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Constructing the Stigma

Streszczenie

Percepcja innych osób zależy w dużej mierze od procesów kategoryzacji społecznej.
Na spostrzeganą inność jednostki wpływa kultura, w której się dana osoba wychowuje, sytuacje społeczno-polityczne kraju, w którym ta osoba mieszka, a także szereg indywidualnych czynników, takich jak; umiejętności poznawcze, nawyki poznawcze, emocje czy potrzeba poznawczej bliskości. W opisanych w artykule badaniach wzięło udział 300 studentów w wieku od 18–19 roku życia. Wyniki wskazują, że osoba niepełnosprawna czy chora jest spostrzegana w dużej mierze w negatywny sposób, mianowicie ocenianą osobę studenci spostrzegają przez pryzmat posiadanej niepełnosprawności, zaburzenia czy choroby. Te negatywne przymioty według studentów uniemożliwiają realizację własnych potrzeb, aspiracji, wartości czy osiągnięcie wysokiej pozycji społecznej W opinii badanych niepełnosprawność powoduje wiele problemów w zakresie społecznego funkcjonowania, zdobywania akceptacji innych, czy nawiązywania relacji z innymi – zdrowymi ludźmi. Stwierdza się, że wyniki przeprowadzonych badań powinny zostać zaimplementowane w procesie edukacji, zwłaszcza studentów, którzy w przyszłości będą pracować z osobami ze specjalnymi potrzebami.

Słowa klucze: stygmatyzacja, społeczna kategoryzacja, percepcja, pedagogika specjana

Abstract

Perception of other people is influenced mainly by the social categorization processes. Otherness depend on the culture the perceiver was raised in, the socio-po-

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litical situation of his or her country, and on the individual factors such as: cognitive abilities and cognitive habits, emotions, or the need for closure. The current studies were conducted in the group of 300 students from 18 to 19 years old. It has been showed that the disadvantaged person is perceived mostly in the negative way, that is through their disabilities, disorders and illnesses, which are thought to be interfering with the realization of the needs, aspirations, values or a good social position. In students opinion the disability creates many problems in the social functioning, gaining acceptance of others, or in starting new relationship with normal - able persons. It has been concluded that the outcomes of the current study should be implemented in the education processes, especially of these students who are planning to become teachers or special educators in the future.

Keywords: stigma, otherness, social categorization, perception, special education

Introduction

How we perceive people and whether we see them as *others* is influenced by, among others things, our system of social categorisation. This system differs in individuals in its number and content of categories (Stephan & Stephan, 1996; Macrae, Tanger, Hewstone, 1994; Żółkowska & Żółkowska, 2010). Categorisation, as underlined by Moscovici, refers to a certain tendency that combines objects (including people) into separate classes based on their common properties. This ability to "compartmentalise" and to classify objects has a very important adaptive function (Moscovici, 1994). Thanks to this ability we do not have to "learn" every person individually and from scratch – we can use this accumulated knowledge about types of people and we can go beyond the provided information, that is we can deduce information about missing data and predict, as well as automatically process this information about another person, which saves both time and mental resources (Stangor & Crandall, 2000; Lazarus, 2002; Smith et al., 1993). Research shows that when we have to choose from many possible categories, we usually focus on the first available one and discard the others . Such categories that appear automatically without conscious effort are, for example, gender, age, race, social role, and knowledge available at any given moment about any given category (Miles et al., 2010). The primary categorisation method is to divide people into those who are similar to us and those that are different from us, that is, into our "own" and "others" (Tajfel, Richardson & Everstine, 1964; Tajfel & Cawasjee, 1959; Żółkowska, 2004). At the same time, as T. D. Nelson stresses, this process does not result from specific premises and knowledge about one's "own" or "other" group. Causes or consequences are not analysed here. Nor is an assess-

ment made of the individual – the individual is only considered as a representative of the group. Judgments about a person (object) are formed quickly, and only that information is captured which confirms fixed beliefs. In addition, these judgments are usually formulated in one's deep conviction of their accuracy. Therefore, if we perceive individuals which, due to a characteristic criterion, we include in one category, this means that we assign all other features of that category to them (Nelson, 2002). A category's stiffness results when an individual's resistance to acquire new content is greater than his or her knowledge about the category or when there is insufficient motivation to seek it out. This resistance can take place without the participation of one's consciousness, and the rejection of new information proceeds automatically (Greenwald and Banaji, 1995). Activating categories alone is subject to various factors, among them are both an individual's traits and social factors.

A particular issue is categorising in the form of stigma. According to Goffman, *stigma* is a strongly discrediting feature that makes the person who possesses it be perceived as different, tainted, or even as "not fully human" (Goffman, 1963). Stigma is similarly recognised by Jones and colleagues, who define it as a "property, which marks the individual as deviant, imperfect, limited, broken or unwanted in any other respect" (Nelson, 2002). Such a negative attribute, in some way, imposes itself on the perceiver and defines the social identity of the person by pushing into the background all other characteristics; therefore, the person is perceived through the prism of that blemish. Goffman was aware that the term *stigma* slightly overfocuses some of the attention on the properties of people and he emphasised that, in principle, we should not talk about attributes and properties because they can have a different meaning in various social contexts. Rather, what is needed is a "language of relationship" (source). This relationship is a certain one between "attribute and stereotype" (Goffman, 1963; Link & Phelan, 2001, 363–85). Given these concerns, B. G. Link and J. C. Phelan, in their work entitled "Conceptualizing Stigma", offered a broad view of stigmatising as a multistage process, assuming the coexistence of several inter-related elements, such as *labeling, stereotyping, separation, loss of social status and discrimination*. In addition, the authors believe that a social stigma implies some kind of power of one group over another (Link & Phelan, 2001, 363–85).

Labeling depends on highlighting and naming some socially significant differences. Labels can become only those characteristics that are socially important -- for example skin colour, sexual preference or mental illness -- although the social significance of individual features can be different in different places and at different times. In addition, the label is not just a property of the person, but it is attributed to him or her and its legitimacy is an open issue. An example is the lack

of strict boundaries between health and illness (Link & Phelan, 2001, 363–85). Labels assigned to the same social groups may vary in emotional content. Some are more or less politically correct -- a "user of psychiatric institutions", "client", "patient" or "mentally ill", and others are offensive, such as "cripple" or "lunatic". *Stereotyping* is another, perhaps best described and studied part of social perception which involves associating distinguished social categories with negative stereotypes. Stereotyping and stigmatising are separate but closely related. However, stereotypes play a large role in de-evaluating negatively categorised people. Adjudication based on visible features next to an entire set of characteristics is a key aspect in the more general stereotyping. Stereotyping is "using stereotypical knowledge when making an opinion on the individual" (Brewer, 1996, 254). In contrast, a stereotype is defined as a "cognitive category, which is used by the perceiving subject in processing information about people" (Hamilton & Trolier, 128).

Stereotypes can fulfill group functions (intergroup differences, maintaining the hierarchy) or perform individual functions (protecting one's self-esteem). Stereotypes performing group functions are widely accepted (they may even have a normative character) and resist change; therefore, they especially confirm a certain type of attitude which sustains and protects them. On the other hand, stereotypes performing individual functions can be dismissed more easily as a threat to the self, and thus the probability is greater that a particular (not based on a category) experience and a particular way of treating a stigmatised person will appear.

Without going into a very great deal of controversy concerning an understanding of, their origins, characteristics and functions (Macrae, Stangor & Milne, 1994), stereotypes can be defined as a specific cognitive representation of social groups, and are rarely the representation of an individual. These stereotypes are characterised by oversimplification (poverty of content), strong affective staining, over-generalisation ("everyone is the same"), and relative stability (low sensitivity to change). For example, the mentally ill stereotype usually consists in beliefs about the person's aggressiveness, unpredictability, reduced intellectual ability, inability to consciously direct their conduct, and so on. As we have emphasised above, in recent years one has often departed from evaluating stereotyping and treating it as a certain rigidity of thought or even moral failure. Many researchers believe that automatic categorising is inscribed into our way of perceiving the world and plays an important role in processing information.

Separating "us" from "them" is the next stage of stigmatising. A negative category is a prerequisite for recognising certain persons as substantially different from the "normal" rest. This perceived difference is not superficial but is about their social identity (they have a "contaminated" identity; a "spoiled identity" by Goffman). Goffman says that perceivingan individual as being fundamentally

different contains the *implicit* belief that one is not fully human. The hitherto described phenomena set the stage for social rejection, discrimination, exclusion and marginalisation.

Most definitions of 'stigma' do not include the obvious element of rejection or do not speak directly about its consequences, such as discrimination. *Discrimination* is the ill-treatment of particular individuals because of their membership in a group; it is selective, arbitrary or negative behaviour towards members of the stereotyped group (Dovidio et al., 276–319).

In recent years, under the influence of widely advocated political correctness, manifestations of direct discrimination against members of different minorities are much less common, but it should be pointed out that discrimination can often have a structural character and not necessarily be expressed by open hostility or aversion. Structural discrimination is understood as various institutional forms of consolidation or the deepening of inequalities between social groups, for instance by an uneven distribution of financial resources (e.g. relatively small expenditures on treatment, rehabilitation, and support unions) or by some legislative regulations, such as unfairly restricting the civil rights of ill and disabled people (Corrigan, Markowitz & Watson, 481–91; Corrigan & Kleinlein, 11–44, Żółkowska & Żółkowska, 2008).

The loss of social status and marginalisation of people negatively categorised completes the process. B.G. Link, L.H. Yang, J.C. Phelan and P.Y. Collins (2004, 511–41) completed the concept by one more element, which is the "emotional reactions" of both those who stigmatise (e.g. anger, irritability, anxiety, pity) and the stigmatised (e.g. embarrassment, shame, fear, anger), arguing that this factor is essential for understanding the behaviour of members of both groups. The authors also emphasise that any category of persons can be effectively stigmatised only when another group has power over them, such as social, economic or political power.

Some researchers point attention to the fact that social stigma can also interact through a series of more subtle mechanisms than just overt discrimination. Often emphasised is the importance of processes running through stigmatised individuals which result from their having internalized negative social stereotypes about themselves(these processes are self-stigmatising "self-stigmas" in contrast to public stigmatisation or "public sigmas") (Corrigan & Kleinlein, 2005, 11–44; Gallo, 1994, 407–10; Caltaux, 2003, 539–43; Ritsher & Phelan, 2004, 257–65). Bruce Link, who dealt with sick people, highlighted the importance of these phenomena in the so-called *modified labeling theory* he formulated and which he verified empirically (Link & Phelan, 2001, 363–85; Link, 1987, 96–112; Link et al., 1989, 400–23). According to this theory people internalise

the social concepts of disease and learn social attitudes towards the ill. In this way, already at an early stage an idea is formed of what it means to be sick, and especially to be mentally ill, and the attitudes functioning in the language about the mentally ill -- the jokes, cartoons, the way they are presented in the media, etc. -- play an important role. In general, a belief is gradually formed that these social attitudes towards the mentally ill are generally negative, which means that, as the case often is, most people reject such a persons as friends, workers, neighbours or life partners and consider them to be less reliable, intelligent, competent, and so on. When someone starts psychiatric treatment, thus receiving the "official label" of a patient, those internalised beliefs take on new meaning for him or her. They become "the expectation of rejection", which has a negative impact on one's self-experience and on social relations. B.G. Link identifies three ways in which sick individuals try to cope with social stigma: by keeping one's illness a secret (secrecy), socially withdrawing (withdrawal) -- limiting social contacts to a narrow family circle or those marked by the same stigma -- and by educating others (education) -- actively attempting to change unfavourable social attitudes. However, according to research (A. C. Watson, L. P. River 2005, 145–64) self-stigmatising does not concern every mentally ill person. Some are indifferent to existing negative stereotypes and discrimination, and still others respond to them with "righteous anger". The reaction depends on the acceptance of stereotypes and on the strength of group identification. Other authors consider this process as the polar opposite of consolidation (empowerment), understood as gaining or recovering a sense of control over one's life and treatment which is connected with high self-esteem and the feeling of self-efficacy (Fitzsimons and Fuller, 2002, 481–99; Corrigan, 2002, 217–28; Shih, 2004, 175–85; Corrigan & Calabrese, 2005, 239–56). C. T. Miller & A. M. Myer also came to similar conclusions by saying that the prophecy (involuntarily inciting behaviour that confirms the belief of the stereotyping person) may be revoked by the object if one is aware of the stereotype and takes compensatory measures to deny it (Miller & Myers, 1998). C. M. Steele's research also shows that stereotypes can lead to the stigmatised individual's independence; he/she may withdraw from the area of life that is covered by the stereotype or by distancing oneself from it (Steele, 1998). Although recent studies suggest that these results can moderate the level of awareness in the stigmatised person (Pinel, 1999), conditions for the appearance of each result has not been fully defined. However, in all cases the stigmatised person's experiences are more negative than those of the non-stigmatised.

The causes of adverse social categorisation, according to Goffman, can be:

– bodily weakness , such as obesity, physical disability, and facial deformities.

– individual blemishes seen as signs of weak will or character defects, such as mental illness, addiction, homosexuality, unemployment, incarceration, and prostitution.

– tribal stigmas of race, nationality and religion.

In principle, one can say that all forms of social maladjustment or differences can, in certain circumstances, become the reason for treating someone as *different* and can arouse similar, negative public reactions.

Slightly different categories are offered by B. G. Link, L. H. Yang, J. C. Phelan and P. Y. Collins. The authors' unfavourable categories include:

– visibility (the ability to hide)

– origin and the related ability to control (the degree of "culpability", – personal responsibility")

– a threat to others,

– the degree of disruption of social relationships,

– aesthetic properties,

– the degree of "centrality" (important for the feeling of self-identity),

– reversibility (in the case of a disease – "curability"),

– time elapsed from the onset of the stigma.

These unfavourable categorisation characteristics determine both the subjective aspects of experiencing them, ways of coping with them and the social reactions they inspire (Link et al., 2004, 511–4; Crocker, 1999, 89–107; Crocker & Major, 2003, 232–7). Attention should also be turned to a rather special kind of unfavourable categorisation, namely, to the families and friends of the stigmatised people ("stigma transferred" in different contexts: "courtesy stigma", "associative stigma", "stigma by association", sometimes "family stigma"). Goffman argued that at least in part they share the burden imposed on their loved ones (Goffman, 1963; Stengler-Wenzke et al., 2004, 88–96; Struening et al., 2001, 1633–8).

The category of *other* has a social and personal dimension. It is the context that decides whether, and what feature of, a person is assessed as *other*. Apart from the face there are no appearance features,, and behavioural traits that would be treated as *other* are intercultural and timeless (Johnson et al., 1991). [The face is prominent because our perception of it has a specific location in our brain (Tre-

hub, 1997)]. In addition to the face, treating someone as *other* will depend on the culture, socio-political situation, the place of the group in society and on what is happening within that group (Archer, 1985; Crocker et al., 1998; Pfuhl and Henry, 1993). O'Leary's research (O'Leary, 1993) shows that old age in the U.S. is treated as a sign of weakness and disease, and in Japan it is identified with wisdom and high status. In the Middle Ages the Catholic Church allowed homosexual marriages (O'Brien, 2006). Over the years, the stereotype of the student or professor has also changed.

Categorising people as *others* also depends on the perceiving person. As studies reveal, people are more willing to use rigid schemas while evaluating others when their own cognitive capabilities are limited, for example, by distracting factors or by the load of another cognitive task. Important also is the evaluating person's motivation to control one's assessments and to aspire to an accurate assessment of the other person. Also essential are the intentions as well as a sense of human responsibility for one's prejudices against others. Yet another factor are emotions. Feelings of happiness and anger intensify our tendency to use stereotypes when judging others, while other moods, as sadness, do not have such an influence on perception (Nelson, 2003). According to R. Cialdini, we use simple categorisation when we do not have the time, energy and mental resources to make, in a given situation, an exhaustive analysis and also when we are in a rush, when we are uncertain, stressed, indifferent, tired or preoccupied with something else (Cialdini, 1993).

The above information fills us with optimism, as it turns out that we are not condemned to the use of rigid categories, schemas, stereotypes and prejudices. When people are motivated and have well-rehearsed, different ways of perceiving others at their disposal, they are able to avoid a social categorisation that can contribute to the development of a false image of the perceived person. Macrae states that if activation of a stereotype can become a routine, automatic process actuated by external stimuli, then there is no reason why a similar mechanism could not involve the inhibition of stereotypes (Macrae et al., 1994).

This information is extremely important for education. Planned modification of both social and individual factors can influence categorisation, and thus counteract the consequences of adverse social categorisation.

Research objectives

The aim of the study is an attempt to answer the following questions:

1) How do young people aged 18–19 years studying at the Faculty of Pedagogy in Szczecin interpret concepts, otherness, stereotype, and stigma?

2) How do students perceive the following categories: crippled, physically disabled, mental illness, a person with an eating disorder, a person with cancer, and a person with diabetes? 3) In what way in educating the students of Pedagogy can we develop the controlled ability to refrain from using unfavourable social categorisation?

Categorisation is a complex, multistep process, which is why each study must focus more on its selected elements (Link et al., 2004, 511–41). In studies on categorisation and stigmatisation, methods are drawn from various fields, for instance from social psychology, sociology and pedagogy. The most numerous are studies on opinions and social attitudes towards the sick and disabled (Rabkin, 1980, 15–26; Bhugra, 1989). These are conducted on representative groups of society or on some narrow groups, such as territorily defined ones, or those whose attitudes are either of particular importance for understanding categorisation (e.g. children), or of great practical importance in perceiving the *other*, e.g. employers, doctors, teachers, and politicians. Research of this kind uses such methods as social distance scales, semantic differential, various measures of attribution, and scales measuring emotional reactions (Link et al., 1999).

Experimental studies, for example, use short descriptions of people and their behaviour in different situations (the so-called "vignettes" illustrations) that act as a stimulus to which subjects are supposed to react to in some way. This method is usually combined with other methods, such as measuring social distance. Experimentally manipulating variables such as age, gender, severity of symptoms or medical diagnoses can isolate and measure the subjects' impacts that modify public reactions. Behavioural identitiesgenerally cause a more unfavourable assessment, are connected with a higher level of anxiety and greater social distance if accompanied by information that a person is being treated psychiatrically (Wahl, 1999). Experimental behavioural studies, in turn, are designed to capture and measure elements, otherwise unavailable in survey polls, of attitudes towards the sick and disabled and the impact of labels on social interaction. There are many variations of these experiments (Farina, 1998; Rasinski, Viechnicki and Muircheartaigh 2005; Farina, Allen & Saul, 1968; Farina et al., 1971). They may, for instance, consist of assessing human behaviour when someone is led to the mistaken belief that he or she is dealing with a mentally ill person, such as when that person is searching for a place to live or work. Sometimes, laboratory conditions are created for these artificial situations, in which an assessment of the participants' behaviour and reactions is conducted. Such studies indicate that information about the history of psychiatric treatment alone, in the absence of any signs of mental disorder in a stereotyped person , often leads to a false interpretation of his or her behaviour and underestimation of one's potential, and

can significantly impede, for instance, finding employment, housing or admission to school. One can also evaluate the label's impact on the behaviour of stigmatised individuals. It was shown that a falsely conviction research participant causes others to stigmatisehim or her, negatively affectingone's behaviour in social relations and, in consequence, provoking an unfavourable evaluation.

Qualitative research is also being conducted which shows stigmatised attitudes towards people and their own experiences. Robert Edgerton (1967) presented the lives of people with disabilities in institutions. Similar aspects also drew the attention of B. Blatt and F. Kaplan (1966). J. Mattinson wrote about the specificity of the life of stigmatised people outside the institutions (1971).

Studies on attitudes of the social environment towards other persons (disabled persons) were conducted by J. R. Mercer (1973). Research by J. R. Mercer and A. M. Henschel (1972) was an important contribution to the debate on the social model of health and disability. The importance of personal experiences of people with disabilities has also been noted in such works as R. Bogdan & S. Taylor (1976, 1994), L. Heshusius (1981), C. Kliewer (1998), and C. D. Kliewer & Biklen (2001). Family life with stigmatised people was discussed in the works of L. Davis (1995), M. Dorris (1989), Featherstone H. (1980), D. L. Ferguson & P. M. Ferguson (1986), E. F. Kittay (1999), and A. P. Turnbull and H. R. Turnbull (1979). Social factors, particularly the normalising practices for sick and disabled people, can be found in the works cited above by E. Goffman (1961, 1963) and M. Foucault (1965, 1975). Cultural factors shaping the experiences of disabled people were described by R. Bogdan (1988), R. H. McDermott and Varenne (1995), H. Mehana (1979, 1991), H. Mehana, A. Hertwerk, and J. L. Meihls (1986), J. Richardson (1999), H. Varenne and R. McDermott (1999). A huge role in special education was played by the works of T. M. Skrtic (1991) and S. Tomlinson (1982), G. Coles (1987), S. Danforth & V. Navarro (1998, 2001), N. Ervelles (2000), C. A. Grant & C. E. Sleeter (1986), R. D. Linneman (2001), V. Richardson, U. Casanova, P. Placier & K. Guilfoyle (1989), L. Rogers and B. B. Swadener (2001), C. Sleeter (1986), T. J. Smith (1997), P. Smith (1999 a, b), and S. J. Taylor (1988).

Qualitative research uses different methods and techniques of data collection, which can be, among others, narrative interviews, biographies, focus group interviews, case studies, and collective case-study analyses of documents and texts. This last technique was used in this study.

The study used a hermeneutic perspective. Use of a quality strategy seems to be a good solution since it allows one to show the complexity of social categorisation in both the individual and social context. It enables an in-depth analysis which answers the questions "What is going on?" and "Why and how is it happen-

ing?" (Shavelson & Towne 2002, 99). It shows both knowledge and experience that have been obtained by the subjects in everyday life, and defines meanings of selected social categories -- in this case, the category of the *other*. It allows one to understand the essence and quality of this category's subjective reception of. Adopting the quality strategy seems to be very important, especially in special education and when preparing teachers to work with people having disabilities. The value we noted can be described as naturalism–anti-naturalism opposition and models of cognition that are associated with it: objectivism and constructivism. After using quantitative research in special education for a long Period by which it was possible to identify the size of the selected phenomena, a more in-depth exploration of the phenomenon needed to be conducted -- including one from the subjective perspective (Harry, 1996, 292–300; Peshkin, 1988, 17–22).

The research acquired written, non-standardised statements (indirect communication) under the researcher's supervision. The aim of such a study was to obtain data for a generalisation. The detailed technique was that of written narration on a given topic. The topic, in this case, was the only stimulus. The subjects had one hour to write an essay. The subjects wrote the essay only in the presence of researchers. The students wrote arbitrarily. Qualitative data was based on presenting a possibly compact picture of the phenomena. In the description we tried to include knowledge of the subjects, their experiences, and the alleged causes of social categorisation (Denzin & Linkoln, 2005).

The preceding studies were a preliminary analysis. It was the subsequent planning phase that included the research concept: it stated the problems, determined the output ideas, chose the units of analyses, refined the exact list of research operations, and selected the research techniques. The choice of essay as a form of transmitting content was determined by the principles of exhaustion, that is, the ability to obtain the necessary content directly from the sender; representativeness, which was implemented by random selection of the group; homogeneity, that is, homogeneously selected material; and the principle of relevance. Thus the material, through use of the essay technique, was an adequate source of information for the research tasks.

The research employed the full story as the unit of analysis. In order to ensure its efficacy, the principles of measurement were also specified. The study used pro-analysis involving encoding of the material. Four competent judges examined the essays, and on their basis formulated the category nomenclature to which they assigned a given statement. This was done in a way that each judge, after reading the texts, formulated his or her categories as questions, definitions or theorems. Then the judges compiled all the questions and jointly selected those that should remain in the later stages of the study. Selection of the categories was made by

voting (categories were chosen by a majority of votes). Then the judges would determine the extent to which a particular statement "fit" into that category. If a statement could not be clearly assigned to only one category, -- that is, its contents represented at least two categories or multi-meaning symbols -- then multi-valued logic was used to scale the answer. The answers to the questions were then coded by selecting a point on the Likert scale (Fishbein, 1967). The adopted categorizing key included categories subject to the objectives of the studies, the essence of the research problem, and the initial hypotheses. The categorization key was disjointed and comprehensive; in other words, each element was included in one category and those categories did not intermingle. The key was objective and reliable, meaning it enabled the appropriate classification of communication.

The next step was to develop and interpret the results. Qualitative studies are not statistically representative and cannot be the basis for generalizations about certain behavior in the general population. The number of respondents is usually much smaller than even in surveys . However, we can speak of "representativeness" colloquially. This involves the selection of study participants who present the most varied positions while belonging, at the same time, to a relatively homogeneous group. We conducted the study on a random sample of 300 people aged 18–19 from West Pomerania. All subjects were first-year students of Pedagogy at the University of Szczecin and the Higher School of Humanities. The studies were conducted between 2010 and 2011. Seventy-five percent t of respondents were female (75%). The majority, 57%, lived in Szczecin. The other 28% lived in large towns with 20–50 thousand residents, and 15% in smaller towns of less than 20 thousand. Eighty-three percent of the respondents were graduates of secondary or profile schools and 17% had graduated from technical secondary schools.

Research results

Categories of "other" -- stereotype and stigma in the respondents' interpretation

An analysis[2] of the respondent's written statements, it turns out that ***other*** is associated with such terms as *free, distinct (lifestyle, clothing, behaviour), different, unique, alien, original, unusual, walks one's own paths, sick, strange, unusual, avant-garde, loneliness, self-reliance, extraordinariness,* and *uniqueness*. In individual statements the following terms also appeared: *Jew, Pygmy, Muslim, gay, lesbian, Eskimo*. Categories by which people can be considered as *other* were considered by the subjects as *individuality, passion, values, national origin, religion,*

[2] The order of presenting the terms results from the frequency with which they were mentioned by the respondents.

interests, behaviour, attitudes, appearance, skills, original ideas, loneliness, fear of non-acceptance, skin colour, work. The causes of *otherness* according to the respondents are *the desire to distinguish one's otherness, rebellion against functioning norms, the desire to stand out in a group, disease, different appearance, different interests, different skills, the way of education, religion, personality traits,* and *life's conditions*. Such categories, according to the respondents, depend on which group the *others* are dealing with, either through *acceptance (or only tolerance),* or *rejection*, or *elevation on a pedestal, admiration, approval,* or through *disrespect, contempt, alienation*, an *other* person can *enjoy one's otherness, feel successful, but also feel lonely, sad, not understood,* **and** *excluded.*

Stereotype, according to the respondents, is *something immutable, old rules, unchanging views, well-worn ideas about someone or something, the attribution of false or partially false assessments of qualities to people, habits, compartmentalisation, assigning a label to someone, generalisation, model, old canon but still present to which one can refer, opinion about a group of people based on one person's behaviour (e.g. doctors take bribes), the Pole-alcoholic, judgment, view-point based on false, unproven assumptions resulting from insufficient knowledge about a given person or phenomenon, common opinion, notion about people, a general usually inadequate mistaken belief*. The respondents distinguish *stereotypes of behaviour and thinking. They mentioned such stereotypes as nasty mother-in-law, red-fake, Pole-thief, Pole-drunk, a shallow (stupid) blonde, good pupil-suck up or nerd, modern girl-"superficial-materialistic", tanning-bed fan, frytka*[3]*, ballerina-anorexic, and obese-lazy person.* The causes of stereotyping are *superficial knowledge or lack thereof, lack of contacts and experience, passing on widespread views to future generations, repeating popular beliefs, lack of communication with the world, a dislike for someone or something, poor education, living in rural areas, difficulties in opening up to something new, personality.*

The effects of stereotyping are *conflict of generations, limitations in experiencing novelties, lack of development, shame and disgrace to our society (Pole=thief), making fun of people, hurting people, social exclusion, lower self-esteem, aggression, backwardness, isolation from the environment, a sense of being in control, fear, aversion to making friends, a person may adopt features that are made from this opinion,* and *enter into the assigned role or accept an assigned place in society.*

Stigma is understood by the respondents as *a distinction in a negative sense, shame, stigmatisation, persecution, bad behaviour, punishment, rejection, evaluation factor by people, worse, stupid, humiliating, deviation, the feeling of stig-*

[3] The term comes from the nickname "Frytka", one of the participants in the *Big Brother* reality show – she was known for her controversial behaviour.

matisation, exclusion. Stigma categories are *morality, culture, religion, dress, behaviour, personality, physical special marks, origin, social status, intelligence.* The reasons for stigmatising are considered by the respondents to be *other views, the desire to ridicule someone, the desire to spread one's values, the lack of conformity, different values, standing out from the group, special characteristics, race, appearance, the tendency for people to stigmatise those who differ from them, cultural or sexual differences.* The results are *isolation, aggression towards the person and the person towards the group, disrespect, hostility, ethnic cleansing, low self-assessment, bad feeling, sadness, suffering, alienation, loneliness, suicide, positive or negative depends on how you interpret it, suffering, lack of acceptance, and fear of the stigmatised and the stigmatised of the group.*

Categories: a physically disabled person, cripple, mental illness, a person with an eating disorder, a person with cancer, a person with diabetes

Respondents were asked to express their views on *mental illness, a physically disabled person, a cripple, a person with an eating disorder, a person with cancer,* and *a person with diabetes.*

A physically disabled person was associated by the respondents with such terms as *architectural barriers, pain, surgery, wheelchair, sanatoriums, loneliness, depression, rehabilitation, need for care, access ramps, hospital, lack of acceptance, insecurity, shame, helplessness, crutches, dependence on others, discrimination, ridicule by others, disability pension, lying in bed, asking for help, lack of freedom, unpleasant experiences, powerlessness, limitations, being a burden, paresis, paralysis, hospice, worse job prospects, lack of independence, dependence on aid, PFRON (Public Foundation of Disabled People Rehabilitation), cane, accident, grief, anger, assistant, prosthesis, pension, Paralympic games, elevator, frustration, decree of disability, pity, disabled able-bodied at work, amputation, diapers, adapted housing, anguish for the family,* and *needs financial assistance.*

The category ***cripple*** brought about the following associations: *physical or mental limitations, infirmity, someone for whom nothing works out, someone who cannot live normally, a person with problems in everyday life, an introverted person, someone who has complexes, a person who is not accepted by his or her surroundings, someone helpless, needy, unnecessary, burdensome, not working, disability pension, a recluse, discriminated against, isolated from the world, poor, a person who is different, someone who is ridiculed, ignored, unsure of him or herself, a person who feels a grudge towards oneself and others, a person who is pointed at, an unhappy person, dependent on aid, no will to live, shyness, rebuffed, loneliness, begging, scorn, pity, compassion, milksop, dope, helpless in life, someone for whom something did not work out, someone nasty, vulgar, idiot, brainless,*

wheelchair, alien, crippled, one-handed, crazy, nincompoop, a secondary citizen, a person living on the periphery, crock, slouch, dummy, fool, muff, underdeveloped, oaf, helplessness, and *an outcast of society.*

In the case of ***a person with diabetes***, respondents pointed to *a person who has problems with blood sugar levels, diabetes causes various health problems, someone who has to take insulin, must be on a diet, diabetes is hereditary or acquired, is someone who must mark the blood sugar level and be on a diet, and so on.* In their statements the respondents pointed out the health consequences of not treating diabetes, described the difficulties in their functioning due to the regime in of carrying out tests and being on a diet, pointed out the types of diabetes, symptoms, causes, and pointed to the need for treatment and medical consultation.

A similar interpretation occurred in the case of ***a person with cancer***. This concept, to the respondents, is associated with *a suffering person, treatment, chemotherapy, pain, transplants, frequent stays in the hospital, fighting for one's life, mental breakdown, lying in bed, inability to perform important activities, death, hair loss, vomiting, metastases, hospice, handkerchief on the head, despair, anger, grief, and loss of a sense of security.* From the respondents' statements there emerged two images. One is *a suffering person, in need of treatment, care, support, depressed, pessimistic about the treatment, with no desire to fight the disease, waiting for death, sad, physically and mentally weak, drugged, nervous, powerless,* and *helpless.* The second image is *a sick person, sufferer, but fighting the battle and optimistic about the treatment and the outside world, a strong person, copes well with difficulties, full of faith, optimism, persevering,* and *supports others.* As can be seen, the respondents, depending on their knowledge and experiences, evaluated life with the disease either as an impediment or a condition that can be accepted and which can be used to optimise the lives of the patients and their environment.

Mental illness is associated with such terms as *delusions, aggression, lack of contact with the environment, auto-aggression, seizures, incapacitated, dangerous, suicides, mood changing, incapable of an independent life, in need of treatment, unpredictable, excluded, unreliable, isolation, odd behaviour, irresponsibility, impaired thinking, lack of emotional balance, immoral, alienation, insanity, drugs, maybe loneliness, misunderstanding, chaos, madness, arouses fear,* and *difference.*

For ***a person with eating disorders*** the most often mentioned associations were *bulimia, anorexia, health problems, the inability to cope with problems, low self-esteem, morbidly taking care of one's own body, physical exercise, stress-related digestive problems, neuroses, genetic defects, eating disorders as a result of mental disorders, diseases of the body, as a result of surgery, allergies, can*

lead to death, the reasons are complex, doing it unconsciously, influenced by emotions, the need to control one's life, do not rely on fashion, have problems which they cannot cope with, the desire to be accepted, loved, needs psychological help, a lost person, needs support, medical aid, support of loved ones, they are negatively perceived by the environment, can be perceived as someone who blindly follows fashion, but this is not the case because they are sick people who are shutting themselves out, lose the joy of living, their appearance is the centre of attention, always imperfect in their opinion, they are unhappy people, with complexes, falling into depression, also experiencing syncope, are weakened, have headaches, do not have strength, weakened, exhausted body, cannot focus on anything, do not want to meet with anyone, they are lonely, those are dangerous illnesses, faces are sad, a disease of the soul, a disordered function of the satiety centre, constant hunger, starvation, overeating, taking examples from fashion magazines, suffering, undervaluing, hair loss, depression, shame, lies, weakness, striving for perfection, the Pro-Ana code, pain and suffering, narcissistic, mentally weak, and *in need of treatment.* In a very small percentage of the statements (7.5%), respondents mentioned obesity as an eating disorder. This category was associated with such terms as *stress eating, remorse, eating too much, stimulates others to ridicule, to laugh,* and *genetically burdened.*

Conclusions

As is apparent from the presented data, social categorisation by the 18–19 year-olds is conditioned, among other ways, by the views prevalent in their social groups as well as by their knowledge and personal experiences.

The studies revealed that young people possess basic knowledge about a disease or dysfunction, know the medical terms, can identify the chosen symptoms, and understand the causes and effects of the dysfunction, both medically and socially . Among the categories there are those which young people possess extensive and current knowledge about, for instance information about *a person with eating disorders.* We noticed, with great satisfaction, that the respondents' knowledge on this subject is based on the latest research, which is not always properly popularised in the media. It can be presumed that this subject is properly discussed in high school. I also suppose that young people, when they compare information that is popularised in the media with their own experiences, note media hype and, therefore, look for ways to extend their knowledge on their own and search for reliable information concerning these disorders. The statements indicated that the respondents have many personal experiences. They wrote about dealing with people with eating disorders and about their own illnesses. A similar situation

occurred with statements on the topic of *a person with cancer.* The respondents' statements provided two images of the diseased person – ill and withdrawn and an ill person who is not only coping with his or her own weaknesses but helps others and constitutes a role model for them. These images have been shaped as a result of personal experiences (family, neighbours) and from knowledge acquired at school as well as in the media. It should also be stressed that such a positive image of a diseased person appeared only next to the description of this category. In other cases, categorisation was based on identifying concepts related to biological dysfunctions, medical factors, rehabilitation and describing the difficulties in personal and social functioning. In all categories the respondents noticed ill (disabled) people as needing help and support and incapable of an independent, productive life. Unfortunately this is a typical perception for the medical model. As results from the research, it is still very deeply rooted in Polish society. That it is possible to change such a perception is exemplified by the category of *a person with cancer.* Another example of changing the stereotype from the medical to the social can be the *cripple* category. In the respondents' statements social traits are much more clearly expressed. Unfortunately, most of them are negative features.

Analysing the terms *other, stereotype,* and *stigma* is interesting in itself. The respondents, possessing the ability to define them, indicate their significant differences, and identify the causes and consequences of social categorisation. In defining *other*, as an example, the respondents indicated traits that differed from themselves but were positive . *Other* is someone distinct but deserving tolerance, acceptance and even admiration. The causes of *otherness*, according to the majority of respondents, are beyond the control of people and stem from gender, race, and physical or mental properties.

Implications for education

The literature and research results give grounds to assume that although it is widely recognised that stimulation of categorisation is automatic, the evaluation of other people is not always the result of a reflex activation. As S. Moscovici writes, two processes can co-exist: 1) automatic activation (to which all individuals are prone), 2) controlled abstinence (occurring in properly motivated people who demonstrate a low tendency to succumb to prejudice, and possess well-mastered, different ways of perceiving others) (Moscovici, 1994). The second process can be used in education to change negative social categorisations.

Our studies showed that such a need exists. The respondents perceive ill and disabled people unfavourably. A sick (disabled) person is perceived through the prism of illness, injury, impairment and the impact these disorders create in fulfilling needs, their well-being, aspirations, and values. Illness (disability) is

also, in the respondents' opinion, a factor causing difficulties in social functioning, gaining acceptance, proper social position, and establishing normal relations as well as performing social roles that promote independence and a dignified life. Illness (disability), according to the respondents, is a cause for exclusion and even dehumanisation.

While planning educational activities the following indications, among others, can be used: 1) *Contact provision.* Studies show that frequent contacts with representatives of different groups can contribute to the weakening of negative categorisation. However, mere contact is not sufficient; studies revealed that 50% of the respondents formed a positive attitude as a result of contact but that the other half intensified their hostile attitude. The reason for this may be that the stereotype is activated at the sight of a group member even before contact is initiated. According to G. W. Allport, important factors are the status of participants (social position), the contact (cooperation or competition), participant personalities(level of prejudice, authoritarianism), and the circumstances in which contact occurs. Allport believes that positive intergroup contact must meet four conditions: equal status, common goals, intergroup cooperation, and support from well-known figures (Allport, 1979); 1) *The superior goal.* As results from studies on categorising, cooperation in pursuit of a common goal weakens or even eliminates unfavourable intergroup attitudes (Nelson, 2002); 2) *Common group identity.* Intergroup reluctance can be reduced by abolishing distinct group categories as well as by encouraging people belonging to both groups to begin regarding themselves as members of a larger common group (Majo, 1994); 3) *Cooperation within the group*. *Developing empathy, role-play.* Cooperation within the group reduces negative attitudes towards representatives of another group. An emergent positive attitude towards the representative of a foreign group promotes a positive attitude toward the whole foreign group. More significant results in changing an attitude towards other people are achieved through role-plays and scene-plays, which aim at increasing empathy towards stereotyped people. A factor perpetuating such an attitude change is its frequent repetition and support given it by the authorities (Ajzen & Cote, 2008); 4) *Enrichment of knowledge* can change intergroup relations, increase perceived similarity (*Others* are also *US*), reduce anxiety, and increase perceived diversity. Within this framework the following models are distinguished: a) the bookkeeping model – information inconsistent with the stereotype leads to its transformation; b) the conversion model – information inconsistent with the stereotype leads to its radical change; c) the education model stereotype of a lower order (the subtyping model) – information inconsistent with the stereotype leads to the creation of a lower order stereotype so that the initial stereotype will not need to be changed (Aronson, Wilson and Akert,

2009); 5) *Social color-blindness* states that in taking actions to eliminate or diminish intergroup differences the competences of the assessed individuals should be emphasised. Underscoring competence diminishes the role of such categories as race, appearance, and religion. (Steele, 2003); 6) *Motivation.* Research shows that the majority of people feel they are harming *others* by using categorisation. Accordingly, there is a need to develop motivation to avoid such behaviour. Studies show that automatic stereotypes can be removed and replaced by a natural attitude. Such an attitude discourages expression of hasty judgments and induces one to try to conduct an assessment using individual information about a given person, which is how people with low levels of prejudice act -- but it requires very strong motivation. Unfortunately, without proper education such an attitude is rarely manifested because most people are discouraged from making such a cognitive effort (Clinton, 2009).

P. G. Devine's research (2008) also shows that in some people, namely those who value egalitarianism more than others, there often occurs an activation of egalitarian ideals and beliefs rather than an automatic activation of stereotypes. In people who have continuous access to egalitarian beliefs and values, social perception is not connected to the automatic activation of stereotypes. Here, automatically triggered are egalitarian attitudes and an individualised way of perceiving others. Therefore, thanks to education, people can change their default way of social perception by giving up on stereotypical information in favour of egalitarian attitudes and values (Leanne et al., 2008).

Changing social categorisations through education is undoubtedly a difficult process because, among others reasons, we cannot just throw stereotypes out of our thoughts (Kurcz, 1994). Such education requires complex and time-consuming actions, but these *are* necessary, particularly in training future teachers and educators.

In working on changing social perceptions, however, we have to remember that education itself (also at the university level) generates its own negative categories, prejudices and even often discrimination against the *others* (Hello, Scheepers & Me'Rove, 2002).

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