How to Overcome Mental Illness Stigma in Canada

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People with mental illness and mental health problems are the most stigmatized globally (Overton & Medina, 2008). This situation is not different for Canada. Normally, negative perceptions and false assumptions about mental illness are mainly the cause of this discrimination. According to Goffman (1963), stigma is usually caused by a discrediting attribute of the discriminated person. In these case, these stereotypes occur to a group of people when their characters are regarded as being inferior or different to societal norms. These characters taint the image of the person and make him/her be perceived as having a "spoiled identity." In Canada, an average of 20% of the individuals suffer from mental illness every year. This situation is further aggravated by the fact that only a third of the persons who have mental health problems seek medication. In this regard, it essential to evaluate the effects of stigma on mentally ill individuals.

According to the American Psychiatric Association [APA], (2000), mental illness is a significant psychological or behavioral syndrome that results from biological, behavioral, or psychological dysfunction in the person. Mental illness leads to increased risks of a person suffering death, disability, pain, or losing some of his/her freedoms. Actually, in Canada, most of the 4000 individuals that commit suicide annually suffer from mental health (Mental Health Commission of Canada, 2012). Consequently, an understanding of how mentally ill persons can cope with stigma is essential in reducing the occurrence of sufferings on these persons.

There are six dimensions of stigma, which are concealability, course, aesthetics, peril, disruptiveness, and origin (Ahmedani, 2011). In the element of peril, the general public often fears people with mental health problems because they find them to be frightening, unpredictable, and strange. This issue highlights the aspect of aesthetics and the nature of mental

disorders. In particular, the social cues are always shown by the psychiatric symptoms such as awkward physical appearance or social skills (Ahmedani, 2011). Noteworthy, the society's inability to differentiate between mental illness and abnormal behaviors can also result in the formation of prejudices and avoidance.

The dimension of origin in the stigma of mental illness is based on the belief that these ailments are caused by biological and genetic factors (APA, 2000). This view has a direct impact on the dimension of control. In this case, the society assumes that people with mental illness should be able to control themselves. Accordingly, those who are unable to control themselves are regarded as lacking personal effort and being irresponsible (Ahmedani, 2011). In this regard, mental health problems brought by the use of hard drugs are viewed as controllable and avoidable ailments. Consequently, the society is usually less sympathetic to such individuals. On the contrary, illnesses due to disorders that are not directly caused by the person are treated with mercy. An example is post-traumatic stress disorder (PTSD). The aspect of compassion supports the dimension of pity in mental stigma.

The concealability dimension of mental illness evaluates the difficulty or ease of identifying the health problem. According to research by Angermeyer and Matchinger (2005), people with mental illness that are more visible such as schizophrenia are more discriminated than those whose symptoms are hard to detect. In the dimension of course and stability, people always question about the likelihood of the sick individual getting well (Ahmedani, 2011). Finally, the dimension of disruptiveness examines how the mental disorder impacts the relationship between the mentally ill individual and the rest of the society.

Stigmatized attitudes on people with mental health are always in the form of social stigma. An internalization of stigmatized views on the mentally ill person results in self-stigma.

Finally, professional stigma occurs due to perceptions help by health officers about their patients. Social stigma is mainly structural since it is based on beliefs that are held by the majority of the society (Ahmedani, 2011). In this case, the discriminated persons are treated as inferior. Accordingly, the stigmatized persons may have limited access to services and various opportunities.

Corrigan et al. (2001) opine that social stigma is based on socio-cultural, motivational, and cognitive models. Under the socio-cultural model, stigma occurs to justify social injustices. For example, this may be a way for the society to explain the unjust treatment of the mentally ill persons. The motivational model asserts that stigma occurs to satisfy the psychological needs of individuals. Since mentally ill persons are usually from low socio-economic groups, the discrimination may occur due to their inferiority. The social cognitive model aims at creating a cognitive framework that can be used to differentiate mentally ill persons from ordinary individuals.

According to Corrigan (2007), continuous social public stigma makes a discriminated person feel guilty about his/her condition. Usually, self-stigma results in a person having low self-esteem, which affects his/her efficacy. Finally, although health professional stigma is not common, studies by Volmer, Mäesalu, and Bell (2008), showed that medical students who prefer to stay away from people with mental disorders are always less willing to counsel patients who have Schizophrenia. This kind of prejudice can negatively mentally ill patients who are vulnerable and may be unable to realize they are being discriminated.

The excessive reliance on positivism in medical diagnosis has monopolized the truth. As a result, positivism is no longer value-neutral; instead, it leads to social inequality (Foucault, 1977). Bio-medical models are established in under positivism, and they usually confuse truth

with diagnostic perspectives. Accordingly, these models require people to act in a specific pre-determined manner, which makes them lose their power. Under social constructionist view, sociologists examine the distinct way in which mentally ill persons relate to the world (Callero). In sharp contrast with positivists, constructionists are of the opinion that since all people are unique, they react and interact with the society differently. In mental illness, psychologists use medical discourses that identify diseases and distinguish mentally ill persons from ordinary persons. These techniques fail to factor in the uniqueness of each person since they categorize them as "normal" or "abnormal," and "acceptable" or "unacceptable" (Walker, 2006).

According to Brown (2007), the categorization of individuals into "abnormal" or "unacceptable" groups erodes their identity, and, in turn, establishes one that fits the associated cultural view of the mental illness. One overarching nature of positivism is that it infers mental illness as being freestanding, and is thus an "objective truth." Therefore, this view disregards the social construction of illness (Conrad and Baker, 2010). As a result, clinicians categorize mental illness into abstractions that are simply identified by examining a cluster of symptoms (Walker, 2006). Thus, persons who do not comply with social norms are viewed as being mentally ill. From this perspective, the use of scientific methods in the examination of mentally ill persons have monopolized the "truth" and limited the power of persons who are regarded as being mentally unhealthy. Interestingly, if all people were mentally ill; positivists could argue that behaving in an insane manner shows that a person is mentally healthy. Obviously, this would be wrong, and shows the bias approach of this method. This approach has led to ordinary human beings in some cultures being perceived as mentally ill in others. Therefore, the positivism approach has destructive ethical and cultural consequences. For example, Western cultural views of mental illness are different from that of non-western societies.

Wertheimer and Rappoport (1978) also note that contemporary medical analysis of mentally ill persons is ineffective. Using the David Rosenhan 1979 experiment, these researchers note that the prognosis and diagnosis approach to mental illness is subjective. In this case, there are a lot of biases in the medical examination process of this persons. Consequently, the determination of whether a person is mentally ill or not depends on the psychiatric opinion, which may be biased. In fact, an 'expectation bias' always leads to health care officers declaring some people as being mentally ill. In this view, these officers limit the power of individuals to behave or react in ways that not the norm of the society.

According to Callero (2003), regimes of power not only control a bounded rational subject, but they also bring the self into existence through the imposition of severe disciplinary actions. Therefore, medics, therapists, and specialists assume the position of power when they use techniques such as measurement and assessment to examine individuals and identify their health status. As a consequence, these persons dominate others and categorize those who do not comply with social norms as being mentally ill.

Wiley (1994) also notes that a person's environment influences his/her behavior. In particular, he asserts that the human self is a reflexive process of social interactions. The reflexive process shows that a human being has the capacity of being subject to one's self and at the same time be the object (Callero, 2003). Thus, human reflexivity is not biological; rather, it emerges out of human social experiences. In this regard, the self is a reflective process that controls a person. Further, due to human beings complex social and intellectual capacities, they have far more sophisticated systems of signs and gestures that constrain and facilitate reflection, action, and perception.

Given that worldviews are diverse, the classification of mental illness based on western diagnostic systems should be viewed only as a social construction (McCann, 2016). Psychiatrists usually ignore the variances in cultures and experiences of individuals during diagnosis, which often results in wrong conclusions. Since that a person's views are shaped and influenced by his/her experience, which affects his/her behavior, it is essential for these officers to consider these factors. Further, this insight shows that culture helps in identification of illness and determine appropriate responses to it. In this regard, people may articulate similar behavioral tendencies differently depending on their cultures.

An example of how individuals react differently depending on their culturally sanctioned norms can be seen in schizophrenia. According to World Health Organization (1979), people with schizophrenia respond and behave differently. According to the WHO (1979), people in more developed countries such as the United and Kingdom and Denmark experience more symptoms of schizophrenia than those in developing countries like India and Nigeria.

According to McCann (2016), the variances in how people with Schizophrenia react is mainly due to their different cultural beliefs, which affects the courses of their mental illness. In developed countries, Schizophrenia is regarded as a persistent biological impairment, whereas, people in developing countries view it as a curable ailment. In most of the African nations, for example, schizophrenia is considered as spirit possession, which can be treated through exorcism. Yang et al. (2010) also note that Chinese believe that excessive thinking causes schizophrenia. The Chinese beliefs are based on Confucianism, which emphasizes on harmony and balance to enables a person to have equilibrium in the control of his/her feelings.

How to Overcome Stigma

To overcome mental illness stigma, individuals must use various strategies which include giving excuses, disclosing their weakness in advance, and making changes to their bodies (Goffman, 1963). Making changes to bodies simply implies that a person with mental illness may use tools such as hearing aids, spectacles, or walking sticks to improve the quality of his life. This equipment can enable him/her to interact with the rest of the society easily and efficiently reduce the cases of stigma.

Another alternative to overcome stigma is the use of excuses. Discriminated persons should make excuses for their lack of skills or inability to interact with ordinary people. This tactic can cause people reduce the expectations that they have of the person. Unfortunately, this hiding normally leads to isolation, depression, and anxiety (Goffman, 1963). It also leads to self-stigma. A person with mental illness can join a support group. Support groups enable persons to avoid cases of isolation. They also offer programs and internet resources that reduce cases of stigma by educating persons with mental illness.

Finally, a stigmatized person can assume that the public is ignorant. Goffman (1963) states, “as when a hard of hearing person fails to respond to a remark proffered to him by someone ignorant of his shortcoming; sleepiness, as when a teacher perceives a student's petit mal epilepsy seizure as momentary daydreaming…” (105). Therefore, most of the stigmatizing remarks made by ordinary persons are usually due to their ignorance. These individuals can also use humor to cope with their challenge and to enable them to socialize easily with ordinary people. Importantly, humor breaks the tension between stigmatized persons and ordinary individuals and allows them to socialize.

Canada’s Role in Mental Health

The Canadian government plays an essential role in mental health regulation and the provision of healthcare services. Accordingly, the government enhances access to services, improves quality of mental health treatments, and protects patients. The government's role in mental treatment are as follows:

Establishment of regulations.

Through the Canada Health Act, the government can ensure that all its territories and provinces offer quality healthcare to its citizens (Butler & Philips, 2013). The Canadian Health Act requires all the territories and provinces to adhere to principles of universality, accessibility, portability, comprehensiveness, and public administration (Butler & Philips, 2013).

Direct Delivery of Mental Health Services and Benefits to Federal Client Groups

The federal government has a duty of delivering mental health care services and benefits to specific populations. In particular, it has a role of providing medication to prisoners and individuals in the Canadian Forces. It also provides healthcare to members of the RCMP, First Nations and the people of Inuit people, veterans, and some refugees (Butler & Philips, 2013). Finally, it provides treatment to all persons who work for the federal government.

Expanding Access to Mental Health Home Care Services

The government provides insurance for short-term acute mental health home care services. These services enhance access to the treatment of mental health (Butler & Philips, 2013). Further, it improves response, which enable quick recovery of mental health individuals.

Mental Health Promotion

Through the Public Health Agency of Canada (PHAC) Mental Health Promotion program, the Canadian government coordinates and promotes actions on mental health treatment. In particular, it establishes policies and programs that aim at fostering positive mental health

treatments (Butler & Philips, 2013). Further, it seeks to address issues such as poverty, unemployment, and homelessness, which contribute to mental health problems.

Research and Data Collection

The Canadian government also provides funding for research on mental health treatment. The federal government's research funding agency supports the research on the functioning disorders in the brain, mental health, and mental illness through the Institute of Neurosciences, Mental Health and Addiction (INMHA) (Butler & Philips, 2013).

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