Health Discrimination and Perception of Individuals with Medical and Mental Needs

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Abstract

Health discrimination, the process of disadvantaging an individual based on a medical diagnosis and its associated stereotypes, is an increasing global problem. Recent studies demonstrate that more cultures are practicing health discrimination. Prejudice from health is an especially complex topic because each condition has assumptions based on physical appearance and symptoms. For individuals with medial labels, health discrimination hinders their daily progress. While there is a significant amount of research about the retrogressive impacts on health discrimination, literature examining the origins of health discrimination is not as comprehensive. Our study examines the prejudice that precipitates health discrimination. We hypothesize that people will perceive individuals with medical and mental needs as different after viewing media clips which portrayed negative perceptions of individuals with medical and mental needs. We tested this concept using undergraduate students from three lower division psychology courses at a small liberal arts college. Each class saw a media clip which corresponded with three different health conditions: physical need, mental need, and a combination of physical and mental needs. Statistical data were obtained through surveys designed for each media clip. The results of this study were significant showing that negative perceptions and health discrimination exist in college students.

Health Discrimination and Perceptions of Individuals with Medical and Mental Needs

Health Discrimination, or prejudiced treatment of an individual based on a medical diagnosis, is a widespread problem facing the modern world. The core of the issue is health is a broad topic because as it impacts everyone differently. Body chemistries, lifestyles, and genetics are a few reasons for this diversity. Diversity is also demonstrated by the amount of people worldwide who face health concerns. Over one billion people or approximately 15% of the world population have medical or mental needs and between 110 and 119 million people struggle to function independently (World Health Organization, 2011). These numbers also represent a significant portion of the world's workforce and a financial strain on many communities. However if people who receive a medical diagnosis are able to cope, they are able to function in society. Unfortunately health discrimination is creating unnecessary barriers these individuals striving for independence.

Health discrimination was defined with four methods in this study. First was if a medical or mental need was perceived as humorous. While humor is a known coping mechanism for stress, some individuals with medical and mental needs find it offensive and it inhibits the coping process. Also it is easy to misinterpret laughter. People tend to laugh when they are nervous or under tension (Milgram, 1963). The second form of evaluation is if an individual interprets a stereotypical statement towards a medical label as justified. If individuals do not see a problem with their personal bias, prejudiced beliefs which hinder progress will prevail. The third measure of health discrimination we used was if medical or mental needs were easily associated with negative stereotypes. A diagnosis is not necessarily a negative event in someone's life. However the idea that medical and mental needs are bad is a view disseminated in popular culture. The fourth concept used to identify health discrimination is if an individual believes that medical and mental needs not require sensitivity. If an individual interprets a situation depicting health discrimination as innocuous, they will practice health discrimination until they realize how their actions inadvertently create harmful effects on communities.

In our study we refrained from using the terms "disabled", "mental illness", or "mental retardation". These labels have negative connotations (Roush, 1986, Bring Change 2 Mind, 2012, and Special Olympics, 2011) and using them on the survey would have interfered with honest responses. The word "disabled" sounds similar to the slang term "dis" which means to insult an individual. Since "disabled" has negative connotations in this study, we did not want individuals interpreting whether a medical label itself was positive or negative. Through substituting "disability" with the word "needs", we reduced the tendency to evaluate the condition as opposed to the person. The use of the word "needs" indicates that a diagnosis may indicate attention but it does not evaluate how a specific label impacts an individual's daily life. Also "medical and mental needs" encompass more conditions as an individual does not need to be classified as "disabled" in order experience health discrimination. A "physical need" is when a medical need is visible due to anatomical defects, use of assistive equipment or services such as braille signs or handicap parking. A "cognitive need" refers to a diagnosis from the DSM or evaluation criteria, relating to a psychological concern. The combination of "physical and cognitive need" defines a diagnosis that involves specific characteristics in behavior and visual appearance. The cohesive mental and physical differences formulate a biased perception of individuals.

Multiple forms of discrimination are common obstacles for individuals with medical or mental needs. Medical conditions themselves are stressful and dealing with racism on top of a

diagnosis adds to the emotional toll. Lifetime discriminatory treatment is more likely to be experienced with minorities as opposed to Caucasians (Kessler, Mickelson, & Williams, 1999). Minorities that encounter additional discrimination during a diagnosis could turn to harmful practices like self-medication instead of pursing medical treatment. American immigrants classified as a minority who perceived discriminatory treatment were more likely to partake in substance abuse (Tran, Lee, & Burgress, 2010). Substance abuse is a known coping mechanism for individuals in stressful situations such as medical treatment. Since substance abuse causes health issues by itself, seeing individuals with medical labels use self-medication is concerning. Racism and health discrimination is not just a trial for patients but also their caregivers. McHatton and Correa (2005) found that single Hispanic mothers of mental needs children faced more stress because of discrimination. Raising a child with severe mental or medical needs as a single caregiver is a taxing position in itself. However when racism is a barrier to the essential services and support their children need to function, the situation becomes even more burdensome for caregivers.

Another element of health discrimination is the global stigma toward mental illness. Over 450 million people in the world suffer from mental disorders (World Health Organization, 2010). For many nations health resources are limited and directed toward communicable diseases. Stigmatized issues like mental illness where the symptoms are not as apparent are a lower priority. A study from Zambia portrayed public perception of mental illness as an individual's fault (Kapugwe, Cooper, Mwanza, Sikwese, Kakuma, Lund, &, 2010). Members of Zambian society believed that individuals with mental illness either wanted attention or participated in substance abuse (Kapugwe et al., 2010). Another idea was that the individual participated in taboo religious practices and as a result became possessed by evil spirits (Kapugwe et al., 2010). Complicating the issue was the common misperception that HIV/AIDS caused mental illness (Kapugwe et al., 2010). Zambia like most countries located in Sub-Saharan Africa is impacted by the HIV/AIDS pandemic. While the virus that triggers HIV/AIDS does not directly attack the brain often, other STIs (sexually transmitted infections) like syphilis cause mental degradation. Also people who are diagnosed with stressful medical conditions can develop mental illnesses like depression from their traumatic experiences. However sexual health is a taboo topic in Sub-Saharan Africa in part because of the HIV/AIDS pandemic, making it difficult to start a conversation about attitudes toward mental health (Kapugwe et al, 2010). As a result few resources were offered, preventing people from pursuing help (Kapugwe et al, 2010). Interestingly, the same attitudes toward mental illness the African researchers identified are prevalent in high income countries. This further illustrates that the mental health stigma is an increasing global health problem.

Although Africa has different cultural barriers than America, both areas of the world share the cultural view that people bring cause illness through their actions. There are conditions that are linked to lifestyles but not every condition is linked to risky behaviors. Besides when an individual diagnosed with a medical or mental need, judging them with past behaviors does not help them cope with the stressful situation. Judgment is especially evident in genetic diseases or conditions that are caused by mutations in chromosomes (Klitzman, 2010). Due to advances in medical technology people at risk (biologically related to individuals with genetic conditions) can use genetic testing to see if they would develop the disease. Some of the individuals did not want to test for the disease mainly because of the stigma relating to the illness and personal guilt that they caused the condition (Klitzman, 2010). A frequent concern expressed with the stigma was insurance coverage and job security (Klitzman, 2010). For example one of the common fears

was that if someone tested positive for a fatal diagnosis like Huntington Disease, employees would assume they were going to die (Klitzman, 2010). This belief threatened that individual's job security at a time when medical bills become overwhelming (Klitzman, 2010). The same prejudice triggered anxiety with insurance companies (Klitzman, 2010). Insurance companies tend not to invest in people with fatal diagnoses as that is an overall financial loss for the company. Lack of insurance coverage serves as another barrier from pursuing treatment.

While treatment is used by most individuals with a medical label, the ability to cope with daily life is just as imperative. Treatments are developed from years of scientific experiments and they take time to work in an individual's body. Living with a chronic condition is a daily stressor and if people struggle to cope with their condition, medical treatment will not alleviate this entire burden. Medical treatments are not a buffer for prejudice experienced in daily life. This concept is especially important because it is possible to have several medical diagnoses at the same time, also known as cohort conditions. Individuals with severe cognitive needs, specifically Down's syndrome, and a type I diabetes diagnosis had a basic comprehension of diabetes and used jargon with the condition such as glucose tablets and insulin (Dysch, Chung, & Fox, 2011). However each participant described their diabetes as a negative aspect of their emotional, social, and physical lives (Dysch, Chung, & Fox, 2011). Since type 1 diabetes is a permanent and life threating condition, negative perceptions are concerning. Diabetes is not going to subside for any period of their life and on frustrating days, people may decide to not to take their medication. Another challenge is that individuals with cohort conditions as in addition to communities (Kapugwe et al, 2010) incorrectly believed that one diagnosis triggered other medical labels (Dysch, Chung, & Fox, 2011). Conditions can overlap with and a medical diagnosis, but this correlation does not necessarily indicate that one diagnosis causes all medical concerns. Assuming that a condition is the primary source for every personal problem adds to the negativity making coping more arduous. Coping is a challenge alone for individuals with severe cognitive needs, because it is frustrating to comprehend why they have a condition (Dysch, Chung & Fox, 2011). Understanding why they have a medical diagnosis which is a question brought up with many individuals without severe cogitative needs. Also interpreting lifelong conditions as completely bad with no positive aspects makes coping difficult. Social interactions are another stressor for individuals with cohort conditions. Another participant mentioned her frustration with eating out because people were insensitive and would order food she could not eat (Dysch, Chung, & Fox, 2011). This frustration illustrates that society is not aware of how to accommodate or show compassion for individuals with medical needs. Also individuals should have self-advocacy training to make their needs and expectations known in these situations. Social support is important to anyone with a medical diagnosis especially when there are no logical reasons for why they have a condition. However when social settings are not a source of beneficial support, it adds to the emotional toll.

Aversive social interactions relating to health discrimination also occur in the workplace. Individuals who can cope with their conditions are able to have jobs, which helps with the financial burdens they face from medical treatment. Although there are laws against discrimination in the United States, there is still a huge amount of health discrimination because of interviewers' biases in employment interviews (Miceli, Harvey, & Buckley, 2001). Even when there is proof that an individual is qualified for a position, the discrimination based upon looks and stereotypical lowered expectations often cause individuals with labels to not likely to be hired (Miceli et al., 2001).When an individual with a medical label is hired, they are paid less, experience workplace hostility, and terminated frequently (Miceli et al., 2001). Coworkers and

employers who do not understand why an individual misses work for medical appointments make the work environment unpleasant for individuals with medical and mental needs. Firing an individual due to an excessive amount of absences is a typical response in most companies. This lack of understanding is often complicated by company policy. A man mentioned the struggles of having diabetes in the workplace because the injection of insulin has a similar appearance to illegal substance use such as heroin (Dysch, Chung, & Fox, 2011). Many companies have strict drug policies that result in immediate termination when there is evidence of substance abuse. However when an employer understands diabetes and why the individual was injecting insulin, the biased reaction is avoided.

Individuals aspiring for graduate professions such as psychological counseling, face greater hurdles. Graduate students with mental and medical needs struggle to find adapted materials and get extended time for examinations (Taube & Olkin, 2011). It has been shown that individuals tend to have common misconceptions about various medical and mental labels, including professionals supervising clinical trainees (Taube & Olkin, 2011). For example, a misconception of a blind counseling trainee is that they would struggle to read a person's change of expression, because they couldn't see their face (Taube & Olkin, 2011). However, body language is easily misread across cultures. A counselor who happens to be blind can serve as an advantage for certain clients. Discrimination influenced by misconceptions also affects clinical-skills development for trainees with medical needs as well as their therapist-client relationships (Taube & Olkin, 2011). If a professional mentor does not have the confidence that the student can succeed in the field due to their medical or mental need, the student's self-confidence will suffer and they may decide not to pursue that career.

Research on comparing initial perceptions of medical or mental needs and prejudice is not easily accessible. We feel that preventing the impacts health discrimination involves understanding how these perceptions develop. In this study, the research hypothesis is that individuals with medical or mental needs will be perceived differently. The alternative hypothesis states that there will be a perceived difference of individuals with perceived medical or mental needs.

Method

Participants

Eighty-four participants from a small liberal arts college in the Southwest took part in the study. All gave their informed consent and received no compensation from the experimenters. However their course professors granted credit for participation in the experiment. Participants were recruited in three lower-division psychology courses. The first condition had 45 participants, the second condition had 26 participants, and the third condition had 13 participants.

Materials

The study was conducted in three separate classrooms with a computer and projector. Media clips for each of the three versions of the test were displayed. The media clips were all from the popular situational television comedy *Seinfeld* and selected to match the conditions of the experiment. There were three clips selected for each of the conditions. The first clip displayed a conversation the characters had about handicapped parking spots used by individuals with physical needs. The second clip featured another conversation about a character's girlfriend who had behaviors characteristic with an eating disorder or a mental need. The third clip showed one of the main characters Kramer after a dental procedure. The procedure required the use of

Novocain, which made Kramer appear to have several cognitive and physical needs. Answer sheets that corresponded with each version of the test were also provided.

Design

Three different classes were randomly assigned to the three conditions of the test. The three conditions were reactions toward a physical need (handicap parking spot), abnormal behavior (eating disorder), and a combination of both the previous conditions (physical and cognitive need). Each of the versions had a corresponding anonymous survey, with a Likert–like scale for four questions to gauge the participants' reactions (1= low bias and 6=high bias). Question 1 evaluated perceptions of humor with medical and mental needs. Question 2 measured personal bias towards a character in the clip. Question 3 appraised personal bias toward stereotypes of mental and medical needs. Question 4 asked the participants' opinions on the actions displayed in the clip. The survey questions for each condition and the course of the Likert-scale are displayed in Table 1.

Procedure

The experiment consisted of one self-paced session with no practice runs. The total time amount for the experiment was about 10 minutes. After participants filled out informed consent forms they were instructed to watch a brief video clip on the projector screen. Participants were told that the experiment was measuring perception of media clips. Once the clip was over, experimenters handed out surveys and instructed participants to fill them out. When the participants were done filling out the survey, they were collected by the experimenters. A debriefing was provided at the end of each session. Data was entered in the Statistical Package for the Social Sciences (SPSS) program for statistical analysis.

Results

We wanted to investigate if people would perceive individuals with medical and mental needs differently. We had four different questions to assess if the results were statistically significant for each condition (Physical Needs, Mental Needs, and Physical and Cognitive Needs). Due to the considerable disparity in sample sizes among the three different conditions, we used the Kruskal-Wallis non-parametric test.

The results for all the conditions were significant, and there were observable differences between the medians of each of the questions. For Question 1 both the Physical Needs and Mental Needs conditions had the most bias (Med=4 for both). In Question 2 the Physical and Cognitive Needs condition had the most bias (Med=5); the participants believed that Kramer was mentally challenged, as demonstrated by his behaviors and speech in the clip. Since Kramer actually did not have cognitive and physical needs, believing that he did indicates health discrimination. In Question 3 the Physical Needs condition had the most bias (Med=5). Finally in Question 4 the Mental Needs condition had the most bias (Med=4). For Question 4, the participants in Condition 2 agreed with the *Seinfeld* characters' reactions to the girl with a perceived eating disorder. Participants did not see the girl in question in the clip so they assumed that the characters were correct by labeling her with an eating disorder. The participants in Condition 3 gave consistently low ratings of the willingness to give Kramer a job, even when the survey did not mention job specifications, based on his behaviors and perceived disability. See Table 2 and Figures 1 to 4 for the descriptive statistics.

We found that for Question 1, p =.03. We found that for Question 2, p<.001. We also found for Question 3, that p<.001. Lastly we found that for Question 4, p =.01. Therefore, we rejected the null hypothesis for all four questions, meaning that participants viewed the medical and mental needs as different in each condition.

Discussion

The purpose of this study was to see if perceptions of medical and mental needs from students in undergraduate psychology are influenced by prejudice. Based upon previous study's findings, the research hypothesis was that individuals with medical or mental needs would be perceived differently. Our results support this hypothesis.

The results of this study were significant, showing that negative perceptions and health discrimination exist in the participants. Individuals perceived each of the characters portrayed in the clips as different based upon their behaviors (see Figures 2 and 3). The participants also demonstrated that they would discriminate or agreed with the discriminatory behaviors of those on the clips (see Figure 4). Overall this study indicates that health discrimination does exist in the media and within the personal biases of the participants.

Individuals with Mental Health Needs and Individuals with both Physical and Cognitive Labels experience the highest percentage of social stigma and discrimination. We agree with Klitzman's (2011) observation from interviewing individuals at risk for genetic conditions, that health discrimination has a different appearance with every person. Stereotypes and stigmas affect all aspects of life of individuals with medical and mental needs. Health discrimination comes up in insurance negotiations (Kliztman, 2011), job searches (Miceli et. al , 2001 and Taube & Olkin, 2011), treatment (Kliztman, 2011 and Kapugwe et al, 2010) and daily interactions (Dysch, Chung, & Fox, 2011). Individuals with medical and mental needs are impacted by health discrimination consistently.

Health discrimination is something that is preventable. The best way of combating the harmful effects of health discrimination is education about personal biases. Prejudice is a survival instinct for humans, but when people are aware of their stereotypes it is easier to accept diversity. More resources and educational material for open discussions about health discrimination need to be developed. Diversity programs that educate people about their own personal biases should stress health discrimination as a prevalent form of prejudice along with racism and homophobia. Another method to combat health discrimination is to promote self-advocacy. Unfortunately people with medical and mental needs are going to encounter assumptions. However when they are able to address stereotypes and change their environments, it is easier for people to cope with a medical label.

We had some limitations in the current study. First this was run with only undergraduate psychology classes. The results could change with more participants from a variety of academic fields. Second, our sample sizes varied considerably between each condition which could have affected the data. Lastly, performing the study in a small college with a specific demographic may be limiting. Implementing a modified version of this experiment at geographically and culturally diverse locations may provide a better overview of the problem. It is hoped that by educating individuals about health discrimination and its affects in each of our lives, we will be able to effect change in the treatment and perception of individuals with medical and mental needs. In the future, we would like to replicate this study with students from other academic fields, such as education or healthcare, whose desired career paths require interactions with medical and mental needs on a daily basis.

Using this research, we plan to educate people about stereotypes and discrimination to bring awareness to individuals about their potential biases. Understanding and compassion from a community will help individuals with medical labels cope with their daily lives. It is hoped that by educating individuals about health discrimination and its affects in each of our lives, we will be able to effect change in the treatment and perception of individuals with medical and mental needs.

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Table 1:
Survey Questions and Likert-scales for Each Condition

Question #	Condition 1: Handicap Spot (Physical Need)	Condition 2: Eating Disorder (Mental Need)	Condition 3: Mental and Physical Need
1	How funny did you find this media clip? Likert-scale: (1 = not funny at all, 6 = very funny)	How funny did you find this media clip? Likert-scale: (1 = not funny at all, 6 = very funny)	How funny did you find this media clip? Likert-scale: (1 = not funny at all, 6 = very funny)
2	Do you agree with Kramer that handicapped people do not need the parking space? Likert-scale: (1 = strongly Disagree, 6 = Strongly Agree)	Do you think that George's date has an eating disorder? Likert-scale: (1 = strongly disagree, 6 = strongly agree)	Do you agree that Kramer is mentally challenged? Likert-scale: (1 = strongly agree 6 = strongly disagree)
3	How concerned are you that George decided to take the parking space? Likert-scale: 1 = no concerned, 6 = very upset)	Do you think that the date may just be trying to get attention for herself? Likert-scale: (1 = strongly disagree, 6 = strongly agree)	Do you feel that Arnold Deans Fry treated Kramer appropriately? Likert-scale: (1 = strongly disagree, 6 = strongly agree)
4	In your personal opinion how appropriate was the group's reaction to the situation? Likert-scale: (1 = very inappropriate, 6 = very professional)	In your personal opinion how appropriate was the group's reaction to the situation? Likert-scale: (1 = very inappropriate, 6 = very professional)	How likely would you hire Kramer for a job based on this media clip? Likert-scale: (1 =Very unlikely, 6 = Very likely)

Table 2

Inferential Statistics Comparing the Conditions of Each Question

	Condition 1 Handicap Spot	Condition 2 Eating Disorder	Condition 3 Physical and Cognitive Need	p
Question 1	4	4	3	0.03
Question 2	1	4	5	0.00
Question 3	5	2	3	0.00
Question 4	3	4	2	0.01

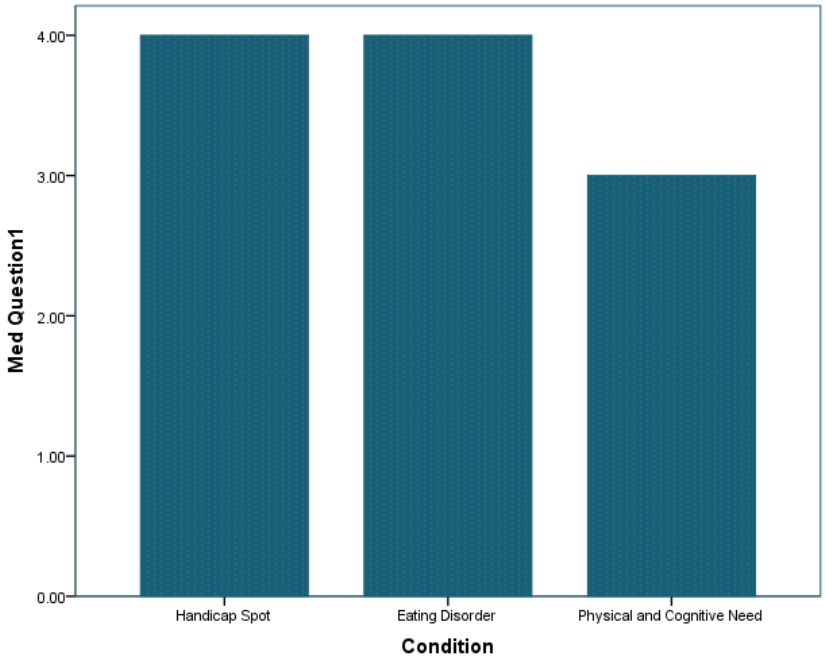

Figure 1. Graph comparing the medians of each condition for Question 1. Table 1 displays the text of the actual questions.

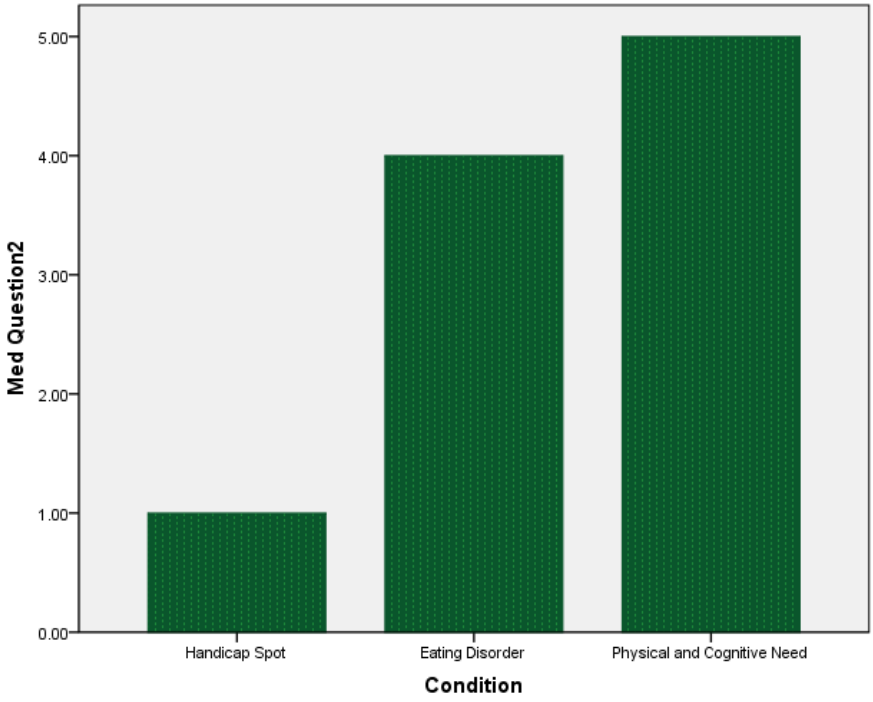

Figure 2. Graph comparing the medians of each condition for Question 2. Table 1 displays the text of the actual questions.

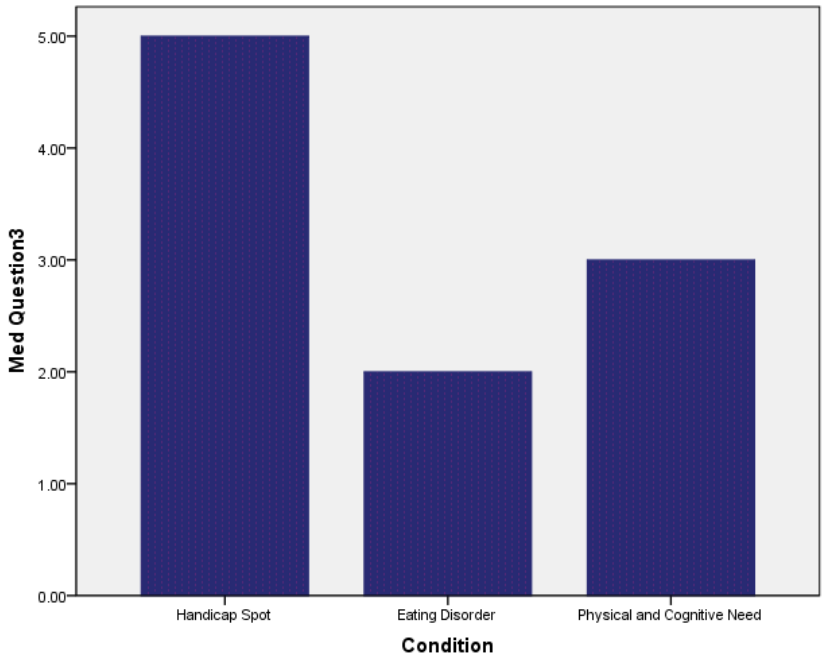

Figure 3. Graph comparing the medians of each condition for Question 3. Table 1 displays the text of the actual questions.

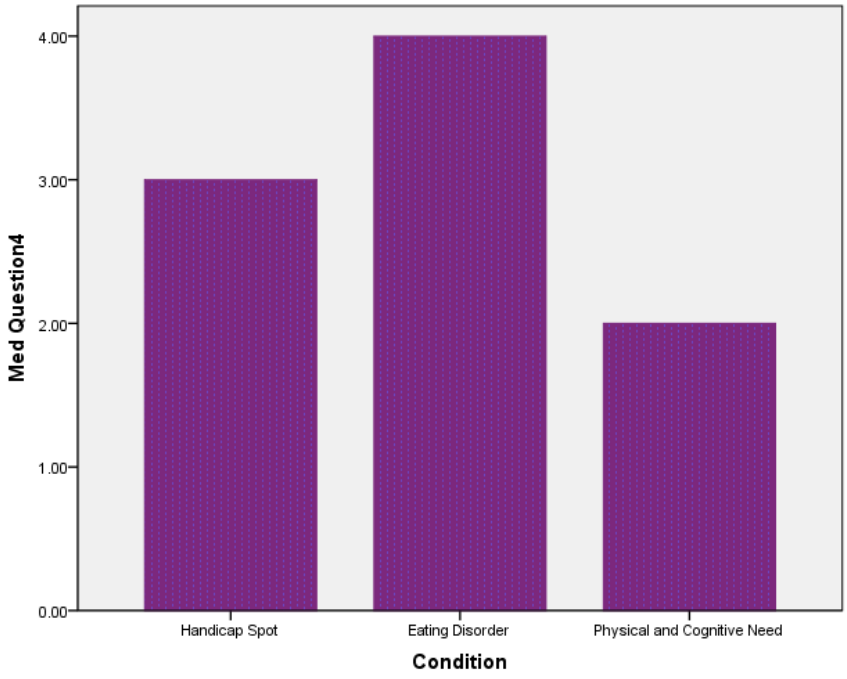

Figure 4. Graph comparing the medians of each condition for Question 4. Table 1 displays the text of the actual questions.