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The effects of pity on self- and other-perceptions of mental illness

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ABSTRACT

Previous research has demonstrated that pity may have a positive influence on public perceptions of individuals with a mental illness but has not adequately addressed the potential negative impacts of pity perceptions. Seventy-five research participants with serious mental illness completed measures of pity, public stigma, shame, hopelessness, personal empowerment, self-esteem, depression, and quality of life at baseline. Measures of hopelessness, personal empowerment, self-esteem, and depression were repeated six months later. Bivariate correlations found significant associations between pity and "other" effects of stigma including dangerousness, fear, segregation, avoidance and perceived stigma. Baseline pity was significantly correlated with self-effects of stigma such as shame, hopelessness, lower empowerment, lower self-esteem, depression, and decreased quality of life. At six-month follow-up, baseline pity was still associated with increased hopelessness and depression along with decreased empowerment and self-esteem. Anger, avoidance, perceived stigma, shame, and self-esteem were significantly related to pity in multiple linear regressions. Outcomes of path analyses suggest that the significant positive relationship between pity at baseline and depression at six-month follow-up was mediated by self-esteem and hopelessness. Individuals who view mental illness with pity experience negative self- and other-effects of stigma. These effects persist 6-months later. These findings have important implications for stigma-reducing advertising programs.

1. Introduction

The distress and challenges of mental illness often evoke pity from others. The public sympathizes with the trials wrought by psychotic and mood symptoms that undermine life goals related to work and independent living. Adaptations of attribution theory (Weiner, 1995) to public perceptions of mental illness have framed pity as a beneficial mediator in the relationship between belief about the causes of mental illness and behavioral responses (Corrigan, 2000; Angermeyer and Matschinger, 2003; Obonsawin et al., 2013). According to Weiner, a public who believes people are not responsible for their mental illness (e.g., the illness is genetic) is likely to react with pity and be motivated to help. Help might mean more formal counseling interactions or informal consideration about the person's overall wellbeing. Alternatively, a public that believes people are responsible for their mental illness (they choose to have schizophrenia) are likely to react with anger leading to coercive behaviors (people with mental illness should be institutionalized or forced to take treatments).

Pity, however, may also have negative consequences. Research suggests, for example, that the public seems to endorse "benevolence stigma" more when agreeing with pitiful conceptualizations (Corrigan et al., 2001). Benevolence stigma is kindness to perceived "unfortunates" leading to behavior akin to how parents treat children (Taylor and Dear, 1981; Rahav et al., 1984; Madianos et al., 1987; Brockington et al., 1993). Benevolence leads to authoritarian responses; namely, that professionals or family members need to make decisions for people with mental illness because they are seen to be incapable of acting wisely (Brockington et al., 1993; Corrigan et al., 2001). This undermines self-determination where people with mental illness ultimately control life goals and interventions they might pursue to achieve these goals.

The impact of pity varies depending on whether it is adopted by the public in general or by people with mental illness themselves. Largely absent from the literature, and one purpose of this study, is understanding the impact when people with mental illness endorse the idea of pity and mental illness. Impact is divided into two categories in this paper: other effects and self-effects. Other-effects refer to individuals' perception of other people with mental illness, not themselves. We expect that people with a mental illness who endorse pity will see others with a mental illness in a more stigmatizing manner; e.g., devalue the "group" labeled mentally ill. These are direct perceptions of others with mental illness and not meta-cognitions of these perceptions. We

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Fig. 1. The relationship of pity on self-esteem, hopelessness, and depression.

expect these negative perceptions may lead to greater endorsement of authoritarian or coercive interventions. Self-effects refer to individuals' perceptions of themselves as people with mental illness: I'm ashamed of myself. One recent study showed that views of pity about people with mental illness undermined assertions of self-determination (Sousa et al., 2012). Hence, we would expect to find pity is associated with less personal hope and more depression. One goal of this study is to verify these relationships.

We hypothesize a directionality among relationships such that pity has negative impact on other effects and self-effects. We seek to test the direction between pity and self-effects by collecting subsequent indices of self-effects six months after baseline. Consistent with other research, we expect people with mental illness who endorse pity about psychiatric disease will have lower self-esteem (Corrigan et al., 2005; Harris and Fiske, 2006); see Fig. 1. Lower self-esteem will correspond with hopelessness which will lead to depression.

2. Methods

People with serious mental illness were recruited from two community-based rehabilitation programs in the Chicago area. This study is part of a larger project on mental illness stigma; additional information on the larger sample were reported elsewhere (Rüsch et al., 2009; Corrigan et al., 2011). IRBs at the Illinois Institute of Technology and at both rehabilitation programs approved the study before recruitment began. All participants were fully informed of the study and consented to participation. The sample is described in Table 1. They were 44.8 years of age, on average, and more than two-thirds male. The sample was more than half African American and a third European American. About two thirds of the group had at least attended college and had never married. In terms of income, 95.3% reported annual earnings below $ 20,000. At the time of the study, 2.4% of the sample was working full time, 15.3% part-time.

Information was also collected about the person's experiences with mental illness. Axis I diagnoses were made using the Mini-International Neuropsychiatric Interview (Sheehan et al., 1998) based on DSM-IV criteria. Twenty-three (27%) participants had schizophrenia, 22 (26%) schizoaffective disorder, 30 (35%) bipolar I or II disorder, and 10 (12%) participants had recurrent unipolar major depressive disorder. In addition, 33 (39%) research participants in the sample had comorbid current alcohol- or substance-related abuse or dependence. Research participants reported, on average, having been hospitalized 8.7 times (SD=13.5). Sixty eight percent of research participants had been prescribed anti-psychotic medication at the time of the study. Seventy-five of the original group of 85 completed follow-up measures. No significant differences in demographics (age, gender, ethnicity, education, and marital status) were found between the 10 participants who dropped out and the 75 participants who remained in the study. There were no differences in perceived stigma or experience of discrimination as a function of race in the present sample.

Table 1
Demographics and other illness-related variables on the final sample of 75 individuals with mental illness.

Variable	Present sample (n=75)	Drop-outs (n=10)
Age mean	44.25	49.20
SD	9.85	7.70
Gender % female	30.7%	40.0%
Ethnicity Black/African American	56.0%	70.0%
European American	34.7%	30.0%
Hispanic	5.3%	0.0%
Other	4.0%	0.0%
Education high school diploma or less	33.3%	50.0%
some college	46.7%	40.0%
Bachelor's or graduate degree	20.0%	10.0%
Marital status single	70.7%	50.0%
married, separated/divorced, widowed	29.3%	40.0%
Living in a long-term relationship (>2 years)	0%	10.0%

2.1. Measures of pity and other effects

Pity and public stigma was assessed at baseline using the 27-item Attribution Questionnaire (AQ-27; Corrigan et al., 2003, 2012). The AQ-27 asks research participants to respond to individual items about a person named “Harry” using a nine point scale (9=very much).

Harry is a 30 year-old single man with schizophrenia. Sometimes he hears voices and becomes upset. He lives alone in an apartment and works as a clerk at a large law firm. He has been hospitalized six times because of his illness.

Exploratory and subsequent confirmatory factor analyses shows the AQ-27 yields nine factors: pity, plus four factors consistent with attribution theory: responsibility, anger, help, and coercion. The AQ-27 includes another four factors that correspond with violence perceptions and stigma: dangerousness, fear, avoidance, and segregation. The pity subscale comprised three items “I would feel pity for Harry;” “How much sympathy would you feel for Harry? ” and “How much concern would you feel for Harry? ” We were concerned that the item “I would feel pity for Harry;” per se is conceptually distinct from sympathy and concern. Research suggests, for example, that public understanding of pity and sympathy diverge in significant ways (Gerdes, 2011). Hence, we used the single item rather than the three item factor as the proxy of pity in the remainder of the study. Alphas for each subscale are presented in Table 2.

Two additional measures of the other effects of pity were administered at baseline: perceived stigma and perceived group value. Perceived stigma was assessed using 12-items from the Perceived Devaluation and Discrimination Questionnaire (PDDQ; Link, 1987). A sample item was “Most people think less of a person who has been in a psychiatric hospital” which participants answered on a 6-point agreement scale (6=very strongly agree). Higher scores indicate higher perceived stigma (Cronbach's alpha for our sample =0.85).

Perceived value of the group of people with mental illness was measured by two items (Rüsch et al., 2009): “I think the group of people with mental illness is … very bad/very good” and “… not powerful at all/very powerful” (items rated from 1 to 9). The split-half reliability of this scale was satisfactory (0.74 according to the Spearman Brown formula) with higher mean scores indicating higher perceived value of the group.

2.2. Measures of self-effects

We included measures that assessed how pity negatively impacts the person’s sense of self: shame, empowerment, and self-esteem. We then included measures of the clinical effects of reduced hope and empowerment: greater depression and diminished quality of life. Shame-proneness was assessed using the short version of the Test of Self-Conscious Affect (TOSCA-3;