

## **Effect of stigma in inclusive classrooms at mainstream schools**

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### **Abstract**

*Inclusion is a most discussed phenomenon at our society. Children with disable needs, when they go to mainstream schools, face a lot of problems. One of them is stigma. Mainstream education is a key policy in the promotion of social inclusion (Scottish Executive, 2000; Department of Health 2002).*

*Stigma is a complex term defined as a visible or invisible attribute, deeply discrediting, that disqualifies its bearer from full social acceptance, often resulting in several forms of discrimination (Goffman, 1963). There is evidence that different educational settings may expose children to different levels of stigmatized treatment. Due to their cognitive impairments, the social identities of intellectually disabled children can be devalued and depersonalized into stereotypic caricatures (Crocker et al 1998).*

*Literature suggests three strategies most used against stigma.*

**Key words:** stigma, school, disability, strategy, teacher

### **Introduction**

Mainstream education is a key policy in the promotion of social inclusion (Scottish Executive, 2000; Department of Health 2002). Yet there are few studies comparing the perceptions of young people with intellectual disabilities (IDs) when leaving mainstream as opposed to segregated schooling.

The term stigma dates back to the Greeks who cut or burned marks into the skin of criminals, slaves, and traitors in order to identify them as tainted or immoral people that should be avoided (Goffman, 1963).

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Most definitions of stigma comprise two fundamental components, namely the recognition of difference and devaluation (Dovidio, Major, & Crocker, 2000). They also emphasize that stigma occurs in social interactions. As such, stigma is not considered to reside in the person but rather in the social context (Crocker, Major, & Steele, 1998; Hebl & Dovidio,

2005). What is stigmatizing in one social context may not be stigmatizing in another situation (Crocker, Major & Steele, 1998).

Being a victim of stigma has many negative consequences, such as poor mental health, physical illness, academic underachievement, infant mortality, low social status, poverty, and reduced access to housing, education, and jobs (Allison, 1998; Braddock & McPartland, 1987; Clark, Anderson, Clark, & Williams, 1999; Yinger, 1994). Additionally, once an individual is labeled as possessing a stigma they are viewed as deviant from others. Being labeled as deviant may lead to rejection from the —normal population, isolation, restriction of social opportunities, and reduced self-esteem (Goffman, 1961).

Today, stigma is described as “a severe social disapproval due to believed or actual individual characteristics, beliefs or behaviors that are against norms, be they economic, political, cultural or social” (Lauber, 2008, p. 10). It is characterized by a lack of knowledge about disability, fear, prejudice, and discrimination. In its most advanced forms, stigma leads to exclusion of the person from several spheres of social functioning and it causes feelings of guilt, shame, inferiority, and a wish for concealment (Stuart, 2004). Stigma students with special needs is a complex issue with the capacity to affect all facets of a person’s life, such as the opportunity to find housing and employment, enter higher education, obtain insurance, and get fair treatment in the criminal justice or children welfare systems (Everett, 2006; Charbonneau, 2007). Thus, stigma robs students with special needs of particularly important life opportunities vital to achieving life goals, obtaining competitive employment, and living independently in a safe and comfortable home (Corrigan and Kleinlein, 2005).

Stigmatization impacts on people’s quality of life and social and psychological well-being. It causes stress, anxiety and further stigma. In the public domain, it can result in reduced acceptance, disapproval, discrimination, rejection and social exclusion. Consequently, persons with disabilities were deprived of employment opportunities and obliged to depend on social securities. For some people with mental illness, they refused to seek help for their disorder, which would prevent them for receiving necessary treatments.

### **Levels of stigma**

Stigmatization occurs on societal, interpersonal, and individual levels. Recently, Pryor and Reeder (2011) articulated a conceptual model that seeks to bring greater clarity to the current but diverse literature on stigma. Building on previous theories (Corrigan, 2004; Herek, 2007), this model depicts four dynamically interrelated manifestations of stigma (see Figure 1). *Public stigma* is at the core of Pryor and Reeder’s model and represents people’s social and psychological reactions to someone they perceive to have a stigmatized condition. Public stigma comprises the cognitive, affective, and behavioral reactions of those who stigmatize (perceivers). The second type of stigma in Pryor and Reeder’s model is self-stigma. *Self-stigma* reflects the social and psychological impact of possessing a stigma. It includes both the apprehension of being exposed to stigmatization and the potential internalization of the negative beliefs and feelings associated with the stigmatized condition. The third type of stigma is stigma by

association. *Stigma by association* is analogous to Goffman's (1963) courtesy stigma and entails social and psychological reactions to people associated with a stigmatized person (e.g., family and friends) as well as people's reactions to being associated with a stigmatized person. Finally, *structural stigma* is defined as the "legitimatization and perpetuation of a stigmatized status by society's institutions and ideological systems" (Pryor & Reeder, 2011). The four manifestations of stigma are interrelated.

### **Stigma on education**

There is evidence that different educational settings may expose children to different levels of stigmatized treatment. Due to their cognitive impairments, the social identities of intellectually disabled children can be devalued and depersonalized into stereotypic caricatures (Crocker *et al* 1998). This may lead to the stigmatized individual experiencing differential treatment and being systematically avoided, derided and marginalized (Dovidio *et al* 2000). It has been found that young people with IDs educated in integrated schooling often believe that their social identity is devalued (Szivos-Bach 1993). Sensing that others do not like, value or respect one represents a major threat to self-esteem (Baumeister & Leary 1995). Meanwhile, there is evidence that those educated in segregated settings may be protected from an insight into the devalued status that people with IDs can hold in society (Todd 2000 ).

In the educational field, a 2004 study carried out by Special Olympics<sup>12</sup> of 4000 middle school students from across Japan examined their beliefs and attitudes towards student peers with intellectual disabilities. Overall the students underestimated the capabilities of students with intellectual disabilities and were hesitant to interact with them. On the other hand, they were willing to include students with intellectual disabilities in their schools and classrooms. In the 2004 Canada Benchmarking Attitudes to Disability Survey, 55% of the Canadian thought that children with physical disabilities would best be taught alongside other children but there were only 33% of the people for children with mental illness.

### **Teacher's stigma and attitudes**

Further evidence, which supports the presence of a societal bias, is found when examining and measuring teachers and professors' attitudes towards disable students. The negative attitudes of educators are reflected in Kavale and Fornes's (1995, 1996) study, which revealed that when teachers were made aware of the presence of an disable students those teachers differentiated almost 80% of students with disable students from their peers without disable students as having problems with distractibility, hyperactivity, and adjustment (also see Mishna, 2003). Throughout the literature, there is a common negative attitudinal theme that arises in response to those with disable students. For example, one study found that instructors frequently reported feeling sorry for those students with disabilities (Frymier & Wanzer, 2003; Pernell, McIntyre & Bader, 1985) and perceive them as not only more difficult to teach but also less intelligent (Darch, Walker, & Gersten, 1988; Frymier & Wanzer, 2003; Gerber & Sernmel, 1984).

Some of these negative attitudes may be due to the negotiation process required between students and teachers when they are determining how accommodations will be met. This is understandably a difficult and stressful process for the student as well as the teacher, and often educators appear to be reluctant to provide accommodations to students or seem suspicious of their non-visible disability (Frymier & Wanzer, 2003).

Another common negative attitude that is reported by teachers and professors is the judgment that those with disabled students are lazy or not trying hard enough. This finding was supported in Lock and Layton's (2001) study, which showed that some professors' belief that students use learning disabilities as an excuse to get out of work. This negative perception is unfortunate because abundant in the literature are reports of students labeled with disabled students working themselves into a state of exhaustion (Barga, 1996; Denhart, 2008; Gerber, Ginsberg, & Reiff, 1992; Reiff, Gerber, & Ginsberg, 1997; Reis & Neu, 1994) and even developing headaches and physical illness from the workload required to compensate for the difficulties that their disabled student causes them (Rodis, Garrod, & Boscardin, 2001).

### **Student behavior as a basis for teacher expectations**

The studies described so far measured the effect of several labels—mentally retarded, emotional/behavioral disability (or its earlier designation, emotionally disturbed), and learning disabled. In a more nuanced study by Levin, Arluke, and Smith (1982), 75 high school teachers were asked to evaluate a ninth grade student as described in a school psychologist's report. To vary the diagnostic labeling, a quarter of the teachers were told that the student was dyslexic, a quarter that he was emotionally disturbed, a quarter that he was mentally retarded, and a quarter that he had no disorder. In addition to the labeling information, half of the teachers were given a writing sample that was at grade level, and half were given a sample at below grade level. To add another dimension, teachers were asked questions not only about their optimism regarding the student's academic success, but also about their willingness to offer services to help the student succeed (e.g., create special lessons, stay after school), as a measure of their expectations for their own behavior. They found that only the emotionally disturbed label was significantly more negative regarding optimism for student success compared with the no label condition. In contrast with the findings about the labels, the student writing samples had a much greater impact on teachers' expectations for the student's success, with the below-grade-level sample adversely affecting expectations. Lastly, the study failed to uncover any significant main effects of labeling or student behavior (in the form of the writing sample) on teachers' estimation of their willingness to provide extra help. The researchers thus concluded that (a) not all labels have the same impact on teacher expectations; (b) student behavior may have a greater impact on teachers' expectations than do many labels; and (c) teachers' expectations can be adversely affected, while their classroom behavior may not be.

### **Strategies used against stigma**

The literature identifies three general approaches for countering stigmatizing attitudes and discriminating behavior associated with disable children. These are education, contact, and protest (Corrigan & O'Shaughnessy, 2007). Although each of these stigma reducing approaches has some degree of validity on the surface, they are not uniformly effective (Wang, 2011).

The first strategy to fight stigma originates from the belief that stigma is related to poor factual knowledge about mental illness and disability, and seeks to inform the general public and health professionals by replacing inaccurate stereotypes and false assumptions of mental illness, and disable children with facts and accurate conceptions about the illness (Rusch, Angermeyer, & Corrigan, 2005). The limitations of this kind of intervention are that many stereotypes are resilient to change (Corrigan & Penn, 1999), and it has been argued that education modifies literacy and, sometimes, attitudes, but rarely behavior (H. Stuart, 2005).

The second strategy aims to change negative attitudes toward the mentally ill through direct interactions with affected persons. Direct and face-to-face interactions are examples of contact interventions (Van der Meij & Heijnders, 2004). Contact appears to be the most promising strategy for reducing stigma (Corrigan & Penn, 1999), especially when contact is one-on-one: when people are seen as having equal status and when people are working together in a cooperative rather than competitive manner (Islam, & Hewstone, 1993). This is showed better by the inclusion policy.

The third strategy works on conveying messages to report and to believe reported negative and inaccurate representations of mental illness and disable children. Advocacy activities, educational support groups, and patient empowerment groups are examples of interventions within the protest strategy. This kind of strategy is usually effective in diminishing negative attitudes about mental illness but it fails to promote more positive attitudes supported by facts. Also, a rebound effect may occur and can be observed in the stigmatizing beliefs of the public (Corrigan & Penn, 1999), meaning that protest does not necessarily change people's prejudice about mental illness.

The challenge of combating stigma is still prominent in the mental health field and much more needs are to be done. The fight against stigma is a complex endeavor, with multifaceted implications, and must be examined from multiple perspectives (e.g., mentally ill individuals, their families, and healthcare professionals) to increase knowledge and experience about the best strategies for antistigma campaigns. Until now, few studies focusing on the perspective of those having mental illness, relatives or mental health practitioners, have been published and there is a paucity of research using everyday life settings for examining strategies to fight stigma. Most efforts have focused on directly improving community attitudes even though it seems relevant that antistigma programs would also address patients and their relatives. Studies conducted in this manner reported few suggestions, which were mainly concerned with improving information on mental health issues for the public (Gaebel, Bauman, & Zasko, 2005).

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