KING'S College LONDON

INSTITUTE OF PSYCHIATRY,
PSYCHOLOGY & NEUROSCIENCE

Module:
Mental Health in the Community

Week 2:
Current conceptualisations of mental health

Dr Jennifer Walke

Topic 1:
Stigma and mental health

Topic list

This week, we will be looking at the following topics:

- ***Topic 1: Stigma and mental health***
- Topic 2: 'Nothing about me without me':
  The growth of the expert by experience
- Topic 3: Evaluating service user involvement

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Defining stigma

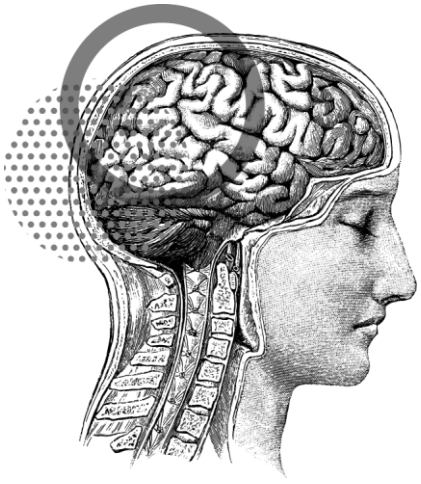
Goffman's social stigma:

"an attribute, behaviour, or reputation which is socially discrediting in a particular way causes an individual to be classified by others in an undesirable, rejected stereotype rather than an accepted, normal one. Discrimination can lead to disadvantages. Some may accept discrediting prejudices, and lose self-esteem, leading to feelings of shame, a sense of alienation and social withdrawal."

(Ritsher et al. 2003; Ritsher & Phelan, 2004)

Goffman (1963); Ritsher et al. (2003); Ritsher & Phelan (2004)

Historical context



Historical context: illnesses, diseases, conditions or disorders?

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History of disorder classification: Early to mid 20th century

Lunacy Commissioners' coding schemes: marked shift from anecdotal observation to systematic classification

New system:

- aetiology (cause) was distinguished from diagnosis
- causes were identified with input from psychiatrists and patients
- sought to establish medical history of the patient and their family

WHO
(World health organization)

British psychiatry then moved toward the WHO's International Classification of diseases (ICD)

Early 20th C to 1940s — Mid 20th C to 1980s — Late 20th C to present

Health Archives (2018)

History of disorder classification: Mid to late 20th century

ICD-based system:

- departure from cause and effect dichotomies
- increasing recognition of varied causes of mental distress
- efforts to classify new diagnoses

Proliferation of disorders: aetiological factors reframed as diagnoses, conflating source and symptoms of problems (e.g. alcoholism)

Led to wider dissent

New diagnoses greeted with resistance towards new classification

Early 20th C to 1940s — Mid 20th C to 1980s — Late 20th C to present

Copeland et al. (1971); Kreitman (1961)

History of disorder classification: Late 20th century to present

Discourse expanded beyond medical domain, to arrive at a model that encompassed the biophysical, psychological and sociological

Darian Leader

"Commodification of the psyche" has been reflected in the explosion of diagnoses

From 1-2 dozen (early 20th century) to 360+ (late 20th century)

Superficial states like shyness have been pathologised as defining disorders

Some of this can be attributed to drugs companies

DSM-V publication has reignited the debate in recent years

David Rosenhan: The "Pseudopatient" Study

avid Rosenhan

- influenced by the work of R. D. Laing and Szasz
- his experiments questioned the validity of psychiatric diagnosis

Sample: Rosenhan and 7 cohorts; none with psychiatric diagnoses

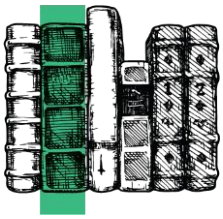
Aim: Get admitted to institutions across the US, presenting with only one symptom: hearing a voice

Result:
- they were kept for between 8 and 52 days
- 7 were diagnosed with schizophrenia
- not one was judged "sane"

Rosenhan et al. (1969-72)

Rosenhan (1973)

David Rosenhan: The response

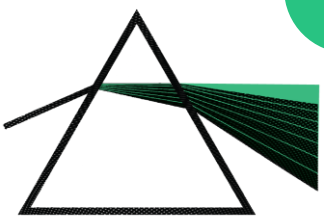


Following publication of Rosenhan et al. (1973), psychiatrists went on the defensive

The study's impact was reflected in the DSM-III (1980) - introduced more rigorous diagnoses

Rosenhan's experiment was more anthropological study than test of diagnostic practice

However…



Patient actions were taken out of context once admitted

Behaviour was misinterpreted through this diagnosis 'filter' and pathologised in line with it

Rosenhan (1973)

Consequences of stigma in treatment

Adverse connotations of labels may elicit hostility in social and clinical attitudes, and treatment.

> *A sample of psychiatrists was asked to read a case vignette and indicate likely management and attitudes to the patient on a number of semantic-differential scales. Patients given a previous diagnosis of personality disorder were seen as more difficult and less deserving of care compared with control subjects who were not. The personality disorder cases were regarded as manipulative, attention-seeking, annoying, and in control of their suicidal urges and debts. Personality disorder therefore appears to be an enduring pejorative judgement rather than a clinical diagnosis.*

Lewis and Appleby (1988)

Today, prejudice is commonly disseminated and reinforced by media scandals about dangerous patients.

Lewis & Appleby (1988)

Living with a label

Living with a label: manifestations and measurement of stigma

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Stigma research

Stigma: Encompasses problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination)

based on attitude surveys, media representations

focused chiefly on schizophrenia

Most Stigma Research

excluded direct participation by service users

included few intervention studies

Thornicroft et al. (2007)

Limitations of stigma research

Moreover, it has been proposed that stigma research has been limited in the following ways:

I. academic writings on stigma have made few connections with legislation concerning disability rights policy.

II. Most work on mental illness and stigma has been descriptive, overwhelmingly describing attitude surveys or the portrayal of mental illness by the media. Less is known about effective interventions to reduce stigma.

III. there have been notably few direct contributions to this literature by service users.

IV. there has been an underlying pessimism that stigma is deeply historically rooted and difficult to change.

V. stigma theories have de-emphasised cultural factors and paid little attention to issues related to human rights and social structures.

A study of perceived stigma in schizophrenia patients and their families revealed stigma related to mental health care accounted for nearly a quarter (22.3%) of all stigma experiences reported.

Thornicroft et al. (2007, 2009)

Cultural factors in stigma

Most studies about effective interventions to reduce stigma and discrimination originate in high-income countries (HICs)

Yet, there are recognised cultural and socioeconomic influences on stigma, including:

Notions of "mental illness" and explanatory models
e.g. psychiatric symptoms may be attributed to supernatural forces

Cultural meanings of impairments and manifestations
e.g. stigma's impact on marital prospects may have a different impact in a different society

Concepts of self and personhood
e.g. higher levels of family cohesion may offer more support, but also contribute to the more widespread impact of stigma

Thornicroft et al. (2009)

Economic factors in stigma

Socioeconomic factors:

- e.g. poverty and access to healthcare
- long associated with outcomes of mental illness
- determine the context in which stigma is enacted and experienced

> *Rates of both anticipated and experienced discrimination are consistently high across countries among people with mental illness*

Thornicroft et al. (2009)

Suggests measures like disability discrimination laws might not be effective without interventions to improve self-esteem

Anti-stigma targets and campaigns

Anti-stigma targets and campaigns

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Anti-stigma campaigns

- **Public Awareness Campaigns**
- **Social Interaction**
- **Education**
- **Media Reporting**

Other popular approaches include:

- annual events (Mental Health Awareness Week)
- celebrity advocates
- "real-life" testimony and case studies

Stigma from psychiatry itself

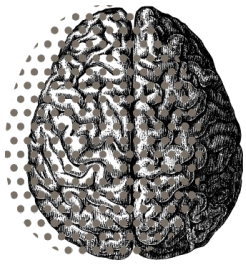
Vanessa Pinfold

- mental health professionals and the system itself are implicated in creating and perpetuating stigma
- both factors necessary targets for anti-stigma initiatives

> *Suggestions for psychiatric reforms included the improvement in doctor's attitudes — particularly in regard to 'listening' to the patient and structure of doctor-patient relationships, increased profile for psychiatry within the medical establishment, and reduced emphasis on the biomedical model including improved access for psycho-social interventions.*

Corker et al. (2013); Rose et al. (2015)

Stigma within psychiatry itself



Beate Schulze

Blind spot in psychiatry regarding their own contributions to stigma

Mental health professionals have concerns about their image and position in the industry

These warrant specific focus of anti-stigma campaigns

MAKE TIME TO CHANGE

Campaigns like Time to Change (UK) and Mental Health Europe have helped long-term reduction in stigma

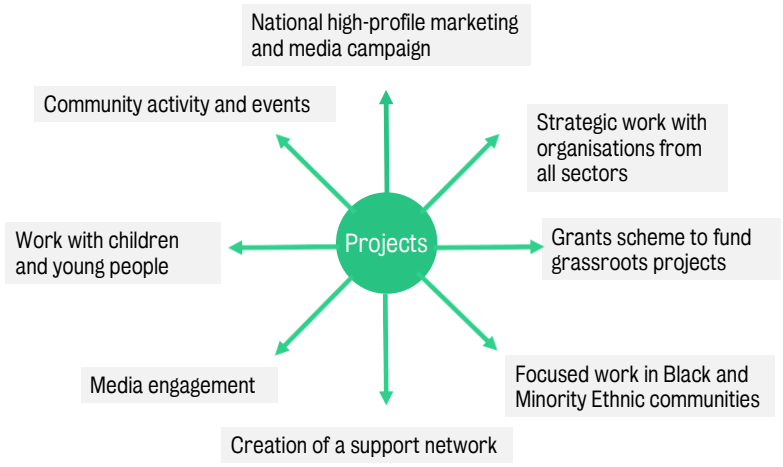
These help promote help-seeking behaviour, social inclusion and the dismantling of hierarchies and stereotypes

Schulze (2007)

Time to change

MAKE TIME TO CHANGE

- Campaign to end stigma and discrimination against people with mental health problems in England
- Est: 2007
- Run by: Mind and Rethink Mental Illness
- Funded by: Department of Health, Comic Relief and The Lottery



Evans-Lacko et al. (2013)

Time to change: Social marketing

MAKE TIME TO CHANGE

Anti Stigma Social Marketing:

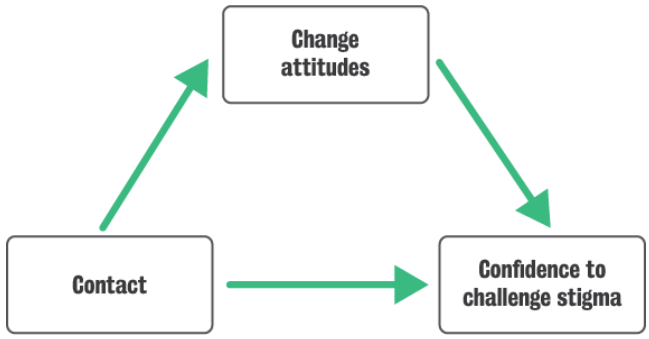
Engaged public via mass media channels, calls to action and social events

Modest but positive and significant improvements with campaign

Association between positive intergroup contact and improved attitudes/willingness to challenge stigma

Social contact can be an effective tool

Mass media social marketing most effective on intended behaviour



Mediational model of the role of attitudes in explaining the effects of contact on confidence to challenge stigma

Evans-Lacko et al. (2013)

Art and stigma

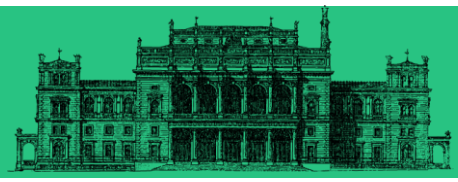
Museums enable discussion of difficult histories by acknowledging:

Varied perspectives of contributors

How dominant views emerge for social and political reasons

Patients traditionally had little voice in these collections, but recent exhibitions have sought to redress this

Bethlem's Museum of the Mind



- curated thematically rather than chronologically
- encourages exploration of commonalities in experience rather than linear progression

User input at the museum of the mind

Important: both the museum's display and website prominently feature user narratives

The museum heavily promotes user involvement by:

- Incorporating the stories and personal testimony of mental health service users
- Actively seeking to recruit volunteers with lived experience
- Supporting the work of SLaM's Recovery College by offering a venue for courses and workshops
- Involving those with lived experience in learning programmes
- Celebrating achievements of those who have experienced mental ill-health
- Supporting the work of the Bethlem Gallery and SLaM's Occupational Therapy department by providing a retail outlet for art and crafts

Moving forward

Moving forward: challenges and suggestions

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The hearing voices network

The following principles can help prevent and challenge stigma:

Seeing mental distress as human

Keeping the person in the driving seat

Supportive communities

Key challenge: identify which interventions will change behaviours and reduce discrimination

Research would benefit from refocusing on discrimination rather than stigma, and on actual, rather than intended behaviour change

Strengthen evaluations of initiatives

Enable people with mental health difficulties to receive legal protection from discrimination, comparable to that for physical disabilities

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End of topic