Understanding and Changing Behaviors Toward Stigmatized Diseases

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Perceived stigma often prevents many individuals from seeking treatment for serious health problems, such as STDs and psychiatric disorders. The stereotyping literature suggests that stigma can be ameliorated by introducing a positive exemplar, but only if people include that individual into the stigmatized group. We find that people’s preexisting attitudes toward seeking treatment determine how they will be affected by inclusion of a positive exemplar. Increased treatment seeking occurs when individuals with preexisting negative attitudes include the exemplar; however, this relationship reverses for individuals with preexisting positive attitudes who are actually less motivated to seek treatment when stigma is decreased.

[to cite]:

[url]:
http://www.acrwebsite.org/volumes/14560/volumes/v36/NA-36

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Advances in Consumer Research (Volume 36) / 895


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One of the major barriers to getting individuals with stigmatized diseases (i.e. STDs and psychiatric disorders) to seek treatment is the shame and distress caused by having to admit one has the disease. A large amount of research has documented the many consequences an individual must endure should he or she be associated with a stigmatized group. For example, Young et al. (2007) found that people not only view individuals suffering from STDs as being immoral in the sexual domain (e.g. being promiscuous, having premarital sex) but people also view these individuals as being immoral in nonsexual domains (e.g. lying, shoplifting). Being associated with a stigmatized group can be so debilitating that individuals are reluctant to seek treatment despite the obvious health and social benefits of doing so. For example, in the United States, approximately 60% of people with psychiatric disorders failed to receive any treatment within a one year period (Wang et al. 2005). This sample included both individuals with relatively minor disorders (e.g. adjustment disorders) and individuals with serious illnesses (e.g. schizophrenia), suggesting that even those who should have had the ability to seek help (i.e. those with minor disorders) decided not to do so.

Recent research from the stereotype literature suggests a method to directly address this stigma associated with the disease. The stereotypes associated with individuals suffering from stigmatized diseases often motivate others’ negative expectations and prejudices (Corrigan 2004). Thus, one way to address stigma is by leveraging the finding that the way exemplars are categorized can change the evaluations (and hence the stereotypes) of groups they belong to (Bless et al. 2001; Kunda & Oleson 1995). More specifically, when positive exemplars are included in a group, the characteristics associated with the exemplar will be assimilated to the evaluations of the group. For example, when a favorable exemplar like Colin Powell is included in the group of Republicans, subsequent evaluations of the Republican Party become more positive (Stapel & Schwarz 1998). On the other hand, the exclusion of a favorable exemplar will lead to subsequently more negative evaluations of the group. This occurs because the exemplar is used as a standard of comparison, so the group as a whole appears worse off, leading to a contrast away from the positive attitudes toward the exemplar. Thus, we predict that inclusion of a positive exemplar will have beneficial effects for individuals with a negative stereotype regarding a particular patient group (e.g., the mentally ill).

We hypothesize that this is moderated by preexisting attitudes towards treatment. The degree to which negative stereotyping is a barrier to treatment, and hence the benefit of the inclusion mechanism, should be particularly strong for individuals who doubt the efficacy of mental health treatment. Specifically, inclusion of positive exemplars should be beneficial for individuals with preexisting negative attitudes toward treatment seeking. That is, inclusion of a positive exemplar should, by reducing negative group stereotypes, motivate these individuals to take steps towards treatment, even if these steps will involve (potentially prolonged) association with the stigmatized group. Conversely, when their views of those suffering from a stigmatized disease are altered, individuals with preexisting positive attitudes toward seeking treatment will likely react very differently. For individuals who are already highly inclined to seek treatment and readily believe in its effectiveness, making them view the group more positively (through inclusion) may reduce treatment seeking by undermining the perceived extremity or severity of the disease, in turn reducing motivation to use treatment to be rid of the disease and dissociate themselves from the stigmatized group.

In our experiment, we measure whether or not individuals express intentions to seek treatment if they experience symptoms of the mental disorder depression. Prior to participating in the formal experiment, participants completed the “Attitudes toward Seeking Professional Psychological Help Scale” (Mackenzie, Knox, Gekoski, & Macaulay 2004). During the formal experiment, participants read an article describing the symptoms of depression and were also introduced to a positive exemplar, Uma Thurman, who had suffered from depression in the past. Next, participants completed questions that led them to either include or exclude Uma Thurman from the group of individuals suffering from depression (Bless & Wänke 2000). Following this task, participants read a scenario that described a situation in which they were experiencing symptoms of depression and then answered questions related to treatment seeking behavior. We find a 2-way interaction (?=−0.51, p<.05) between manipulated inclusion (versus exclusion) and measured attitudes where individuals with more negative attitudes toward mental health services are more likely to seek treatment when they include Uma Thurman compared to when they exclude her. However, individuals who have more positive attitudes toward mental health services display the opposite pattern