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STIGMA AND MARGINALISATION: STRUCTURAL VIOLENCE AND THE IMPACT ON MENTAL HEALTH

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INTRODUCTION

Social workers traditionally offer emotional, social and financial support to people who are in distress or in crisis. Although the problems presented are usually problems in daily living, these clients often are suffering from a mental disorder such as depression, anxiety, post traumatic stress disorder or substance abuse. These problems in daily living, rather than the symptoms of their emotional state or disorder *per se,* usually causes their distress and their need to seek help (WHO, 2001a). Sadly, their problems are also often exacerbated, or even caused, by the stigma and marginalisation experienced worldwide by those with mental disorders.

It is important, therefore, that all social workers understand the complex relationships between marginalisation and mental health and mental disorders. This includes understanding the role of structural violence in relation to mental health. This article will discuss some of these relationships and aims to encourage social workers to be alert for and address these issues in their practice.

MENTAL DISORDERS AND MENTAL HEALTH

Mental disorders include conditions such as psychological distress associated with life situations, events and problems; common mental disorders such as depression and anxiety disorders; severe mental disorders, for example, schizophrenia; substance abuse disorders; abnormal personality traits, and organic conditions (Lavikainen, Lahtinen & Lehtinen, 2000). The clients that social workers engage with clearly often include those who experience these conditions.

Mental health, on the other hand, is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community" (WHO, 2001b:1). Social workers can recognize this "state of well-being" as the goal that they hope their clients will achieve, whether by working developmentally with the clients individually, with their families, in groups or with structures within their clients' communities (Payne, 2005; Potgieter, 1998; Sturgeon, 1998; Sturgeon & Keet, 2005).

MENTAL HEALTH ISSUES

The boundary between the social and emotional issues that social workers deal with and "mental disorders" is thus both artificial and unhelpful. To illustrate the point, a poorly functioning mother, if referred to a child welfare agency, may be primarily considered a neglectful mother, and receive services focused on assessing and addressing her ability to care adequately for her child, although she and the social worker may be unaware that her behaviour is the result of her depression, which therefore goes untreated. However, if instead she was referred to a mental health setting, her mental and emotional state would be assessed and addressed, and if depression was diagnosed she could receive medication and counselling, although her mothering issues may not get adequate attention.

Social workers in general practice, therefore, always need to be comfortable to explore the possibility of an underlying mental health problem which, if addressed, could benefit the client.

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In other words, social workers need to be comfortable engaging holistically with all aspects of their clients' experience.

DE-INSTITUTIONALIZATION

The adoption worldwide, including South Africa, of mental health policy to de-institutionalize and provide community care for people with mental disorders requires that pharmacological and psychosocial interventions be provided in non-specialized health care settings, where much of the initial mental health assessment will also be undertaken (Lazarus, 2005; Talbott, 2004; WHO, 2010a). Only acutely ill people will be cared for in psychiatric hospitals, and they will return to the community as soon as possible (Barton, 1999; Kritzinger & Magaqa, 2000; RSA Mental Health Care Act No. 17 of 2002). Thus increasing numbers of people receiving community based care requires social workers in community settings to be aware of the possibility that help seekers may be suffering from mental disorders. No longer will people with mental disorders only be the concern of mental health service providers (WHO, 2010a). It is hoped that community based social workers will engage creatively with people with mental disorders in the community. This includes critically engaging in research and policy development around the new challenges that this policy has created.

MENTAL DISORDERS ARE COMMON

Mental disorders are highly prevalent world-wide and there is evidence that mental health is an essential and inseparable component of health and ill-health (Prince, Patel, Saxena, Maj, Maselko, Phillips & Rahman, 2007). However, although mental disorders are treatable, provision of mental health services is inadequate worldwide, but particularly in developing countries (Saxena, Thornicroft, Knapp & Whiteford, 2007). Despite evidence of the long-term positive effects of mental health promotion and prevention programmes, these aspects of mental health are also neglected (Herrman, Saxena, Moodie & Walker, 2005; Hosman, Jane-Llopis & Saxena, 2006).

Mental disorders are common, in that 14% of the global burden of disease is attributed to neuropsychiatric disorders (Prince *et al.*, 2007); one in four people will experience a mental illness that would benefit from treatment and one in four families has one member suffering from a mental or behavioural disorder (Barry & Jenkins, 2007; Murray & Lopez, 1996; WHO, 2001a). In South Africa neuropsychiatric disorders comes second after HIV/AIDS in years of life lost due to disability (YLD's) (Norman, Bradshaw, Schneider, Pieterse & Groenewald, 2006). "In low income countries, depression represents almost as large a problem as does malaria (3.2% versus 4% of the total disease burden), but the funds being invested to combat depression are only a very small fraction of those allotted to fight malaria" (Mathers & Loncar cited in WHO, 2010b). That these figures surprise many, including those working with people in distress, illustrates the extent that mental illness is "hidden".

In addition, mental disorders are associated with risk factors for communicable and non-communicable diseases, e.g. heart disease, cancer, diabetes, HIV infections and maternal and child health, and are a contributory factor to unintentional injuries and accidents as well as intentional injuries (Prince *et al.,* 2007). Conversely, health conditions increase the risk for mental disorders, e.g. HIV/AIDS and heart disease are associated with depression (Prince *et al.,* 2007). In South Africa, a study found that 44% of people living with HIV/AIDS have a diagnosable mental health condition compared with 17% in the general population (Freeman, Nkomo, Kafaar & Kelly, 2008).

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Dr. Vijay Ganju, the Secretary-General/CEO of the World Federation for Mental Health, stated in his introduction to World Mental Health Day 2010, the theme of which was "Mental Health and Chronic Physical Illness: The Need for Continued and Integrated Care":

> "Four chronic illnesses – cardiovascular, diabetes, cancer and respiratory illnesses - are responsible for 60 percent of the world's deaths. Our understanding of the relationship between these chronic illnesses and mental illness has increased dramatically in the last two decades. We now know that persons with these chronic illnesses have much higher rates of depression and anxiety than the general population. Major depression among persons experiencing chronic medical conditions increases the burden of their physical illness and somatic symptoms, causes an increase in functional impairment, and increases medical costs. The presence of mental illness with long-term illnesses impairs self-care and adherence to treatment regimens and causes increased mortality.
>
> The bottom line is that mental illnesses occur with chronic mental conditions in many patients, causing significant role impairment, work loss and work cutback. They also worsen prognosis for heart disease, stroke, diabetes, HIV/AIDS, cancer and other chronic illnesses." (Ganju, 2010).

An example of acknowledging the link between chronic illness and mental health is a World Federation for Mental Health programme, "The WFMH Africa Initiative on Mental Health and HIV/AIDS", which is currently engaging with researchers, social service professionals and those infected and affected by HIV/AIDS in Southern Africa to advocate for greater attention to be given to the mental health needs of people living with HIV/AIDS, their families and caregivers (WFMH Africa Initiative on Mental Health and Aids, 2010).

SERVICE DELIVERY

Contrary to public perception, many mental disorders are treatable with medication and psychosocial support (Patel, Araya, Chatterjee, Chisholm, Cohen, de Silva, Hosman, McGuire, Rojas & Van Ommeren, 2007; WHO, 2006a). There is also strong evidence of the positive long-term effects of mental health promotion and prevention – usually performed by people other than mental health professionals (Hosman *et al.,* 2006; Petersen, 2010; Sturgeon, 2006). Barry and Jenkins (2007:53) advocate a socio-ecological perspective to mental health promotion which "highlights the interdependencies among social systems operating at different levels" and "shifts the focus of mental health promotion programmes beyond an individualistic focus to also consider the influence of broader social, economic and political forces". This requires attention to the "wider structural influences on behaviour, such as the role of poverty and discrimination, and how these are mediated through local community norms and values". This is surely the province of social work.

Despite the need, inadequate attention is given to mental health issues worldwide. This includes policy, legislation, service delivery, human resources and funding. As a result, people with mental disorders are marginalized, particularly in developing countries (Flisher, Lund, Funk, Banda, Bhana, Doku, Drew, Kigozi, Knapp, Omar, Petersen & Green, 2007; WHO, 2010b). One third of all countries have no mental health policy; 30% of all countries have no specified budget for mental health care, and of those that do, 25% spend less than 1% of the total health budget on mental health (WHO, 2005a); the treatment gap for serious disorders is 35-50% in developed countries and 76-85% in low and middle income countries (WHO, 2004 in Saxena *et al*, 2007); the treatment gap for schizophrenia is 32%, 56% for depression and 78% for alcohol

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abuse (WHO, 2004 in Saxena *et al.,* 2007). Twenty-two percent of countries worldwide and 45% of low income countries exclude people with mental illness from disability benefits (Saxena *et al*., 2007; Thornicroft, 2006).

STRUCTURAL VIOLENCE

Structural violence is defined for the purposes of this article as "the unjust distribution of wealth; marginalisation, discriminated access to medical care and education depending on one's class; unemployment and xenophobia" (Schumacher, 2008). Structural violence is caused by social structures or institutions which are responsible for preventing people from meeting their basic needs. Structural violence is often supported, directly or indirectly, by policy, legislation and funding allocations and thus tends to go unrecognized. As such it is tolerated, ignored or simply accepted.

STRUCTURAL VIOLENCE AND MENTAL HEALTH

Clearly structural violence is present in the mental health field, in that people with mental disorders world-wide have discriminated access to both mental health care and employment. In addition, marginalization and stigma negatively affect all aspects of their daily living (Saxena *et al.,* 2007; WHO, 2001a).

Structural violence/abuse in the mental health field is insidious and as damaging as physical violence as it can make people feel disempowered, hopeless, helpless and even guilty that they have caused problems for their family.

POSSIBLE REASONS FOR STRUCTURAL VIOLENCE IN THE MENTAL HEALTH FIELD

Considering the factors presented above, it is puzzling why people with emotional problems or mental disorders are marginalized in so many ways, compared with people with physical disabilities. It is suggested that the reason is an inter-related combination of lack of awareness and knowledge (Saxena *et al.,* 2007; Stein, Wessels, van Kradenberg & Emsley, 1997); stigma, which keeps mental illness hidden (Link & Phelan, 2006; Saxena *et al*., 2007; WHO, 2001a), and the resulting discrimination and disempowerment that prevents people with mental disorders demanding fair access to resources. As stated by Sartorius (n.d.) in a paper produced for a meeting organized by the Health and Consumers Protection DG, European Commission:

> "The stigma of mental illness and the consequent discrimination are the chief obstacles to the improvement of mental health care and the rehabilitation of those disabled by mental illness."

Generally speaking the general public, as well as those with the authority and power to institute the changes required, are poorly or misinformed about mental disorders, fueled often by the media, equating such conditions with "laziness", "being crazy," "violent," "hopeless". If not understanding that mental disorders are both common and treatable, it is not surprising that the public do not motivate for equitable services or that legislators, policy makers and governments do not provide such services. Being so disempowered, people with mental disorders do not demand the services to which they are entitled (Meagher, 2002; Sayce, 2000).

Sartorius (n.d.), in his presentation to the meeting organized by the Health and Consumers Protection DG suggested, however, that "The reduction of discrimination is more important than the elimination of the stigma that triggered it". This suggests that, while all efforts should be made to address stigma through, for example, education, it is the resulting discrimination

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that affects all aspects of the lives of people with mental disorders, compounding theirs' and their families' emotional problems and distress (Link & Phelen, 2006). It is these problems in daily living that frequently bring people to ask for help.

Two important areas of daily living affected by discrimination concern relationships and employment. Loneliness, isolation, difficulty in finding a job and resulting financial distress are common problems (Harnois & Gabriel, 2000). People are forced to hide their diagnosis or prefer not to share their feelings for fear of discrimination. They may avoid relationships altogether to keep their problems hidden (WHO, 2010b). Unlike if they were suffering from a physical illness, they often do not receive much understanding and support and may even be avoided. Employers tend to be ignorant or afraid of mental disabilities, so are reluctant to employ people affected by mental illness. Work-places are seldom user-friendly to people with emotional problems (WHO, 2010b).

Families also suffer from the discrimination of having a mentally disordered member. Families can also be avoided and blamed, and if the person with a mental disorder is the breadwinner, suffer financially. Families may require the support of the health services, employers and friends in caring for their relative, but because of inadequate mental health funding, public ignorance and stigma, this support is often absent (Barry & Jenkins, 2007).

MULTIPLE MARGINALISATION

The impact of mental disorder is compounded if there are other reasons for discrimination. Examples include people with mental illness who are migrants (xenophobia); those recently urbanized; women with a mental illness in patriarchal contexts; those living in areas of high unemployment and/or poverty, which includes low and some middle income countries. Globalization has led to increasing migration between regions and countries, placing more people with mental disorders in danger of multiple marginalisation (Bhavsar & Bhugra, 2008).

MARGINALISATION CAN LEAD TO EMOTIONAL PROBLEMS/MENTAL DISORDERS

In addition to marginalisation affecting those with mental disorders, marginalisation in itself is a risk factor for mental disorders. Marginalisation can occur on the grounds of, for example, race (skin colour, hair form), nationality, gender, age, religion or any characteristic that is used to exclude people from resources that are available to others. These resources often include educational facilities, housing resources (including living in safe, well serviced areas), employment opportunities, medical services and political power (Coppock & Hopton, 2000; Swartz, 1998). "Certain groups within society such as women, children and refugees, are at particularly high risk of suffering from mental disorders *and* having their human rights overlooked or violated due to marginalization and discrimination." (Drew, Funk, Pathare & Swartz, 2005:84).

MAJOR RISK DETERMINANTS OF MENTAL HEALTH

"Risk factors" refers to conditions that increase the probability of the onset of a mental health problem as well as the problem being more severe and of longer duration. Lack of access to resources correlates with the "risk determinants for mental health", therefore marginalisation of any form contributes to these risks. These risks include poverty and economic instability, unemployment, lack of education, lack of housing, poor nutrition, early life disadvantage, displacement and social disadvantage (Hosman *et al.,* 2006; Petersen, 2010). These "risk

factors" constitute the conditions that social workers are familiar with, and social workers should be aware of the risks these conditions pose to mental health.

Desjarlais, Eisenberg, Good and Kleinman (1995) discuss clusters of problems in low income countries One cluster includes substance abuse, violence and abuse of women and children, which leads to mental health issues around aggression. Another cluster involves problems such as heart disease, stress and depression, with resulting changes in social behaviour, interpersonal support and coping. They note that these clusters are "more prevalent and more difficult to cope with in conditions of high unemployment, low income, limited education, stressful work conditions, gender discrimination, unhealthy lifestyle and human rights violations" (Desjarlais *et al.,* 1995:6). Again, these conditions are very familiar to social workers and the link between marginalisation and mental disorders is clear.

IMPLICATION FOR SOCIAL WORKERS – ADDRESSING STIGMA/HUMAN RIGHTS VIOLATIONS WITHIN A DEVELOPMENT PARADIGM

People with mental disorders, diagnosed or not, will be among clients served by social workers in the community. That being said, social workers need to become aware of their own beliefs/ and prejudice regarding mental disorders. No-one is free from some degree of fear or prejudice. Similarly, they need to become aware of the current beliefs, stigma, and marginalisation of people with mental disorders in the geographical and functional areas in which they work. Cursory questioning into current labour practices and medical systems can be very revealing. However, addressing these issues will require not only the efforts of social workers:

> "...many of the activities of mental health promotion are socio-political: reducing unemployment, improving schooling and housing and working to reduce stigma and discrimination of various types….. The key agents are politicians, educators and members of nongovernmental organizations". (Herrman *et al.,* 2005:10)

Structural violence in mental health will only be addressed if it is exposed as a violation of human rights (Drew *et al.*, 2005; Ho, 2007; WHO, 2005b). Bearing in mind the stigma associated with mental disorders and the suggestion that perhaps it is more useful to address the consequences of stigma rather than the stigma itself, it is suggested that marginalisation, including that of people with mental disorders, be addressed using international, regional and local human rights legislation to pressure governments to honor their commitments to all of their citizens. In South Africa, our Constitution and the United Nations Convention on the Rights of Persons with Disabilities (2007) for example, can be used to ensure that the rights of all people, including those with mental health conditions, are protected.

It is also suggested that social workers, well versed in development, follow the advice given in the conclusion to the recent WHO Report on Mental Health and Development (WHO, 2010b:63).

> "Many people with mental health conditions, as well as their families and caregivers, experience the consequences of vulnerability on a daily basis. Stigma, abuse, and exclusion are all-too-common. Although their vulnerability is not inevitable, but rather brought about by their social environments, over time it leads to a range of adverse outcomes, including poverty, poor health, and premature death. Because they are highly vulnerable and are barely noticed – except to be stigmatized and deprived of their rights – it is crucial that people with mental health conditions are recognized and targeted for development interventions. The case for their inclusion is compelling.

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People with mental health conditions meet vulnerability criteria: they experience severe stigma and discrimination; they are more likely to be subjected to abuse and violence than the general population; they encounter barriers to exercising their civil and political rights, and participating fully in society; they lack access to health and social services, and services during emergencies; they encounter restrictions to education; and they are excluded from income-generating and employment opportunities. As a cumulative result of these factors, people with mental health conditions are at heightened risk for premature death and disability. Mental health conditions also are highly prevalent among people living in poverty, prisoners, people living with HIV/AIDS, people in emergency settings, and other vulnerable groups.

Attention from development stakeholders is needed urgently so that the downward-spiral of ever-greater vulnerability and marginalisation is stopped, and instead, people with mental health conditions can contribute meaningfully to their countries' development."

CONCLUSION

For too long people with mental disorders have been considered the concern only of mental health professionals and advocates, although in practice social workers in general practice have been working with the challenges in daily living experienced by this sector of the community. As more people with mental disorders are being cared for in the community, social workers will increasingly be engaging with them as clients. Social workers need to be comfortable working in this field as, with their ability to work developmentally to address the structural, economic and political marginalisation and structural violence faced by people with mental disorders, they are ideally placed to make a substantial contribution, whether by working directly with individuals and families or advocating for the changes needed.

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