Stigma of mental illness

Changing minds, changing behaviour

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A BRIEF HISTORY OF STIGMA

In his influential essay, Goffman (1968) describes stigma as referring to "any bodily sign designed to expose something unusual or bad about the moral status of the signifier". On meeting such an individual, we "construct a stigma theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalising an animosity based on other differences" (Goffman, 1968). For some psychiatric patients, the illness itself or its treatment (i.e. neuroleptics) may signal their outward difference, but even to be seen attending a psychiatric service marks the individual as different. Once stigmatised, the person is made to fit one of a limited number of stereotypes of mental illness (Byrne, 1997) and is effectively sidelined. Sayce (1998) has challenged the use of the term stigma, arguing that "the mark of shame should reside not with the service user, but with those who behave unjustly towards him or her". The degree and type of stigmatisation varies according to prevailing cultural norms (Warner, 1996). Sometimes psychiatrists can unknowingly contribute to this process. In this regard, Linton (1945) could have been writing about psychiatry when he wrote about culture:

> "It has been said that the last thing a dweller in the deep blue sea would be likely to discover would be water. He would become conscious of its existence only if some accident brought him to the surface."

STIGMA: SO WHAT?

Conferring a psychiatric diagnosis on an individual or admission to a psychiatric facility has multiple personal, social, vocational and financial consequences. Patients who have been labelled begin to perceive themselves as different, and self-stigmatisation may occur (Gallo, 1994). A survey by Read & Baker (1996) of the perceptions of 778 Mindlink members reported that, in relation to their mental illness:

(a) 47% had been abused or harassed in public, with physical assault in 14%;

(b) 34% had been sacked or forced to resign from employment;

(c) 26% had moved home because of harassment.

Wolff *et al* (1996) in their community survey (n=215), report that 43% viewed people with mental illnesses as more aggressive, but recorded equally high 'fear and exclusion' scores in respondents who did not share this opinion. Penn *et al* (1994) also confirm the public's choice of maintaining social distance, but advocate a package of information about target individuals (in their study, recently discharged patients with schizophrenia) in much the same way Wolff *et al* identify potential target groups for educational programmes. For Goffman (1968), stigma is social exclusion, and the literature confirms widespread discriminatory practices (Read & Baker, 1996; Byrne, 1997; Sayce, 1998).

STIGMA AND PSYCHIATRY

Negative attitudes and stigma have direct effects on the clinical practice of every psychiatrist. Despite community point prevalence rates of 14% for mental health problems and 1 : 3 general practitioner attendees describing symptoms, in primary care these are the dreaded 'heart-sink' patients, untreated or undertreated (Jenkins, 1998). Dislike of psychiatric patients by doctors is not a new finding: Sivakumar *et al* (1986) reported that 28% of medical students (n=88) believed psychiatric patients were 'not easy to like', but as doctors two years later, this rose to 56%. From the other perspective, in a study of 57 patients referred to a psychiatrist, 82% refused referral, citing the stigma of psychiatric assessment and treatment (Ben Noun, 1996). Pang *et al* (1996) have confirmed psychiatric outpatient drop-out rates of 50%. All stages of mental illness – recognition of symptoms, presentation, treatment adherence and rehabilitation – are influenced by the stigma of that illness (Byrne, 1997).

The issues of funding and recruitment represent further challenges for psychiatry. The speciality remains the Cinderella of medicine, a perennial soft target for budget cuts. Funding for psychiatric research is also scarce: Lam & El-Guebaly (1994) calculate that psychiatric research receives just 3.7% of all Canadian biomedical research funding. In their analysis of factors which attract new recruits to psychiatry, Sierles & Taylor (1996) identified a successful student clerkship (especially in students who reject psychiatric stereotypes), levels of overall resources and research opportunities. Measures which prioritise reductions in psychiatric stigma will have profound and enduring benefits in these key areas.

COLLEGE CAMPAIGN: CHANGING MINDS

Against this background, the Royal College of Psychiatrists convened a Working Party under the Chairmanship of Professor Arthur Crisp, which has evolved into the Changing Minds 'Stigma Campaign'. Following an extensive process of consultation, the committee, which includes users and broad psychiatric representation, has produced a five-year strategy ('Every family in the land: recommendations for the implementation of a five-year strategy: 1998–2003'; available upon request from the External Affairs and Information Services Department of the Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG). The campaign is inclusive and seeks to achieve change through consultation and collaboration with a variety of key groups: patients, carers, other health care professionals, employers, schoolchildren, their parents and teachers, members of the media and the general public. It recognises a variety of existing successful projects in this area, and hopes to learn from as well as complement them.

Six major conditions will provide the focus for initial efforts: depression, schizophrenia, anxiety, dementia, eating disorders and alcohol/drug misuse. Specific projects will attempt to close the knowledge gap between health professionals' and public opinions about mental disorders and their treatments. Prior to the Campaign's launch in October 1998, measures of key public opinions were recorded, and these will serve

as a baseline to measure change and provide measures of efficacy of individual projects and the campaign as a whole. Specific projects have been finalised, but many more will be determined by any of a number of interested parties. It represents the most ambitious campaign the College has ever attempted. So do not sit back and watch this one: if you have strong opinions, or better, ideas on how to effect real change, get involved and put stigma/discrimination on the agenda in your area. Success in this campaign will enhance the social dimensions of patient care and could redefine the practice of psychiatry for the next millennium.

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