Improving the Community for Mentally Ill Individuals

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Introduction: Components of Community

Psychological sense of community is one of the most commonly investigated constructs in community psychology, and it can be considered a defining feature of community life (Townley & Kloos, 2010). This construct was first conceptualized by Sarason (1974) to describe the fact that human experience is based largely on belonging to or being an integral part of a larger collectivity. Sense of community is linked with positive outcomes such as psychological well-being, perceptions of belonging and connectedness, and participation within a community (Townley & Kloos, 2010). Moreover, psychological sense of community is believed to reflect the strength of bonding among community members (Townley & Kloos, 2009).

Researchers believe that there are four essential components to psychological sense of community: membership, mutual influence, integration and fulfillment of needs, and shared emotional connection (Townley & Kloos, 2009). Membership is defined as feeling emotional security, belonging, and identification within one's community. Mutual influence occurs when the community influences the individual and, in turn, the individual can influence the community. Integration and fulfillment of needs includes both the physical and psychological needs of the individual. Physical needs may include healthcare, housing, and employment, while psychological needs refer to belonging and connectedness. Fulfillment of these needs plays an important role in reinforcing commitment to the community. Finally, shared emotional connection encompasses positive affect and shared history within the community.

It is believed that absence of psychological sense of community is the most disintegrating aspect of contemporary life. Absence of this construct is connected with feelings such as loneliness, alienation, and psychological distress (Townley & Kloos, 2010). Consequently, addressing and encouraging a sense of community has important implications for health and well-being.

Sense of Community and Mental Health

Sense of community is believed to be particularly important for groups who are stigmatized or discriminated against, such as people with mental illness. Psychological sense of community can play a role in reducing feelings of stigmatization and marginalization as people with mental illness become further integrated into their neighbourhoods and broader community environments (Townley & Kloos, 2009). Furthermore, psychological sense of community may also be correlated with recovery from

illness through the community's role in providing access to necessary services. However, sense of community has been largely overlooked when dealing with mentally ill individuals (Townley & Kloos, 2010). For example, although the majority of mentally ill individuals state that they consider sense of community to be very important, only 32% of participants reported actually feeling a strong sense of community (Townley & Kloos, 2010).

Health Canada (2002) states that the stigma attached to mental illness creates a significant barrier for acceptance and integration within a community. Goffman (1963) defined stigma as a characteristic that discredits an individual and has the power to reduce others' perceptions of the stigmatized person. A major consequence of stigma is decreased social acceptance of the stigmatized individual or group (Goffman, 1963). Research on the prevalence of mental illness stigma indicates that negative attitudes towards mentally ill individuals exist worldwide (Bjorkman, Svensson, & Lundberg, 2007). A significant percentage of mentally ill individuals are perceived as strange, unpredictable, frightening, and aggressive (Bjorkman, Svensson, & Lundberg, 2007). As a result, communities may be fearful, suspicious, or intolerant of mentally ill individuals. In such cases, stigma acts as a significant barrier that prevents mentally ill individuals from obtaining membership within a community.

Stigmatizing attitudes can have a variety of negative impacts on the mentally ill and can be more damaging and difficult to overcome than mental illness itself (Hinshaw, 2007). For example, research shows that stigma can limit both the opportunities and community involvement of mentally ill individuals. Stigma leads to mentally ill individuals having a reduced ability to gain and/or retain employment, education, medical care, housing, and interpersonal relationships (Kobau, DiIorio, Chapman, & Delvecchio, 2010). Other negative consequences include diminished social roles, increased social isolation, a worsening of symptoms, and increased risk for contemporaneous physical disease (Kobau, *et al*., 2010). As a result, mentally ill individuals may have little to no influence within their communities, be unable to ensure that their physical and psychological needs are fulfilled, and lack the opportunity to develop and share an emotional connection with the community as a whole. Therefore, in order to improve sense of community for mentally ill individuals, it is essential to find ways to diminish the stigma of mental illness.

Social identity theory plays an important role in explaining why stigma occurs and can provide a framework for community programs aiming to reduce stigma. Simply put, social identity can be used to distinguish the ingroup, or those who are like us, from the outgroup, or those who are not like us (Ottati, Bodenhausen, & Newman, 2005). Individuals use their group memberships to define their sense of self and to provide a source of self-esteem. However, the mere act of categorization often triggers intergroup discrimination (Tajfel & Turner, 1979). As humans, we are motivated to maintain a positive sense of social identity. This motivation influences the way that we evaluate and perceive both ingroup and outgroup members (Ottati, Bodenhausen, & Newman, 2005). In cases where there is a status differential, the relatively more powerful ingroup members can use their social identity at the expense of the outgroup. For example, stigma develops from the perception that one's own group is different from—and therefore better than—the stigmatized group (Tajfel & Turner, 1979). Therefore, social

identity leads to a bias in cognitive processing so that the ingroup is regarded positively and the outgroup is regarded negatively (Ottati, Bodenhausen, & Newman, 2005).

In regards to stigmatization of mental illness, the ingroup, or people who hold stigmatizing attitudes about mental illness, are typically afforded a greater level of social power. Sense of power is both developed by and maintained through stigmatization of mentally ill individuals. The ingroup can maintain a positive sense of social identity by negatively evaluating individuals who are mentally ill. For example, mentally healthy individuals may discriminate against mentally ill individuals as a means of creating distance between the two groups to provide a sense of security that one is not at risk of becoming mentally ill.

Overcoming Barriers to Sense of Community

Re-establishing social identity can reduce the stigma of mental illness and therefore enhance sense of community for mentally ill individuals. Contact theory, first proposed by Allport (1958), predicts that positive interactions with members of a stigmatized group could improve attitudes towards that group. Direct personal contact can help dispel negative beliefs about an individual by demonstrating common interests and common humanity among different groups (Allport, 1958). Therefore, interpersonal interactions can provide a mechanism for members of the general public to reshape their perception of mentally ill individuals, allowing these outgroup individuals to become integrated with the ingroup.

Desforges *et al.* (1991) suggest that contact works via three processes: expectation, adjustment, and generalization. First, individuals expect that the member of the stigmatized group with whom they have contact is representative of the group as a whole. Second, cooperative interaction allows individuals to adjust their beliefs to develop a more positive impression of the member of the stigmatized group. In addition to reducing stereotypes, interaction allows people to recognize that stigmatized individuals can be "just like me," which can further enhance positive attitudes by closing the gap between group identities (Couture & Penn, 2003,p. 292). Finally, generalization allows individuals to generalize their newly improved attitudes about the specific group member to the stigmatized group as a whole.

Although contact is the prevailing method of stigma reduction, the effectiveness of contact-based interventions depends on the nature and quality of the contact (Couture & Penn, 2003). For example, contact is far more likely to promote positive attitudes when groups are viewed as having relatively similar status (Hinshaw, 2007). Without an equal distribution of power, the ingroup would have no motivation to open their identity to outgroup members—there would not be a perceived benefit in closing the gap between themselves and the outgroup. In addition, contact that is casually arranged is far more effective at reducing stigma, because it allows for natural rather than artificial interactions between groups (Hinshaw, 2007). Individuals who consider an interaction to be more personal are more likely to be motivated to find the common interests and common humanity necessary to decrease stigma. Finally, in order to have lasting effects, it is necessary that contact is in the form of regular

events, rather than just occasional meetings. This reinforces the development of positive attitudes as well as playing a role in preventing the further development of stigmatizing attitudes.

At present, the majority of contact-based interventions designed to reduce stigmatization of mental illness involve mentally ill individuals providing lectures to educate the public about mental illness and the capabilities of the mentally ill. Although this has been shown to have an effect on the reduction of stigma, the long-term benefits have not been addressed. For example, it has been suggested that such programs only reduce stigma on a short-term basis, while the information is still readily available in memory (Hinshaw, 2007). Therefore, in order to combat stigma it is necessary to design a contact-based program that is casually arranged, that is relatively long-term, and that allows members to have equal status.

Community Gardening as a Contact-Based Intervention

In order to develop a successful community intervention program to decrease stigma and, in turn, improve sense of community for mentally ill individuals, it is necessary to provide an incentive for members of the community to come together and interact with each other in a meaningful way on a voluntary basis. Access to nature is considered a fundamental human need and is linked with various physical and psychological benefits (Tan & Neo, 2009). Therefore, community gardening can serve as the necessary mechanism to bring groups together for purposeful, quality interactions. Among the benefits of a community garden is the significant improvement to overall quality of life for those who participate. Such gardens offer spaces for individuals to participate in leisure activity and encourage diverse community groups to work together (Tan & Neo, 2009). Moreover, community gardens can be seen as catalysts that allow residents to address issues collectively and bond through their improved social networks (Tan & Neo, 2009). The opportunity to work constructively with other members of the community helps forge a sense of membership and shared emotional experience for individuals who may otherwise feel excluded by society.

Community members may feel motivated to participate in the community garden to satisfy a number of personal drives (Kingsley, Townsend, & Henderson-Wilson, 2009). For example, community members who already have an interest in gardening, nature, or learning more about plants may be particularly likely to join this endeavor. However, additional benefits such as making an aesthetic improvement to the community, contributing to environmental sustainability, participating in low-impact exercise, and having the opportunity to socialize all serve as reasons to participate that might appeal to a broad range of community members. Therefore, a shared garden is expected to have a two-fold approach to improving sense of community for mentally ill individuals: not only will the garden facilitate contact, which plays an important role in decreasing stigma, but all individuals involved can also receive additional benefits from the activity itself.

Mentally ill and mentally healthy individuals would have the ability to interact with each other as they planned and carried out tasks related to the community garden. However, "garden politics," or interpersonal conflict related to community gardening, may decrease the effectiveness of this contact-based intervention (Schmelzkopf, 1995, p. 376) Garden politics can include power struggles, over- or under-acceptance of responsibility, or conflict regarding what should be planted and how garden maintenance should be carried out (Schmelzkopf, 1995). In addition to typical "garden politics," this activity poses the additional challenge of ensuring that mentally ill people are adequately represented in terms of power, status, and responsibility. Without such a precaution, the intervention is less likely to reduce mental illness stigma.

Therefore, it is essential that an authoritative body be developed to provide leadership within the gardening community to prevent personal agendas being carried out by the ingroup. An equal number of the members of the general public and mentally ill individuals should be granted authoritative roles (such as lead gardeners) and hold membership on committees related to planning and conflict resolution. This ensures not only that both groups will be fairly represented, but also that the roles and status of each group will be equal within the community garden. Moreover, engaging in a long-term project such as a community garden provides an increased opportunity for contact, which may further encourage individuals to change their attitudes towards community members who are mentally ill. In addition, the community garden project would allow for the longitudinal assessment of attitude change as the result of close interpersonal contact.

Expected Outcomes

Contact theory applied in the form of a community garden is expected to significantly reduce mental illness stigma. It is expected that this project, due to both its duration and the casual nature of participation, will lead to a greater reduction of stigma than current anti-stigma initiatives. The community garden can provide an environment in which mentally ill and mentally healthy individuals have the opportunity to interact with each other. The sharing of power and status between mentally ill and mentally healthy individuals allows for members of the garden to recognize the accomplishments and the strengths that mentally ill individuals can bring to the community. As a result, individuals who currently endorse the stereotype that mentally ill people are less able than the average citizen may reconsider their attitudes and recognize that mentally ill people do indeed hold membership within the community.

In a broader sense, this intervention is expected to lead to a decrease in all stereotypical beliefs, including the beliefs that mentally ill individuals are dangerous, frightening, and unpredictable. Close contact will allow individuals to see that mentally ill people are more than simply a diagnosis or display of symptoms, and that they are able to contribute to the community at both social and productive levels. Furthermore, sharing common interests and striving towards shared goals may diminish the gap between identities for these groups and provide a basis for shared emotional connection. This may

allow mentally healthy community members to realize that integrating mentally ill individuals into the community does not threaten ingroup identity.

Conclusions

Stigmatization of mental illness acts as a major barrier for mentally ill individuals seeking involvement within their communities. Therefore, reduction of this stigma could lead to a dramatic improvement in psychological sense of community. Community-based contact interventions have the potential to provide all four components of psychological sense of community: membership, mutual influence, fulfillment of needs, and shared emotional connection. When designing intervention and stigma reduction programs, it is essential that mental health service agencies take all four components into consideration in order to ensure that the community will be most receptive to mentally ill individuals. In short, decreasing stigma is expected to increase psychological sense of community, which will better the lives of those affected by mental illness.

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