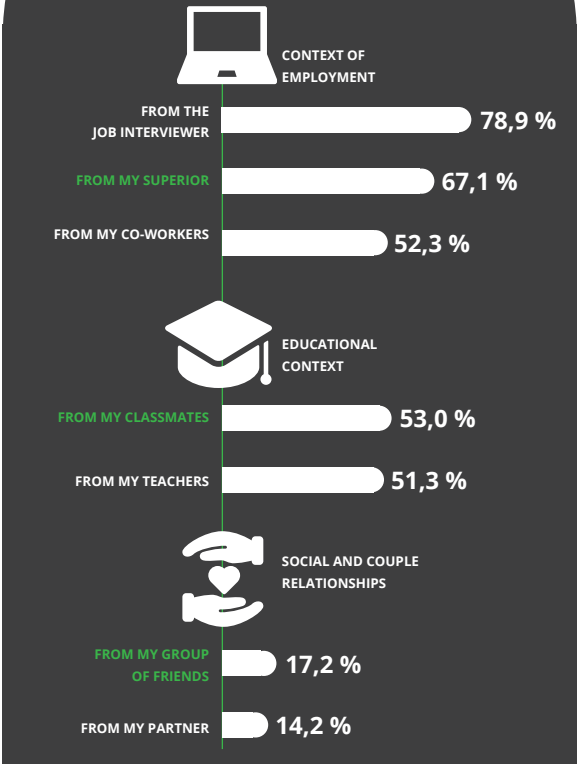
4.

MANAGING STIGMA: HIDING OR REVEALING MHPS

“ **P11:** *My son has driven workmates who don't have cars. If I got out of the car and I said to them 'listen, you ride in the car with my son, but he's on medication, and he takes pills every day to be stable' they would be blown off their feet.*
E: *What do you think would happen?*
P11: *I don't know what would happen, they'd be blown off their feet because he works just like everyone else, he talks like everyone else, he has a family like everyone else, and he works. And, I mean, he drives like everyone else. So, what would happen?" (0.b)*

As we have seen, individuals with MHPs suffer the negative consequences of stigma towards mental health in almost all social environments. Nevertheless, as opposed to other forms of discrimination such as racism or sexism, in this case stigma can be managed by hiding the MHP. As a matter of fact, the public erroneously tends to imagine that individuals with MHPs live in an altered state of reality, that they can't control their emotions, or that they might react in an unpredictable manner at any moment, etc. Precisely because of this, it's relatively easy for individuals with MHPs to hide their condition, since by not fitting these patterns of behaviour, they escape identification as individuals with a MHP.

GRAPH 1.19.
Have you totally concealed your MHP or wished to do so?



> *"People who know that I have mental illness do have this stigma about me. But someone who doesn't know me that sees me on the street without knowing I have a mental illness doesn't see me that way." (0.a)*

Along these lines, some participants in our discussion groups state that when they decide to explain their situation, individuals initially meet the news with surprise, or don't fully believe them. In summary, concealing one's MHP is a strategy that allows them to avoid stigmatization and discrimination.

Graph 1.19. shows the degree to which individuals with MHPs hide their disorder in different areas of their lives.

IN GENERAL, WE FIND THAT INDIVIDUALS TEND TO HIDE THEIR MHP

Individuals most frequently hide their situation in the context of employment, since 4 out of every 5 individuals (78.9%) have hidden their MHP during job interviews (or would have hidden it, but were unable to do so for whatever reason) and 67.1% have hidden it from their superiors. This percentage decreases slightly in reference to workmates, although it continues to be fairly elevated (52.3%).

In an educational context –here, we are referring exclusively to resources not aimed specifically at individuals with MHP— it's also very common for individuals to hide their situation, both from their classmates (53%) and their teachers (51.3%).

Only in social relationships and with partners do we see a significantly lower level of concealment. 14.2% have hidden their MHP (or would have liked to have hidden it) from their current or most recent partner, and 17.2% have done so with all the members of their group of friends. Although this last piece of information seems to indicate that the immense majority tell all of their friends that they have a MHP, it should be specified that, in reality, it's most common for individuals to only tell some of their friends, while it's fairly uncommon for individuals to reveal this information to all of their friends. This question will be addressed in more detail in the corresponding specific document.

As we'll see, the decision to hide or reveal one's MHP and to whom becomes an extremely complex decision.

In general, we find that individuals tend to hide their MHP. As a matter of fact, hiding their MHP doesn't simply mean not explaining it; it also means managing, being aware of and being careful of certain aspects that might be revealing:

- Individuals who follow a daily pharmacological treatment tend to be careful not to take their medication

CONCEAL MHPS REQUIRES A CONSTANT EFFORT

in public spaces or in an obvious manner, in order to avoid questions about it.

- It's very important to control certain side effects of the medication such as trembling, which might betray them.

- Individuals also need to be capable of externally concealing the symptoms of their disorder when they become present. For example, individuals who have auditory delusions might hear voices that talk about them, that judge them or that comment on their actions. When this happens, as many explain, they need to make an effort to ensure that these symptoms aren't perceptible to the people around them.

As a result, even though individuals with MHPs acquire a series of skills and strategies over time that help them to conceal their disorder, and even though doing so is relatively feasible, it requires a constant effort.

In addition, hiding a MHP involves living under the threat that, for a number of possible reasons, their secret might be revealed against their will. Obviously, this threat is a source of tension and worry, and can be a difficult burden to bear.

Although it's most common for them not to explain their situation, individuals with MHPs select certain individuals they consider convenient, because of their closeness or level of trust, to reveal that they have a MHP. Revelation can serve to lighten the burden, since they are free from having to disguise or omit an important part of their lives with these individuals. In addition, they can share their preoccupations related to their disorder with someone.

We will address this matter in more detail, focusing on different contexts in which the conflict between hiding or revealing a MHP is resolved, such as the workplace, school, among friends, etc.

5.

REASONS FOR DISCRIMINATION AGAINST INDIVIDUALS WITH MHPS

The participants in our discussion groups formulated a series of explanations for why they believe that stigma related to mental health and discriminatory behaviour towards individuals with MHPs still persist.

5.1
A VIEW OF MHPS BASED IN THE ERA OF ASYLUMS

> *"People still have a stigma because of what mental health was like a century ago. They used to take the mentally ill and shut them up in an insane asylum for the rest of their lives, they would give them electric shocks, and they didn't give them medication. It was like a miniature hell for the mentally ill, they suffered a lot. And people remember those days, and they think that as mentally ill we wear cones on our head, that we stick our hand in our coat like Napoleon or a hundred other things that aren't true." (0.a)*

One of the explanations that emerges on the causes of stigma in mental health refers to the survival of the image of mental health from the era of insane asylums. Many still associate MHP with these institutions, where people where kept locked away from the rest of their lives. This idea is full of images that reinforce this vision of mental health, such as the "Napoleon hand", the "dunce cap", the "straitjacket", "electric shock treatment", "padded cells", etc.

Even though the treatment of mental health and the current hospital model are now significantly different from in the age of insane asylums, this perception has survived. This image of mental health contributes to stigma and discrimination, by associating individuals with MHPs to these clichés from another age.

5.2 THE MEDIA

Similarly to what we saw in the previous section, participants in our study stated that the media plays a decisive role in portraying those with MHPs in a certain way.

CINEMA AND TELEVISION

Along these lines, participants mention certain films that have helped to portray mental disorders in a very negative light. *Psycho* by Alfred Hitchcock is one of the foundational pillars of the association between MHP and aggressiveness, violence and unpredictability. Although this film debuted in 1960, it continues to play a key role in how people understand MHPs. This vision has been reinforced thanks to other films that have insisted on associating MHPs with murder and violence, such as *The Shining* (1980) or *Silence of the Lambs* (1991). These movies use MHPs as a central element for provoking fear in the spectator.

To the same end, participants also mentioned certain television series that follow the same premise, such as, for example, *Criminal Minds*, where the murderers have different psychological alterations that explain their actions.

The behaviour shown in these movies are very rare, but they have contributed to magnify the perception of their prevalence in society, and they have significantly influences the way MHPs are viewed.

TELEVISION PROGRAMMES, TALK SHOWS AND THE PRESS

"I've been manager of a newspaper, so I have something to say about that. All we need to do is normalize it, but since that doesn't sell, nobody bothers to normalize it with information. Normalizing means talking about it, making it natural. But since we're a business and all of that doesn't sell, we don't do it. And since we don't do it, we don't have the results we should have. And that's it." (0.b)

The way MHP are treated in certain television and radio programs helps to strengthen discrimination. Participants mentioned certain afternoon talk shows in which the sensationalist treatment of certain news stories helps to automatically associate murders with MHP. This insistence on the part of the media in associating MHP and murder helps to consolidate the stereotype of aggressiveness.

Participants also stated that it's common to find news stories that assert that individuals involved in acts of violence or aggression had psychiatric problems, without having verified the information with authorized sources.

In addition, it's mentioned that the media often falls victim to reverse causal error. In cases where it's known that the individual involved has a mental health diagnosis, their behaviour or reactions are automatically associated with their illness, without any sort of verification that that the disorder is a reasonable explanation for their behaviour, or without taking into account any other possible motives.

Although this treatment of information related to MHP contributes to the publication of a significant number of news stories with erroneous information, it's rare for corrections or errata to be published related to this subject. As a result, there is a general feeling that the publication of news with erroneous information on mental health questions is not considered problematic or relevant.

Finally, the media contributes to the spread and popularization of discriminatory language. As we have seen, there are a number of turns of phrase and common expressions that have discriminatory effects on mental health. When the media uses them, they are broadcast throughout society and are echoed by others.

5.3 IGNORANCE AND LACK OF INFORMATION ON MHPS

WHILE OTHER ILLNESSES HAVE RECEIVED SIGNIFICANT MEDIA ATTENTION MENTAL HEALTH IS A GREAT UNKNOWN

In all probability, the reason individuals with MHPs continue to suffer from significant discrimination is the lack of information on disorders, the issues faced by those who have them, their symptoms, etc.

Participants in our discussion groups referred repeatedly to the public's lack of information on MHPs. While other illnesses have received significant media attention and a significant part of society has a minimum understanding of how they work and what their effects are, mental health is a great unknown. Participants often contrast public ignorance about MHPs with the general understanding of the consequences, symptoms and treatment of diabetes.

According to our participants, most individuals who don't have a close relationship with MHPs are unaware:

- Of the kinds of disorders that exist and the differences between them..
- What the symptoms of each are.

- What biochemical imbalances cause certain symptoms.
- The historical evolution of the pharmacological treatment of MHP, and what kind of treatment currently exists.
- The side effects of medication.
- The evolution of disorders and their different phases: that disorders tend to include episodes with the presence of symptoms (crises, outbreaks) and periods of remission. In other words, that MHPs have different intensities at different times.
- That MHPs only affect certain aspects of the individual, not the totality.

It's also common for people to confuse different mental disorders, to erroneously view a single cause as the origin of the disorder, to confuse certain side effects of the medication with the symptoms of the disorder or to be more aware of positive symptoms than negative symptoms[1].

1 The positive symptoms are the series of signs that provoke situations of excitement, alterations of perception, delirious behaviour, etc., while the negative symptoms cause emotional levelling, little communication, disconnection with one's surroundings, etc.

5.4
THE DICHOTOMY BETWEEN PHYSICAL AND MENTAL HEALTH

"It's like if you have a physical problem, one that affects you physically. You get chemotherapy, radiotherapy, your hair falls out, it grows back, you've had an evolution that you can really notice where you go from being sick to healthy. But in mental illnesses, it's not as noticeable, because of the whole personality thing.
P3: *It's really ambiguous.*
P1: *It's really ambiguous, it's not so...*
P3: *There's not really a beginning and an end...*
P1: *Exactly.*
P3: *Like with cancer, where there's a moment when the tumour is gone, you know?*
P1: *Anyway, I think it's less tangible" (0.c)*

The analysis of the information obtained in our discussion groups reveals the general perception of a strong differentiation between physical and mental health, which explains why individuals react differently depending on the type of illness they are facing.

According to this perception, it's easier to accompany someone with a physical illness, to support and care for them, than someone with a mental disorder. The arguments that sustain this affirmation are based on

a series of attributions that significantly differentiate physical illness from mental illness.

It's often stated that a physical illness is tangible and visible, that it's material. It's claimed that physical illnesses have a clear localization (an organ, for example), they are quantifiable (for example, with blood sugar levels in diabetes), or they have a clear end (for example, the fusion of a bone after a fraction, or the cure of a cancer after chemotherapy). Mental illnesses, on the other hand, are intangible, ungraspable and invisible, with no clear location; it's unclear whether they subside or are chronic. MHPs are also considered to be diffuse, intangible, and indeterminate.

This dichotomy between mental and physical issues contributes to the idea that while physical illnesses are easy to understand, mental illnesses are unknown territory and hard to understand. Because of this, it's claimed that it's easier to accompany an individual with a physical illness than an individual with a MHP. The comprehension and the level of understanding of either side of this dichotomy is substantially different: "you don't need to break a bone to understand what it's like, but if you've never had a mental disorder, you can't really understand what it's about."

6.
CONCLUSIONS OF THE FRAMEWORK DOCUMENT

1. Stigma towards mental health is a **diverse and complex phenomenon that takes on different forms depending on the context and the relationships** established. It's made up of a series of negative stereotypes that are activated and operate when people interact with or pass judgement on individuals with a MHP. 76.6% of individual with MHPs state that they have often been attributed some sort of negative characteristic because of their MHP.

2. The **stereotypes regarding MHPs** identified are:

a. Permanent instability: the tendency to consider that individuals with MHPs are constantly in a state of crisis or under the effects of an outbreak.

b. Unpredictability: the tendency to think that individuals with MHPs can unexpectedly begin to act in a socially inappropriate manner.

c. Dangerousness or aggressiveness: the tendency to associate MHPs with violent, aggressive or irrational behaviour, without clear motives or explanations.

d. Laziness: the tendency to consider that individuals with MHPs are lazy, and don't overcome their disorder because they have no desire to.

e. Intelligence or genius: the tendency to consider that individuals with MHPs filter information and stimuli in unexpected, creative or innovative ways, because they aren't bound by social conventions.

f. Emotional flattening: the tendency to consider that individuals with MHPs are absent, don't express emotions, and lack affective resonance.

g. Chronicness: the tendency to consider that MHPs become chronic and don't subside, and that places emphasis on the fatality of the individual's future.

h. Fragility: the tendency to consider that individuals with MHPs are in a state of precarious balance and that anything may unleash a crisis, even if they don't manifest any external symptoms.

i. Inability or dependence: the tendency to consider that individuals with MHPs are lacking the competencies

76.6% OF INDIVIDUAL WITH MHPS STATE THAT THEY HAVE OFTEN BEEN ATTRIBUTED SOME SORT OF NEGATIVE CHARACTERISTIC BECAUSE OF THEIR MHP

they need to manage and direct their own lives.
j. Extravagance: the tendency to consider that individuals with MHPs don't adhere to social norms that govern interaction and communication, which causes them to behave in strange ways; or that they have a communicative style lacking empathy and a lack of capacity for connecting with others.
k. Cognitive deficit: the tendency to consider that individuals with MHPs have trouble with learning, with abstract reasoning or with correctly understanding aspects of everyday life.
l. Contagiousness: the tendency to consider that there is a risk of others succumbing to the disorganized and chaotic "other world" of those with MHP.
m. The fallacy of the single cause: the tendency to consider that the MHP is the principle explanation for all behavioural, cognitive or competency-related aspects of the individual.

Individuals with MHPs state that society has frequently assumed that their MHP is chronic (44.4%), meaning that it won't subside. Instability (42.9%), fragility (40.2%) and social isolation (39.3%) are other characteristics that are frequently attributed to individuals with MHPs.

n. Fragility, negativity and instability are characteristics that are more often attributed to women than men.
o. Intelligence and genius and a lack of emotional expressiveness are characteristics that are more often attributed to men than women.
p. Instability, laziness, dangerousness or aggressiveness are characteristics that are attributed more often to those under 30 years of age.
q. Chronicness is a characteristic attributed most of all to individuals older than 30 years of age, and this percentage increases as the age of the individual increases.

3. Each **MHP** is associated with certain **traits or characteristics with negative connotations**. Discrimina-

tory practices are specific to each disorder.
a. Schizophrenia tends to be associated with aggressive behaviour and violence. It's also common to consider that schizophrenic individuals are unpredictable. As a result, schizophrenia provokes reactions of fear, avoidance and rejection desencadena reaccions de por, evitació i rebuig.
b. Depression, on the other hand, is more often associated with fragility, weakness and self-harm. As a result, individuals with depression are often treated in a condescending, infantile or over-protective manner.

4. Stereotypes are characteristics cast on an individual by their surroundings that define the individual with a MHP. **Self-stigma** happens when these negative attributions are incorporated by the individual and become the basis of their self-image. Self-attributed chronicness (49.0%) is the most frequent. Fragility (45.2%), instability (43.4%) or social isolation (43.1%) are other stereotypes that are most often mentioned when the individual defines themselves.

SELF-STIGMA HAPPENS WHEN THE INDIVIDUAL WITH A MHP INCORPORATES THE CHARACTERISTICS CAST BY THEIR SURROUNDINGS

5. Self-stigma involves the individual judging themselves with the expectation that they will fulfil the stereotypes society casts upon them because of their MHP. For any individual, the way they are viewed by those around them is important, and as a result many individuals with MHPs **incorporate the stigma and discrimination** society applies to them to an even more pronounce degree.
a. The lack of emotional expressiveness, fragility, the lack of intellectual capacity or the chronicness of their MHP are the characteristics that individuals with MHPs tend to cast on themselves to an even greater degree than society does.

6. Among the **general public**, there's a significant **ignorance regarding mental health** and MHPs. The problems of mental health aren't expressed openly.

a. There is widespread ignorance about what MHPs are. There is often confusion between MHPs and other cognitive and degenerative problems (intellectual disability, Alzheimer's, senile dementia, etc.).
b. Ignorance and negative stereotypes promote a fearful reaction to individuals with MHPs.

7. Individuals with MHPs are treated unjustly. The principal types of discriminatory behaviour detected are: the use of discriminatory language, mocking, economic abuse, physical or sexual abuse, avoidance or rejection, condescending treatment, overprotection and control.
a. 80.1% of individuals with MHPs state that they have been treated unjustly in some aspect of their lives (personal, social, in the workplace, or sociosanitary) because of their MHP
b. 54.9% of individuals with MHPs state that in a certain area or on the part of a certain individual, this negative treatment has been fairly frequent or very frequent.
c. 50.7% of individuals with MHPs have suffered from avoidance or rejection, or those around them have distanced themselves from them in some aspect of the individual's life because of their MHP.
d. 47.4% of individuals with MHPs stated that they have been treated negatively with condescending treatment, mocking, insults, coercion or blaming in some aspect of their lives because of their MHP.
e. 51.6% of individuals with MHPs stated that they have been over-protected or controlled (having suffered from condescending treatment, infantilizing treatment or meddling) in some aspect of their lives because of their MHP.
f. Some individuals don't interpret condescending behaviour, control or overprotection as discriminatory treatment. As a result, 23.9% of individuals who state that they have never been treated unjustly because of their MHP indicate, in turn, that they have been over-protected or controlled in an educational context, in the

80.1% OF INDIVIDUALS WITH MHPS STATE THAT THEY HAVE BEEN TREATED UNJUSTLY IN SOME ASPECT OF THEIR LIVES BECAUSE OF THEIR MHP

context of employment, by their family, their partner or in their social relationships. This tendency not to interpret condescending behaviour, control and/or overprotection as discriminatory behaviour is even more pronounced in individuals under 30 (29.6%), whereas in individuals over 45 it's less so (18.6%).

g. 11.9% of individuals with MHPs state that they have suffered physical or sexual aggression in some aspect of their lives (personal, social, sociosanitary or in the workplace) because of their MHP.

INDIVIDUALS USE THE CONCEALMENT OF THEIR MHP AS THE PRINCIPAL STRATEGY FOR AVOIDING OR FACING STIGMA AND DISCRIMINATION

8. Individuals use the concealment of their MHP as the principal strategy for avoiding or facing stigma and discrimination.

a. In their current or last place of employment, 4 of every 5 individuals (78.9%) have hidden their MHP from the person interviewing them for the position (or would have done so, but were unable to for whatever reason), 67.1% have hidden their MHP from their superior, and 52.3% from their workmates.

b. In educational context not aimed specifically at individuals with MHP, 53% have hidden or would have hidden their MHP from their classmates, while 51.3% have done so with their teachers.

c. 17.2% of individuals have hidden their MHP from all the members of their group of friends (or would have done so, but were unable to for whatever reason).

d. 14.2% of individuals have hidden their MHP from their current or last partner (or would have done so, but were unable to for whatever reason).

9. The concealment of a MHP is an additional burden for individuals with MHPs, and requires them to control any elements that might reveal their situation: medication, side effects, their relationship with mental health services, disability accreditations, etc.

10. Individuals with MHPs cease to pursue some of their desires or cease to participate in social activities

88,8% OF INDIVIDUALS WITH MHPS HAVE CEASED TO PARTICIPATE IN SOME SORT OF ACTIVITY FOR FEAR OF DISCRIMINATION

for fear of discrimination. **Anticipated stigma** is the concept used to explain the rejection or discrimination that the individual expects to suffer before they actually do. This phenomenon is different from experienced stigma, or stigmatizing experiences that have actually taken place.

a. 88.8% of individuals with MHPs have ceased to participate in some sort of activity because of their condition[2].

b. 40.9% of individuals with MHPs state that they have often ceased to participate in recreational, cultural or athletic activities to avoid being mistreated because of their MHP.

c. 39.8% of individuals with MHPs state that they have ceased to publicly express their opinions for fear of being unjustly treated because of their MHP.

d. Individuals with MHPs often declare that they have ceased to work (39.2%) or have ceased to seek work (39%) to avoid being unjustly treated because of their MHP.

2 Participating in recreational, cultural or athletic activities; making friends; seeking a partner; studying; asking their family/partner/friends for help; going on holiday; having children; becoming independent; managing their own emotions; using social services; using general health services; using mental health services.

7.
CONCLUSIONS OF THE SPECIFIC DOCUMENTS

In this final chapter, we'll present the conclusions obtained from the different specific documents from *Stigma an discrimination in mental health in Catalonia*. The specific documents centre their analysis on stigma and discrimination in the principal areas of an individual's life: education, employment, family, couple, health, and social relationships.

7.1

STIGMA AND DISCRIMINATION IN AN EDUCATIONAL CONTEXT

TEACHERS

1. In educational settings, many experience **fear, insecurity or doubt** when it comes time to interact with students with MHPs. Teachers may see working with students with MHPs as an additional burden that forces them to leave their comfort zone.

2. When there are no specialized professionals that can help with attending to students with MHPs, **trial and error** becomes the method used by teachers to address their needs

3. The **adaptation** of r**ules, classroom dynamics** and **curricular programs** to the needs of individuals with MHPs are practices that can facilitate academic progress.

4. Teachers tend to seek **assistance from the specialized resources** they have access to in order to address MHPs in educational settings. These resources may include: educational psychologists, pedagogical counselling and orientation teams, special education schools, infant and juvenile mental health centres, etc..

5. Not all specialized resource personnel are **trained** to address the needs of individuals with MHPs. Many have the training they need to attend to the special needs of students, but they lack knowledge of mental health.

6. **18.9%** of individuals with MHPs **have suffered from discriminatory treatment** by teachers in an

29.5% OF INDIVIDUALS WITH MHPS HAVE SUFFERED DISCRIMINATORY TREATMENT FROM THEIR CLASSMATES IN AN EDUCATIONAL SETTING

educational context. The most common discriminatory behaviours are:

a. Avoidance and **rejection**: 8.1% of students have been avoided or rejected by their teachers by, for example, being excluded from teaching activities that their classmates participate in.

b. Overprotection and **control**: 15.2% of individuals with MHPs have suffered from overprotection or control by their teachers.

c. Mocking: 5.2% of students have suffered mocking, blaming, condescending treatment or ridicule because they behaved differently from others.

7. In some cases where the classmates of the individual with MHPs discriminate against them, teachers behave **negligently** and do not intervene to prevent it.

8. Teachers consider that the principal difficulties that prevent them from appropriately addressing the needs of individuals with MHPs are: i**gnorance of the diagnosis, a lack of specialized professionals**, and **a lack of knowledge and tools** needed to give a good educational response to individuals with MHPs.

STUDENTS

9. 29.5 % of individuals with MHPs **have suffered discriminatory treatment** from their classmates in an educational setting. The most common examples of this are:

a. Avoidance and **rejection**: 14.3% of individuals with MHPs notice that their classmates distance themselves from them, or prevent them from participating in group activities.

b. Mocking: 10.8% of individuals with MHPs suffer insults and mocking. Disparaging comments become worse when rumours based on negative stereotypes associated with MHPs begin to spread.

c. Overprotection: 10.8% of individuals with MHPs have experienced overprotection and control by their classmates.

MANAGEMENT OF MHPS

1. Because of fear of being discriminated, most individuals with MHPs decide to **hide their diagnosis**. 51.3% of individuals with MHPs decide to hide their condition from their teachers, and 53% hide it from their classmates. This doesn't simply mean that they neglect to inform them that they have a MHP; it also means carrying out a whole series of actions to constantly hide any detail that could reveal their situation. It's not simply a passive decision, but rather involves constant effort.

2. MHPs are difficult to hide in early educational stages (primary and secondary education), because the use of time and educational spaces is strictly controlled. In addition, teachers play an important role in providing guidance to students.

3. Because of the **difficulty of hiding a MHP**, 3.8% of individuals fail to hide it from their classmates, while 4.5% fail to hide it from their teachers. As a result, in order to hide a MHP, students require:
a. Support from their teachers when they suffer crises in primary or secondary education. The teacher is their principal source of help.
b. Help from classmates in concealing their MHP.
c. The concealment of signs that might reveal their MHP, such as symptoms or medication.

4. Individuals with MHPs prefer to hide their condition, but should they reveal it, they generally only do so partially.
a. 23.2% of individuals with MHPs decide to trust in some teachers, revealing their MHP to them. 30.7% of

individuals with MHPs share their diagnosis with some classmates.
b. 20.9% of individuals with MHPs decide to reveal their condition to all of their teachers. On the other hand, only 10.7% decide to do so with all of their classmates.

5. A lack of understanding about the experience of having a MHP makes it difficult for the individual to openly explain their situation in a clear manner to those around them.

6. When their diagnosis is known in their educational setting, the individual with a MHP tends to **exclude themselves socially as a defence mechanism** from incomprehension and discrimination.

7. **Abandoning** studies or **changing schools** are mechanisms used to hide MHPs that have become public, and/or to distance oneself from discriminatory treatment in an educational setting.

7.2 STIGMA AND DISCRIMINATION IN THE CONTEXT OF EMPLOYMENT

The principal effects of stigma and discrimination detected in the context of employment are:

UNEMPLOYMENT LEVELS AMONG INDIVIDUALS WITH MHPS ARE AT **61.9%**, 44.2% MORE THAN THE MOST RECENT GENERAL UNEMPLOYMENT FIGURE IN CATALONIA (17.7%)

OCCUPATION OF INDIVIDUALS WITH MHPS

1. Unemployment levels among individuals with MHPs are at **61.9%**, 44.2% more than the most recent general unemployment figure in Catalonia (17.7%[3]).
a. In the general population, unemployment is more common among women (19.1%) than among men (16.5%), but in the population with MHP, the reverse is true (67.1%) among men, 56.8% among women.

DISCRIMINATION IN THE WORKPLACE

2. 40.6 % of individuals with MHPs declare that they have received unjust treatment in the context of employment at some point.
a. 18.4% of individuals with MHPs state that this unjust treatment was fairly frequent or very frequent.
b. 22.3% of individuals with MHPs state that this unjust treatment happened rarely.

3. The most common examples of unjust treatment are:
a. 19.5% of individuals with MHPs have suffered from **mocking, insults, coercion, blame and contempt** in the workplace because of their MHP.
b. 14.8% of individuals with MHPs have suffered from

3 Data from the 4th trimester of 2015.

overprotection and control in the workplace because of their MHP.
c. 16.9% of individuals with MHPs have suffered from **rejection or avoidance** in the workplace because of their MHP. Individuals with MHPs may suffer exclusion from interpersonal interaction, such as at break times.

4. There is a tendency for individuals with MHPs to be **under-occupied**.
a. People are often reassigned to under-qualified tasks or inferior levels when their MHP is revealed at work.
b. Within the context of the Law for the Social Integration of the Disabled (LISMI), individuals tend to be assigned under-qualified tasks.

5. Employers tend to **justify this under-occupation** in different ways:
a. For fear that work-related stress will cause the individual to have an outbreak or to act dangerously.
b. Because it's assumed that individuals are less competent because of their MHP.

6. Under-occupation may be the result of a reduction of work expectations for the individual with a MHP. The need to find a job often pushes them to accept under-qualified positions.

7. There is a tendency for employers **not to trust** individuals with MHPs, and to subject them to mechanisms of **control** that undervalue and disable them:
a. This lack of trust is independent of the competence shown by the individual.
b. The lack of trust is more pronounced when the individual with a MHP has a high level of responsibility or works in customer service.

8. Employers tend to see the need to **make their organizational culture more flexible** in order to include the special needs of individuals with MHPs as a risk.

9. **Dismissal** is the most extreme form of rejection that the individual with MHPs can be met with in the workplace, and it's justified by the following:
a. It's argued that individuals with MHPs are unpredictable, inconsistent and dependent.
b. It's claimed that individuals with MHPs request sick leave more often, thus harming productiveness.
c. It's claimed that individuals with MHPs are absent more often than others.
d. It's argued that individuals with MHPs are damaging to the workplace environment and have trouble working with others.

10. Employers with internal CSR policies for health-related issues and/or management teams that are aware of the reality of mental health issues are more willing to adapt to the needs of individuals with MHPs. This happens most often when the MHP begins to affect those who are already employed, and not when hiring an individual that already has a MHP.

STRATEGIES FOR MANAGING STIGMA IN THE WORKPLACE

11. **Concealment** is the most common strategy for facing stigma and discrimination in the workplace. 48.5% of individuals with MHPs hide their condition in the workplace, or would have done so if they could.
a. 67.1% of individuals with MHPs hide or would have hidden their condition from their superior.
b. 73.8% of women with MHPs have hidden their condition from their superior, as opposed to 57.2% of men.
c. 79.2% of youth (under 30) with a MHP hide their condition from their superior, while those over 45 do so 63.3% of the time.
d. 52.3% of individuals with MHPs hide or would have hidden their MHP from their co-workers.

48.5% OF INDIVIDUALS WITH MHPS HIDE THEIR CONDITION IN THE WORKPLACE, OR WOULD HAVE DONE SO IF THEY COULD

12. Individuals who chose to hide their MHP must make a constant effort to control any indication of it.

13. Individuals use **revelation** as a strategy for managing stigma principally when they have established a relationship of trust at work, and when their position has allowed them to show their capacity to work.
a. 38% of individuals with MHPs partially reveal their condition, meaning that they only reveal it to some individuals in the workplace.
b. 13.6% of individuals with MHPs reveal their condition to everyone.
c. 32.9% of individuals with MHPs have or would have explained their MHP to their superior.
d. 73.8% of women with MHPs haven't revealed their condition to their superior, as opposed to 57.2% of men.
e. 31.2% of individuals with a MHP partially reveal it to their co-workers.
f. 12.9% of individuals with a MHP reveal it to all of their co-workers.
g. 62.4% of young men with MHPs reveal or would have revealed their condition to their co-workers. On the other hand, 33.8% of those over 45 have done so. This is not the case with young women, of whom only 25.4% have or would have revealed their MHP to their co-workers.

DISCRIMINATION WHEN SEARCHING FOR EMPLOYMENT

14. Individuals with MHPs have **less opportunities for employment**, both in the ordinary and the protected market, because of stigma and discrimination.

15. **19.2%** of those with MHPs claim to have been **treated unjustly** during job interviews because of their MHP.
a. 26.7% of women indicate that they have received

unjust treatment to some degree, as opposed to 14.5% of men.
b. 43% of women over 45 with a MHP state that they have received unjust treatment.
c. 9.2% of individuals with MHPs indicate that they have received poor treatment (mocking, insults, coercion, blame or contempt) during a job interview because of their condition.

16. There is a tendency among employers and management to consider that individuals with a MHP have **low productivity** and **poor performance**.
a. It's believed that these individuals have more and longer sick leaves than others.
b. It's felt that individuals with MHPs are inconsistent and, as a result, incapable of consistent performance in the workplace.
c. Those with MHPs are viewed as lazy.

17. There is a tendency among employers and management to believe that individuals with MHPs are more problematic, that they increase **workplace conflict** and that they are harmful to teamwork.
a. It's assumed that those with MHPs have trouble interacting with others.
b. It's assumed that those with MHPs lack communication skills.
c. It's assumed that those with MHPs are unpredictable and are a risk for the business, since it's difficult to predict when they will become difficult.

18. There is a tendency among employers and those in charge of hiring to think that individuals with MHPs are **incapable of completely assuming the tasks** they are assigned.

19. Businesses state that they are incapable of detecting what the limitations of an individual with a MHP are, since the MHP makes them intangible.

20. The Law on the Social Integration of the Disabled (**LISMI**) is not effective in helping those with MHPs find employment. There is a tendency to incorporate any other individual with a "disability" before an individual with a MHP.

STRATEGIES FOR MANAGING STIGMA WHEN SEEKING EMPLOYMENT

21. The principal strategy for managing stigma and discrimination when seeking employment is **concealment**. **78.9%** of individuals with MHPs didn't reveal their condition (or wouldn't have, if they could have prevented it) when being interviewed for a position.
a. 86.7% of women have hidden their MHP (or would have done so if they could) when being interviewed for a position. On the other hand, men have hidden their MHP 67.6% of the time.
b. Young people with MHPs (under 30) have hidden their MHP 88% of the time, while those 45 or older have done so 70.3% of the time.

22. Individuals with MHPs prefer to hide their MHP when searching for employment:
a. Concealment ensures that the person will be judged according to their abilities and their CV, not according to stereotypes.
b. Concealment prevents future discrimination from co-workers and superiors.
c. Concealment involves facing a feeling of guilt for having hidden something that is important and relevant to the person.

23. **Revelation** is a strategy chosen only by a small minority when seeking employment. Only **17.8%** of individuals with MHPs revealed their condition when being interviewed for a job. Revelation is associated with the following:

a. Individuals who have never suffered discrimination in the workplace are likely to reveal their MHP.
b. Revelation makes it easier for co-workers to know what is happening and what needs to be done should the individual require help or support.
c. Revelation provides an opportunity to offer information to help understand individuals with MHPs.
d. Revelation helps to fight prejudices regarding MHPs; it's an active way of combatting discrimination.
e. Revelation is associated with the advantages provided by the LISMI or by access to the protected market.

7.3 STIGMA AND DISCRIMINATION IN A FAMILY SETTING

The principal effects of stigma and discrimination detected in a family setting are:

MANAGEMENT OF STIGMA AND DISCRIMINATION

1. When an individual's social environment is unaware that they have a MHP, their family may decide to conceal this fact. **Hiding a MHP** means that the individual and their family must agree on a common story.

2. When an individual's social environment is aware that the individual has a MHP, their family may decide to **regulate and restrict the information on the MHP** they share. They may publicly acknowledge the existence of a MHP without making any sort of reference to the diagnosis or the symptoms.

3. The family may **socially exclude** themselves as a strategy for avoiding stigma and discrimination by drastically reducing their participation in social activities. Social exclusion is linked with feelings of shame and guilt surrounding the MHP.
a. Social exclusion may result in the individual with a MHP having less contact with mental health services.
b. Social exclusion makes socialization more difficult.
c. Social exclusion is a reproduction of the traditional model of exclusion through institutionalization on a family level.

TREATMENT BY FAMILY MEMBERS

4. **50.4%** of individuals with MHPs have experienced **unjust treatment by a member of their immediate family** because of their MHP, and **38.6%** have experienced the same from a member of their **extended family**.

a. There are significant differences depending on the sex of the individual: 56.2% of women with MHPs have suffered unjust treatment by a member of their immediate family, while in men this percentage is only 44.8%.

b. There are significant differences depending on age and sex: 64.3% of young women (under 30) with MHPs manifest that they have suffered from unfair treatment by their immediate family, while 36% of men state the same.

5. In some families, the MHP becomes **taboo**. As a result, it's not referred to, the matter is avoided in family conversations, and the individual is treated as if this part of their lives didn't exist.

6. Families may use the MHP and its symptoms as a way of **discrediting** the opinions of the individual, considering them the result of delusions and a lack of logical criteria.

a. **21%** of those with MHPs have experienced mocking, insults, coercion, blame or contempt at some point in their lives from members of their immediate family.

b. Women with MHPs experience 9.4% more situations of mistreatment than men in the form of mocking, insults, coercion, blame or contempt.

7. **12.4%** of individuals with MHPs have experienced situations of **avoidance, rejection** and **distancing** on the part of members of their immediate family, and 13.1% by members of their extended family as the result of their condition.

8. **Overprotection and control** emerge when the family decides that the individual with a MHP is fragile and dependent, and, as a result, is incapable of facing a social environment that is hostile and threatens their stability. As a result, the family seeks to protect the individual and regulate influence from their surroundings to an excessive degree. Overprotection becomes an additional burden for the families that practice it, since it requires time and dedication.

a. 32.3% of individuals with MHPs have experienced situations of overprotection or control by their immediate family at some point in their lives.

b. 22.7% of individuals with MHPs state that this has happened to them in the past year.

c. 35.9% of young people (under 30) with MHPs state that they have experienced situations of overprotection or control, as opposed to 13.7% of those over 45.

d. Women with MHPs experience situations of overprotection and control 8.9% more than men.

9. The family plays an essential role in the way individuals with MHPs view themselves and, as a result, in the appearance of **self-stigma**. Treatment based on omission, distancing, discrediting or overprotection promote auto-stigma, and cause the person to make the negative stereotypes and expectations applied by their family their own.

MEDDLING BY FAMILY MEMBERS

10. **29.8%** of individuals with MHPs state that their immediate family has **told others that they have a MHP without their consent**.

a. 42.2% of young people (under 30) with MHPs state that their immediate family (father, mother, siblings or children) have told others of their MHP without their consent.

b. Women with MHPs are affected by this situation 11.5% more than men.

11. **29.2%** of individuals with MHPs state that their family has interfered in the management of their finances because they consider them incapable of managing them themselves.

a. 32.6% of men and 25.4% of women state that their family has interfered in their finances.

b. Cases of financial meddling have been detected when money comes from pensions or inheritance. However, no cases were detected involving an individual's salary.

29.2% OF INDIVIDUALS WITH MHPS STATE THAT THEIR FAMILY HAS INTERFERED IN THE MANAGEMENT OF THEIR FINANCES BECAUSE THEY CONSIDER THEM INCAPABLE OF MANAGING THEM THEMSELVES

STIGMA AND DISCRIMINATION TOWARDS THE FAMILY

12. Families are also victims to discrimination and stigma. Discrimination against individuals with MHPs is often extended to their entire immediate family, a phenomenon known as "social contagion." This happens especially when the individual is a minor.

THE DEBATE ON INCAPACITATION

13. Legal incapacitation is a resource that doesn't always correspond to the progression of the individual with a MHP. It's a **rigid legal mechanism** that attempts to answer to a changing phenomenon. As a result, incapacitation:

a. Can perpetuate the negative stereotypes attributed to individuals with a MHP.

b. It can hurt the recognition of the recuperation processes followed by the individual with a MHP.

c. It can be a tool used by the family to gain control of inheritance and property.

d. It can disguise discrimination on the part of guardians.

14. **Dialogue** and **pacts** between the family and the individual with a MHP are key to adapting the rigidity of the legal incapacitation to the individual's spaces of independence.

15. The use of **alternative measures** such as power of attorney or curatorship can help to combine family security and the freedom and autonomy of the individual.

7.4 STIGMA AND DISCRIMINATION IN COUPLES

The principal effects of stigma and discrimination in couples detected are:

PARTNER RELATIONS WHEN THE MHP APPEARS OR IS EXISTING

1. One of the elements that determines relationships between partners is the moment in which the MHP appears. Individuals with MHPs and their partners are faced with different dilemmas depending on whether the MHP existed prior to their relationship or whether it appeared once their relationship was established.

WHEN THE MHP IS DIAGNOSED PRIOR TO THE RELATIONSHIP

2. The individual with a MHP, expecting discrimination, may **avoid close relationships** or chose not to seek a partner in order to avoid the disappointment of being rejected because of their condition.

3. When individuals without MHPs are asked whether they would have a relationship with an individual with a MHP, they express a series of doubts:
a. They refer to stereotypes such as aggressiveness or the lack of social or sentimental abilities, which make it more difficult to establish and maintain a relationship.
b. They express concern about the caretaking responsibilities that might arise from being the partner of an individual with a MHP.

WHEN ONE OF THE MEMBERS OF A COUPLE IS NEWLY DIAGNOSED WITH A MHP

4. The appearance of a MHP involves an **adaptation** on the part of both members of a couple to the new needs derived from the MHP, as is the case with any other medical condition.

5. In some cases, the appearance of a MHP may result in the **termination of the relationship**. Nevertheless, there is a certain agreement that in established relationships, the desire to help and **support** the affected partner generally prevails.

THE MANAGEMENT OF STIGMA

6. **10.2%** of individuals with MHPs **have hidden their condition** from their partner to avoid possible rejection and incomprehension.
a. The decision about whether to hide or reveal a MHP to a partner depends on the type of relationship and its duration. Individuals are more likely to hide the condition at the beginning of a relationship.
b. Young people (under 30) are more likely to hide their MHP from their partner (17.4%), than those over 44 (6.6%).

7. **85.8%** of individuals with MHPs **have revealed their MHP** to their partner (or would have done so, if they weren't already aware of it):
a. The general opinion is that it's important to be able to reveal one's MHP to a partner when the relationship is stable and consolidated. It's convenient for the other person not only to be aware of the presence of the MHP, but also of the implications and routines involved.
b. Revelation is considered a desirable strategy for both parts, since it reinforces trust, facilitates understanding, and generates a positive dynamic within the couple.

c. When the revelation of the MHP isn't accompanied by an attitude of empathy and active listening on the part of the partner, it generally results in the termination or deterioration of the relationship.

8. There is a strong **tension between** the decision to **hide or reveal** a MHP, which causes the person with a MHP to have doubts on when is the appropriate moment to reveal it.

DISCRIMINATORY TREATMENT

DISCRIMINATION PRIOR TO THE RELATIONSHIP

9. **19.2%** of individuals with MHPs **haven't been in a relationship** since their MHP was diagnosed.

10. Individuals sometimes **reject** the possibility of being in a relationship with an individual with a MHP for the following reasons:
a. They suppose that the individual with a MHP will be unstable, unpredictable or aggressive, and as a result they expect the relationship to be a series of highs and lows.
b. They consider that the individual with a MHP is weak, fragile and unstable, and that as a result they will need the care and unconditional support of those around them.

11. People with MHPs are **reluctant to begin or maintain a relationship** for different reasons:
a. Because of anticipated stigma, or fear of being rejected or facing discrimination because of their MHP. They feel unsure, they avoid relationships, and in some cases they isolate themselves.
b. Because they attribute certain characteristics to themselves that might prevent a stable relationship, such as impulsiveness or instability.

THERE IS A STRONG TENSION BETWEEN THE DECISION TO HIDE OR REVEAL A MHP, WHICH CAUSES THE PERSON WITH A MHP TO HAVE DOUBTS ON WHEN IS THE APPROPRIATE MOMENT TO REVEAL IT

12. When any sort of difficulty appears at the beginning of the relationship, it's often attributed to the MHP and not to the reality of relationships.

DISCRIMINATION DURING THE RELATIONSHIP

13. **13.40%** of individuals with MHPs have suffered from episodes of **unfair treatment** by their partner. In 18.9% of cases, this happened fairly frequently or very frequently.
a. 44.6% of women with MHPs have been treated unjustly by their partner because of their MHP, as opposed to 33.8% of men.

14. **Overprotection and control** are the most frequent type of mistreatment between partners. 18.7% of individuals with MHPs have experienced this situation at some point in their lives, and 13.8% have experienced it in the past year.
a. Women suffer from overprotection and control from their partner more often than men (21.6% among women, as opposed to 14% among men).
b. Young people with MHPs have to face situations of overprotection and control by their partners more often (30.4%) than those over 30 (19.7%) or over 45 (12.3%).

15. **11.4%** of individuals with a MHP have suffered **mocking, insults, coercion, blame or contempt** from their partner because of their MHP. Although this type of abuse can also happen without a MHP being present, participants mentioned that their MHP was often mentioned as a way of insulting, degrading and offending them, making this practice particular to discrimination because of mental health.
a. Women are more likely to suffer from this kind of unfair treatment (14.4% of women, as opposed to 6.9% of men).

16. Women with MHPs (5.4%) are more likely to be

exposed to physical or sexual violence by their partner than men (2.3%) at some point in their lives.

17. Individuals with a MHP often experience meddling or pressure by their partners because of their MHP. Nevertheless, 12.7% of individuals don't consider meddling a form of discrimination.
a. 1 of every 10 individuals with MHPs state that their partner told others of their condition without their consent.
b. 9.1% of individuals with MHPs state that they have been pressured by their partner to work because of their MHP.
c. 8% of individuals with MHPs state that their partner has interfered in their finances because of their MHP.
d. 5.7% of women with MHPs have been pressured not to have children by their partner, many more than men (0.7%).

18. One member of the couple having a MHP often causes the other to take on the role of caretaker, which may favour the establishment of a hierarchical relationship of unequal **dependence**. This, in turn, may favour the appearance of discriminatory treatment.

COUPLES WHERE BOTH MEMBERS HAVE A MHP

19. Many people imagine that relationships between individuals with MHPs are more common for different reasons:
a. It's claimed that individuals with MHPs understand one another better, which favours the relationship from the beginning.
b. It's claimed that individuals with MHPs prefer to interact with one another because they share the same spaces, are more likely to socialize, and therefore to establish a sexual or affectionate relationship.

20.3% OF INDIVIDUALS WITH MHPS HAVE BEEN PRESSURED NOT TO HAVE CHILDREN BY THEIR IMMEDIATE FAMILY, THEIR PARTNER, MENTAL HEALTH PROFESSIONALS OR OTHER HEALTH PROFESSIONALS, OR THEIR EXTENDED FAMILY

20. The public tends to imagine that **relationships between individuals with MHPs are harmful**, because these individuals tend to destabilize one another and worsen crisis episodes.

MATERNITY AND PATERNITY

21. Partners and families of individuals with MHPs state different arguments to justify why it's **preferable for them not to have children**:

a. It's claimed that the individual's pharmacological treatment will need to be modified, which could have very negative consequences for the individual, because medication could harm the foetus or the quality of sperm.

b. It's claimed that the emotional destabilization caused by pregnancy or the raising of children could provoke a worsening of the MHP or unleash a crisis.

c. It's considered that individuals with MHPs don't have the necessary capacities to take on the role of parents. It's often stated that although individuals with a MHP may be capable of taking care of children, during a crisis they cease to be capable of doing so because they can't be held responsible for their actions.

d. There is doubt regarding whether individuals with a MHP can be parents for fear of their children developing a MHP as the result of hereditary factors.

22. **20.3%** of individuals with MHPs have been **pressured not to have children** by their immediate family, their partner, mental health professionals or other health professionals, or their extended family.

a. 12.4% of individuals with MHPs have been pressured by their immediate family.

b. 11.1% of individuals with MHPs have been pressured by mental health professionals.

c. 4% of individuals with MHPs have been pressured by their partner.

7.5 STIGMA AND DISCRIMINATION IN THE HEALTH SECTOR

THE PUBLIC HEALTH NETWORK

The principal effects of stigma and discrimination detected in the health sector are:

1. Stereotypes regarding mental health may affect the quality of the attention and treatment received by individuals with MHPs. These results coincide with the findings of Sartorius, (2002), Aydin *et al*. (2003), Schulze and Angermeyer (2003), Patel, (2004), Nordt *et al*. (2006), Grausgruber *et al*. (2007), Jones *et al*. (2008) and Mengod (2007). [4].

2. The principal negative stereotypes faced by individuals with MHPs in the public health network are no different from those found in the general public. These results coincide with studies by Sartorius, (2002), Aydin *et al*. (2003), Magliano *et al*. (2004a), Patel (2004), Nordt *et al*. (2006) and Grausgruber *et al*. (2007)[5].

3. Individuals with MHPs **may receive poorer care when physical discomfort symptoms are interpreted as a mere consequence of the MHP**. These results coincide with research by Schulze and Angermeyer (2003)[6].

a. Individuals with MHPs are discredited when the reasons for their visit are seen as a consequence of their separation from reality.

b. Individuals with MHPs receive inadequate assistance when they are exclusively defined according to their MHP and their organic pain is considered an effect of the MHP.

c. Individuals with MHPs often have their family accompany them when visiting health professionals to avoid

4 "As a matter of fact, when an individual with a psychiatric diagnosis suffers from a physical pathology, their ability to receive treatment at specialized sanitary services or to be appropriately and efficiently treated decreases because of their 'status' as 'mentally ill.'" Quoted in Magliano, L. (2012).

5 "Available data suggests that as health professionals, we aren't immune to sharing stereotypes and prejudices regarding people with schizophrenia with the general population."

6 "These beliefs result in little treatment by doctors of the physical disorders these patients suffer, and there is a tendency to interpret their physical suffering as signs of their mental pathology."

this sort of treatment. In these cases, the family member becomes the reference that gives value to the claims of discomfort on the part of the individual with a MHP.

4. Negative stereotypes may influence the treatment received by those with MHPs.
a. 26.1% of individuals with MHPs claim to have been treated unfairly at some point in hospitals, 9.5% fairly frequently or very frequently.
b. 24.9% of individuals with MHPs state that they have been unfairly treated because of their MHP in primary health care centres, and 10% consider this treatment to have been fairly or very frequent.

5. Women with MHPs are exposed to more discrimination than men.
a. 32.2% of women have suffered from unfair treatment at some point in hospitals, as opposed to 20.7% of men.
b. 33% of women with MHPs have suffered from unfair treatment at some point at a primary health care centre, as opposed to 15.9% of men.

6. Concrete examples of pressure or meddling by health professionals in the lives of those with MHPs are rare. 9% of individuals with MHPs have received some sort of pressure or interference by health professionals because of their MHP[7].

7. Individuals with MHPs may receive treatment of a lower quality. 17.6% of those with MHPs state that they have experienced some sort of situation of abuse, avoidance or neglect, overprotection or control, or aggression at health centres or hospitals.

8. Care for the special needs of individuals with MHPs in sanitary treatment depend exclusively on the empathy of those caring for them. There are no protocols that establish the adaptation of health treatment to the special needs of those with MHPs.

7 They interfered in my finances; they pressured me not to have children; they pressured me not to have a partner; they pressured me not to become independent; they pressured me to work; they pressured me not to work; they pressured me to study; they pressured me not to study; they interfered in my role as a parent; they revealed my MHP to others without my consent.

THE MENTAL HEALTH NETWORK

The principal effects of stigma and discrimination detected in the mental health network are:

1. The social perception of mental health services is affected by the taboo of mental health. **In most cases, society is not aware of the available mental health services**. These services are known to those who have MHPs or who work in this area. This coincides with the findings of Davis & Ford, (2004)[8] .

2. The social perception of mental health services is heavily influenced by stigma and discrimination. **There is a negative social perception of mental health services and treatment**.

3. The existence of a negative social perception of health services and treatment causes those with psychological discomfort or a possible MHP to often avoid visiting these services. **Many are afraid of using these services because they fear being labelled as "crazy."** These results coincide with the studies by Corrigan (2004b) and Keating & Robertons (2004)[9].

4. The negative social perception of mental health services and fear of being labelled may also **cause individuals to abandon treatment, since they no longer feel identified with the idea of the "crazy person" imagined by society.**

5. Individuals with MHPs often state that they occasionally receive unfair treatment from mental health services because of their condition. **40.6% of individuals with MHPs claim to have been treated unjustly on some occasion** at at least one mental health service, and 19.5% claim to have received this treatment fairly frequently or very frequently.

a. 39% of those with MHPs who have visited a hospital

8 "Most of those interviewed didn't know of the mental health services available to them until their condition became severe."

9 "Many individuals don't seek help or minimize contact with services to avoid being labelled as mentally ill."

psychiatric ward state that they have received unjust treatment because of their condition on some occasion. In 17.3% of cases, this treatment was fairly frequent or very frequent.

b. 27.7% of those with MHPs who have visited a day hospital state that they have received unjust treatment because of their MHP on some occasion. In 10.5% of cases, this treatment was fairly frequent or very frequent.

c. 27.4% of those with MHPs who have visited a therapeutic community claim to have received unjust treatment because of their MHP on some occasion. In 17.2% of cases, this treatment was fairly frequent or very frequent.

d. 25.8% of those with MHPs who have visited a psychiatrist claim to have received unjust treatment because of their MHP on some occasion. In 11.9% of cases, this treatment was fairly frequent or very frequent.

e. 25.2% of those with MHPs who have visited a day centre claim to have received unjust treatment because of their MHP on some occasion. In 10.1% of cases, this treatment was fairly frequent or very frequent.

f. Women with MHPs receive unjust treatment more often than men in day centres, community rehabilitation centres, day hospitals, labour insertion services for those with MHPs or hospital psychiatric wards.

g. 49.1% of individuals between 30 and 44 years of age with MHPs state that they received unjust treatment on some occasion in hospital psychiatric wards, while young people (under 30) with MHPs state the same in 33.8% of cases.

h. 31.5% of individuals with MHPs between 30 and 44 years of age state that they have received unjust treatment on some occasion in an adult mental health centre (CSMA), while young people with MHPs state the same 19.3% of the time.

6. Discrimination in the mental health network generally takes the form of assistentialism and paternalism. Overprotection, control, condescending

behaviour and infantilization are the types of discrimination that make up assistentialist or paternalistic treatment. 18.3% of individuals with MHPs have experienced overprotection or control at some mental health service.

a. 10.8% of those associated at some point with an infant and juvenile mental health centre state that they have suffered from overprotection or control.

b. 9.4% of those associated at some point with the psychiatric ward of a hospital state that they have suffered from overprotection or control.

c. 9.1% of those associated at some point with a day hospital state that they have suffered from overprotection or control.

7. 24.4% of those with MHPs have suffered from some sort of meddling by a medical professional from the mental health network.

8. Assistentialism and paternalism towards those with MHPs often have a de-personalizing effect. Mental disorders are transformed into the most relevant attribute of the person, above any of their abilities. These results coincide with the findings of Corrigan (2005)[10] . Per tant, l'assistencialisme i al paternalisme són comportaments que produeixen processos d'autoestigma que no ajuden a la recuperació de les persones amb un trastorn mental.

9. 30.9% of those with MHPs state that they have suffered from some sort of discrimination at mental health services (mocking, insults, coercion, rejection or distancing, physical and/or sexual aggression).

10. 14% of individuals with MHPs have suffered from mocking, insults, pressure, blaming or contempt at services in the mental health network.

a. 11.1% of those associated at some point with a hospital psychiatric ward state that they have suffered

DISCRIMINATION IN THE MENTAL HEALTH NETWORK GENERALLY TAKES THE FORM OF ASSISTENTIALISM AND PATERNALISM

10 "The central theme of the dehumanization described once and again by the users of these services is that they are treated like children, they are excluded from important decisions, and the professionals assume that they are lacking the capability to take responsibility of their own lives." (Corrigan, 2005).

from mocking, insults, coercion, blaming or contempt.
b. 8.3% of those associated at some point with a therapeutic community state that they have suffered from mocking, insults, coercion, blaming or contempt.
c. 7.6% of those associated at some point with a day hospital state that they have suffered from mocking, insults, coercion, blaming or contempt.

11. 12.4% of those with MHPs have suffered avoidance and rejection at some service in the mental health network.
a. 9.2% of those associated at some point with a hospital psychiatric ward state that they have suffered avoidance and rejection
b. 7.3% of those associated at some point with an infant and juvenile mental health centre state that they have suffered avoidance and rejection.

12. 3.9% of individuals with MHPs have experienced physical or sexual aggression at some service in the mental health network.

13. Management figures in mental health network services that limit patients' right to freedom, autonomy or privacy generate discomfort. This discomfort is expressed both by individuals with MHPs who have had first-person experience with these practices and by professionals who express their discomfort when forced to comply with protocols and rules that are excessively restrictive.

14. Structural stigma can be manifested in rules and in protocols as well as in the culture of services.
a. Rules and protocols organize and administer the relationships that take place within the institution or service.
b. The culture of a service involves traditional ways of operating that have been perpetuated by custom. These implicit rules can also regulate the workings and the dynamic of institutions.

15. Structural stigma has a characteristic trait that can make it more difficult to detect. **Both individuals with MHPs and professional figures end up normalizing stigmatizing and discriminatory practices**. These practices aren't questioned, since they are completely integrated into the culture of the service.

RESIDENCES, CARETAKING FOUNDATIONS, SOCIAL SERVICES AND SUPERVISED FLATS

The principal effects of stigma and discrimination detected in residences, caretaking foundations, social services and supervised flats are:

1. Individuals with MHPs state that they have experienced discrimination in residences, caretaking foundations, social services and supervised flats.
a. 29.9% of those with MHPs who have lived in a residence have experienced unjust treatment on some occasion, and 14.6% have experienced it fairly frequently or very frequently.
b. 19.5% of those with MHPs who have lived in a supervised flat have experienced unjust treatment on some occasion, and 2.8% have experienced it fairly frequently or very frequently.
c. 21.4% of individuals with MHPs who have been associated with a Caretaking Foundation have suffered from unjust treatment on some occasion, and 6.7% have experienced it fairly frequently or very frequently.
d. 6% of those with MHPs who have been served by social services have experienced unjust treatment fairly frequently or very frequently. 11.1% of young people (under 30) with MHPs have suffered from unjust treatment fairly frequently or very frequently.

2. 16.9% of those with MHPs who have been attended to by social services have experienced pressure or

meddling at least once on the part of professionals.
a. 7% of those with MHPs state that professionals from social services have interfered in their finances because of their MHP. This is especially frequent among those 45 or older (8.8%).
b. 11.2% of young people (under 30) with MHPs have been pressured to work. Paradoxically, they are also the group that has been most pressured not to work (7.5%).

7.6 STIGMA AND DISCRIMINATION IN SOCIAL RELATIONSHIPS

The principal effects of stigma and discrimination in social relationships are:

1. Having **friends and a good community and social network improve quality of life**. Discrimination and stigma towards those with MHPs tend to reduce their social network, and can place them in situations of social isolation[11], which can become even more significant than the difficulties derived from their MHP.

2. Over half (53.1%) of those with MHPs state that they have been treated unjustly by their group of friends on some occasion because of their MHP. 34.4% state that they have experienced this type of treatment occasionally, while 18.7% state that they have experienced it fairly often or very often.

a. Women suffer from unjust treatment more often than men: 57% state that they have suffered from unjust treatment from their group of friends at some point in their lives, as opposed to 49% of men.

3. Once a MHP appears, the individual's circle of friends may react by treating the individual in a discriminatory manner.

a. Reactions of avoidance, rejection and distancing by an individual's group of friends is the most common behaviour of this type. One-third have experienced this at some point in their lives, and one-fifth have experienced it over the past year. Individuals who experience rejection by their social circle, group of friends or group of peers are very likely to isolate themselves socially and not seek to establish new relationships, as

OVER HALF (53.1%) OF THOSE WITH MHPS STATE THAT THEY HAVE BEEN TREATED UNJUSTLY BY THEIR GROUP OF FRIENDS ON SOME OCCASION BECAUSE OF THEIR MHP

11 This coincides with the conclusions of the article by Thornicroft, G. *et al*. (2004) in which it's demonstrated that stigma provokes the deterioration of social relationships. (*The personal impact of schizophrenia in Europe*. Schizophr Res, 2004. 69(2-3): p. 125-32.)

a way of avoiding rejection. This attitude is aimed at avoiding the discomfort of feeling discrimination. The experience of rejection and discrimination is key to understanding why individuals retreat from society, isolate themselves, or simply reduce contact with others.
b. 23.4% of individuals with MHPs state that they have been over-protected or controlled at some point in their lives. 17.3% indicate that they have experienced this sort of treatment over the past year.
c. 17.8% of individuals with MHPs indicate that they have experienced discriminatory treatment such as mocking, insults, coercion, blaming or contempt at some point in their lives. 9.5% state that they have experienced this kind of treatment in the past year.
d. 3.7% of individuals with MHPs state that they have been the victims of physical or sexual aggression at some point in their lives 1.7% state that they have suffered the same over the past year.

4. Women with MHPs experience discrimination by their group of friends with more frequency than men with MHPs:
a. Overprotection and control happen 12.5% more among women than men.
b. Avoidance, rejection and distancing happen 10.5% more among women than men.
c. Women suffer from twice as many physical and sexual aggressions as men (4.9% of women, as opposed to 2.4% of men).

5. Young people (under 30) with MHPs experience more of all classes of mistreatment and discrimination from their group of friends:
a. 40.8% of young people with MHPs state that they have experienced avoidance, rejection and distancing at some point in their lives, whereas only 30.9% of those over 35 claimed to have experienced the same.
b. 33.6% of young people with MHPs have experienced overprotection and control at some point in their lives,

while only 18.9% of those over 45 state that they have experienced the same.

6. Establishing relationships of friendship based on good treatment, empathy and understanding becomes a challenge for those with MHPs. The factors that increase positive predisposition towards those with MHPs are the product of chance: having had negative experiences, having a personal interest for mental health or forming part of a social space where those with MHPs are present. Good treatment still depends excessively on completely random elements.

7. Individuals with MHPs and their social circles need tools in order to establish fluid, open and frank communication on all aspects of the MHP. Explaining the characteristics of the MHP, the needs that result, symptoms, etc. is something that is learned without any prior instruction, by trial and error.

8. Hiding one's MHP becomes a useful tool for avoiding discrimination in social relationships. Although it's desirable to be able to be open about one's MHP, doing so involves important risks.
a. 45% of those with MHPs hide their condition from most people, and specifically chose which friends to reveal it to. Women (48.9%) chose to selectively reveal their MHPs more often than men (41.1%). This tendency is even more pronounced in women under 30, where 59.5% chose to reveal their MHPs only to certain friends.
b. 31.8% of those with MHPs state that they have revealed their MHPs to their entire group of friends.
c. 11.1% of those with MHPs haven't revealed their condition to any of their friends.

9. In the long term, hiding one's MHP becomes a communicative barrier that results in the deterioration of relationships of friendship.

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STIGMA AND DISCRIMINATION IN MENTAL HEALTH IN CATALONIA, 2016 is a study carried out by Obertament, the Autonomous University of Barcelona and Spora Sinergies with the aim of exploring and identifying the psychosocial factors that are related to stigma and discrimination suffered by those with mental health problems in Catalonia.

Getting to know the reality of this situation is essential in order to continue the struggle against stigma and discrimination and to help us focus our efforts in the coming years.

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