Dehumanization and mental health

Dehumanization is a fearsome word, calling to mind past and current gravest atrocities. People seen as less than human have suffered and suffer violence, deprivation, exclusion and dispossession, and that suffering has been and is routinely ignored or minimized. However, although dehumanization is usually understood as an extreme phenomenon confined to wars, genocides and conquests, it falls on a spectrum. Two decades of social psychological research have shown that it has significant repercussions in everyday life[1].

The burgeoning literature on dehumanization offers three key insights. First, dehumanization ranges from blatant and verbalized to subtle and unconscious: people can be explicitly likened to animals, but also implicitly denied fundamental human qualities such as rationality, self-control and complex emotions. Second, dehumanization takes varied forms, from seeing others as bestial or robotic, to rejecting their individuality or agency, to failing to spontaneously grant them minds. Third, although dehumanization often accompanies negative views of others, it is psychologically and even neurally distinct from prejudice. Seeing people as less than fully human is not the same as disliking them. We can dehumanize those about whom we are indifferent, not only those we hate. Indeed, studies of close relationships show that we can subtly dehumanize those we love.

The vast literature on stigma reveals how people with mental illness are often viewed negatively by the general public, pictured as dangerous, blameworthy and shameful, with adverse implications for equity, well-being and recovery. It has recently become clear that, in addition to these negative perceptions, they are often also denied humanity. People are seen as less human when they receive mental rather than physical illness labels, and people with mental illnesses – especially schizophrenia and addictions – are even more blatantly dehumanized than some vilified ethnic or religious minorities[2].

Dehumanizing attitudes to the mentally ill are not confined to the public, but can also be held by mental health professionals. Researchers have begun to document the causes and consequences of these attitudes. One contributing factor is emotional self-preservation: professionals may dehumanize patients as a way to protect themselves against emotional exhaustion and distress[3]. The anticipation of emotional demands may motivate professionals to deny humanity to others and result in the withholding of empathy and care.

Studies such as these shine a new light on burnout, one of whose primary manifestations is the loss of empathy for others. In clinical settings, this dehumanization-like tendency may lead professionals to disengage from patients, failing to appreciate their emotional experience and reducing them to their diagnosis. Adverse working conditions that foster burnout, such as excessive workloads and organizations that treat employees as interchangeable cogs in an industrial machine, can lead mental health professionals to dehumanize patients, with the adverse effects on clinical care that burnout researchers have documented. One study found that psychiatric nurses who felt unsupported by their organizational superiors were more likely to experience burnout and depression as well as to dehumanize their patients (e.g., showing a greater willingness to bypass their consent)[4].

People who seek mental health treatment need not be denied humanity on the basis of their illness to suffer the impacts of dehumanization. Dehumanizing perceptions of racial minorities might contribute to racial disparities in mental health diagnosis and treatment, such as significantly elevated rates of chemical sedation for African American patients presenting to emergency departments with psychiatric disorders[5], just as race-based dehumanization contributes to harsh discipline in criminal justice and educational settings.

People who believe they are being denied humanity by others typically respond negatively. Just as believing that one is dehumanized based on one's race or political views has been shown to generate antagonistic reactions, so patients' engagement with psychiatric treatment may be undermined by experiences of dehumanization from demeaning media

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representations, dismissive interactions with professionals, and deindividuating encounters with the health care bureaucracy[6].

Dehumanizing perceptions can also be internalized rather than resisted. People who believe that others see them as less than human may come to "self-dehumanize". This phenomenon may have significant clinical implications. A study of patients with severe alcohol use disorders found that those who self-dehumanized more had lower self-esteem and engaged in less functional coping[7]. Research such as this indicates how dehumanization can create vicious cycles that compromise therapeutic aims. Being dehumanized can lead to feeling dehumanized, which can sabotage treatment.

Being perceived as less than human may exacerbate an existing mental illness, but dehumanization might also be a risk factor for developing it. Indeed, studies point to adverse effects of dehumanization which are known psychiatric vulnerability factors. Being perceived as less than human increases people's feelings of social exclusion and also decreases others' willingness to help and show empathy[1]. The resulting social disconnection may amplify risk especially for internalizing and substance use disorders.

In addition to reducing social connection, dehumanization increases tendencies to actively harm people and to tolerate harm perpetrated by others. People with stronger tendencies to dehumanize others are more likely to engage in bullying; men who dehumanize women are more prone to sexual violence and harassment; and people who dehumanize their opponents in ethnic conflicts are more likely to support violent actions towards them[1]. Exposure to violence is a significant psychiatric risk factor, and dehumanization fosters it. At a more systemic level, dehumanization based on race, social class, and immigrant status may reinforce the public acceptance of social disadvantage and economic hardship, known contributors to mental health inequities.

The concept of dehumanization has proven to be a fruitful one for thinking about many forms of interpersonal and intergroup conflict. It complements more familiar constructs such as prejudice, stigma, stereotyping and discrimination by focusing on whether we perceive and treat others in ways that recognize our common humanity. Failures to do so have now been demonstrated in perceptions of diverse social groups, and their destructive implications are increasingly well understood. Research on dehumanization in the psychiatric realm is in its infancy, but strongly suggests that failures to fully humanize people with mental illness are widespread and have significant consequences.

How dehumanization related to mental illness should be addressed is not a straightforward issue. At a population level, a cultural change is required for public perceptions of mental illness to become more humanizing. The promotion of dimensional models may lead people with mental illness to be seen as less drastically "other". Some aspects of dehumanizing media representations of mental illness have measurably declined in recent decades[8].

It is equally important to lessen dehumanization in clinical practice[9]. Dehumanization can be reduced by enhancing empathy in professionals, through selection and training, while recognizing that empathy and problem-solving can sometimes be in conflict, and by promoting face-to-face contact between professionals and patients despite the growing intrusion of medical technologies. Dehumanization can also be diminished by ensuring that patients and professionals are presented as individuals with uniquely identifying attributes, boosting patients' sense of agency by increasing their say over treatment, and attenuating the real and perceived dissimilarity between patients and professionals.

The goal of humanizing care, within and beyond the mental health field, should be widely recognized and shared, and concrete strategies to address this goal should be identified and implemented. In addition to this, the impact of dehumanization on mental health at the population level should become a more explicit and specific focus of research.

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