

Module: Mental Health in the Community

Week 2

Current conceptualisations of mental health

Topic 1 Stigma and mental health

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Lecture transcript

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In Erving Goffman's theory of social stigma, stigma is defined as an attribute, behaviour, or reputation which is socially discrediting in a particular way. It causes an individual to be mentally classified by others in an undesirable, rejected stereotype rather than in an accepted, normal one. Such discrimination can lead to disadvantages in many aspects of life, including personal relationships, education, and work. As a result of the stigma which is internalised, some people with mental illness may come to accept the discrediting prejudices held against them, and so lose self-esteem, leading to feelings of shame, a sense of alienation, and a social withdrawal.

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The early 20th century introduction of the Lunacy Commissioners' coding schemes marked a move from anecdotal observation to systematic classification of mental disorder and its proven or suspected causes. Aetiology was accorded separate status to form of disorder, i.e. diagnosis, and such decisions drew on both medical and lay opinion in seeking to establish a comprehensive medical history of the patient, and where possible, their relatives. This method remained in use until the late 1940s, at which point British psychiatry made the gradual transition towards the World Health Organization's International Classification of Diseases - ICD - Framework.

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A departure from basic cause-effect dichotomies and increasing recognition of multiple and varied causes of mental distress were accompanied by efforts to describe and codify a range of additional disorders. The emergence of new diagnoses, notably depression and personality disorders, was greeted on occasion by confusion, disregard, or resistance towards changing nomenclature and calls for the reinstatement of older terminology.

Moreover, the later 20th century proliferation of psychiatric conditions resulted in several former aetiological factors being reframed as diagnoses, arguably conflating source and symptom of problems, such as alcoholism. This prompted wider dissent, raising questions regarding the reliability of psychiatric labels and national variation in diagnostic practice.

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By the mid-20th century, medical discourse was expanding to become something more than strictly

medical. By the 1980s, textbook advice on the origins and treatment of alcoholism had arrived at a model, which encompassed biophysical, psychological, and sociological considerations. Similarly, therapist and writer Darian Leader asserted that a 'commodification of the psyche has been reflected in the explosion of psychiatric diagnoses, rising from between one and two dozen in the early 20th century to over 360 by the early 1990s.'

Observable, superficial states, such as shyness, are now pathologised as defining disorders. Some of these conditions created and advertised by drug companies, seeking to secure niche markets for their products. Likewise, the publication of the DSM-V has reignited debate on the ever-widening net of mental disorder, that it seeks to cast over unhappiness, personal fortune, and troubling conduct.

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Harvard-based clinical psychologist David Rosenhan was influenced by the work of Laing and Szasz, theorists who rejected the idea of mental illness and viewed it as a social construct. In an era when psychiatry was moving towards increasingly medical frameworks, his experiments prominently called into question the validity of psychiatric diagnosis.

Between 1969 and 1972, Rosenhan and seven other people, none of whom had a psychiatric diagnoses, got themselves admitted to 12 different psychiatric hospitals around the United States. They did this by presenting with a single symptom, saying that they heard a voice, which said words such as 'empty', 'dull', and 'thud'. Once admitted, they acted completely normally. Nevertheless, they were kept in for periods of between 8 and 52 days. Seven of them were diagnosed with schizophrenia and were released as being 'in remission'. Not one of them was judged to be sane.

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After Rosenhan published 'On being sane in insane places' in the journal *Science* in 1973, the psychiatric profession went on the defensive to protest its diagnostic competence. The study struck at the heart of their attempts to medicalise psychiatry and be accepted as proper doctors. Its impact was felt when the third edition of the DSM came out in 1980. Changes had been made which brought more rigour to the diagnostic process.

This was actually an anthropological study of psychiatric hospitals, rather than a test of diagnostic practice. However, patients' actions were taken out of context once admitted. Once viewed through this filter, innocuous, everyday behaviour was misinterpreted and pathologised in line with their given diagnosis.

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The adverse connotations of certain labels - such as personality disorder or schizophrenia - may elicit particular hostility in social and clinical attitudes and treatment. In a study by Lewis and Appleby:

'A sample of psychiatrists was asked to read a case vignette and indicate likely managements 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,' they conclude, 'appears to be an enduring pejorative judgement rather than a clinical diagnosis.'

Today, similar prejudice is commonly disseminated and reinforced by media scandals about dangerous patients, and we will revisit this issue later.

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The term 'stigma' encompasses problems of knowledge - that is, ignorance, attitudes - that's prejudice, and behaviour - which is discrimination. Most research in this area has been based

on attitude surveys, media representation of mental illness and violence, has focused chiefly on schizophrenia, has excluded direct participation by service users, and has included few intervention studies.

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Moreover, it has been proposed that stigma research has often been limited in the following five ways.

First, academic writings on stigma have made relatively few connections with legislation concerning disability rights policy.

Second, most work on mental illness and stigma has been descriptive, overwhelmingly describing attitude surveys or the portrayal of mental illness in the media. Less is known of effective interventions to reduce stigma.

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

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

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

A focus group study exploring the stigma perceptions of people with schizophrenia and their families used a general opening question to elicit situations in which those questioned felt misunderstood or excluded due to the illness. Results revealed that stigma related to mental health care accounted for nearly a quarter of all stigma experiences reported.

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To date, the majority of studies concerned with identifying effective interventions to reduce stigma and discrimination originate in high income countries. Yet, there are recognised cultural and socioeconomic influences on stigma, including those in the following list.

First, notions of mental illness and explanatory models - for example, in many settings psychiatric symptoms may not be seen as indicative of an illness, and sometimes attributed to supernatural forces.

Secondly, cultural meanings of the impairments and manifestations caused by the disorder and its stigma - for example, the impact of stigma on a person's marital prospects may have a different impact on a person's life, depending on the cultural meaning attached to marriage in a given society.

And finally, concepts of self and personhood - for example, higher levels of family cohesion may offer more support, but also go along with a more widespread impact of stigma across family members and generations.

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Socioeconomic factors, such as poverty and access to healthcare, have also long been found to be associated with outcomes of mental illness and determine the context in which stigma is enacted and experienced. Thornicroft et al. found 'rates both anticipated and experienced discrimination are consistently high across countries among people with mental illness.' This would suggest that measures, such as disability discrimination laws, might not be effective without interventions to improve self-esteem of people with mental illness.

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There is evidence that interventions to improve public knowledge about mental illness can be effective and education is indeed often seen as the primary target for reducing stigma across various age groups or directed at specific communities or professions. Efforts have also been made to increase opportunities for social interaction between people with and without mental illness and to promote responsible media reporting of mental health related issues. Other popular approaches include annual events, such as Mental Health Awareness Week, and the use of celebrity advocates in tandem with real-life testimony and case studies, increasingly through online and social media platforms.

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However, Pinfold reports that in interviews with service users, mental health professionals and the system itself were also implicated in creating and perpetuating stigma, with both factors seen as necessary targets for anti-stigma initiatives. Thus 'suggestions for psychiatric reforms included the improvement in doctors' 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 psychosocial interventions.'

The latter point resonates with recent focus groups in which service users and carers voiced concern that ongoing advances in fields such as neuropsychiatry could encourage a reductionist view of mental illness amongst both clinicians and the general public with ever less attention focused on the person behind the label. Particularly contentious was the idea that within stratified or precision medicine, diagnosis and prescribing could be determined by blood tests or brain scans.

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Moreover, Schulze describes a blind spot in anti-stigma programmes driven by the psychiatric profession with regard to their own contribution to stigma. She also relates how mental health employees have incurred stigma and discrimination themselves. For example, through stereotypical media representation, social prejudice, stigma acting as a barrier to patient social integration, thereby counteracting their therapeutic efforts, or imbalances in the distribution of resources. This indicates that the mental health professions have legitimate concerns regarding their image and their position in medicine and society that would warrant a specific focus on anti-stigma programmes on destigmatising psychiatry.

Mass media campaigns, such as Time to Change in the UK and Mental Health Europe, have been found to support the long-term reduction of stigma and discrimination, especially in relation to prejudice and exclusion of people with mental health problems. Such initiatives can also promote help-seeking behaviour, social inclusion, and the gradual dismantling of conventional hierarchies in illness stereotypes.

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Time to Change is a campaign to end the stigma and discrimination that people with mental health problems face in England. Founded in 2007, it's run by the charities Mind and Rethink Mental Illness with funding from the Department of Health, Comic Relief, and the Big Lottery Fund. It aims to empower people with mental health problems or the 3/4 of the population who knows someone with a mental health problem to feel confident talking about the issue without facing discrimination.

They've devised a range of projects, engaging people in all sectors and communities and encouraging them to start a dialogue and hopefully leading to behaviour change. Examples include a national high profile marketing and media campaign aimed at reaching 29 million adults to change their attitudes and behaviour towards people with mental health problems, community activity and events bringing together people with and without mental health problems, work with children and young people to

change their attitudes and behaviour towards mental health, a grant scheme to fund grassroots projects led by people with mental health problems, a programme to support a network of people with experience of mental health problems to take leadership roles in challenging discrimination within their own communities, strategic work with organisations from all sectors to improve policy and practice around mental health discrimination, a programme of media engagement to improve reporting and representation of mental health issues, and focused work with black and minority ethnic communities.

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One component of the Time to Change programme was the anti-stigma social marketing campaign, which engaged the public through mass media channels, calls to action, and participation in mass social events. An evaluation of this activity used online interviews before and after each element of mass media social marketing to rate changes in knowledge, attitudes, and behaviour, and associations between campaign awareness and outcomes. Participants at social contact events were also asked about the occurrence and quality of contact, attitudes, readiness to discuss mental health, and intended behaviour towards people with mental health problems.

The evaluation showed modest, but positive and significant improvements associated with the campaign, especially in relation to intended behaviour. Despite no consistent improvement in knowledge or attitudes at the whole population level, awareness of the campaign was consistently associated with better knowledge, attitudes, and intended behaviour. Additionally, the association between positive intergroup contact achieved through Time to Change social contact events and improved attitudes and willingness to challenge stigma and discrimination suggest that social contact can be used by anti-stigma programmes to reduce stigma and discrimination against people with mental health problems. In terms of overall effects on the target population, it was found that the mass media component of the social marketing campaign seemed to be most effective at influencing intended behaviour.

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Museums can also enable discussion of difficult histories by openly acknowledging the various perspectives of contributors and how dominant or normative views have been created and shaped for particular social and political purposes. Historically, patients often had little or no voice in the way collections were put together or represented. However, recent exhibitions have sought to address this balance by actively seeking involvement from mental health service users past and present. Thus the permanent exhibition at Bethlem's Museum of the Mind is curated thematically rather than chronologically to encourage visitors to explore commonalities in ideas of madness and its treatment, rather than assume a linear progression in approaches.

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Importantly, the venue's displays and website both prominently feature patient narratives, allowing insights into current and historical experiences. More broadly, the museum promotes user involvement in the following ways; incorporating the stories and personal testimony of mental health service users past and present within the museum's interpretation, involving those with lived experience in the development and delivery of learning programmes, actively seeking to recruit volunteers with lived experience, celebrating the achievements of those who've experienced mental ill health through the display of art by service users past and present, supporting the work of the SLaM's Recovery College by offering a venue for courses and workshops, and by supporting the work of the Bethlem Gallery and SLaM's Occupational Therapy departments, and providing a retail outlet for arts and crafts produced on the Bethlem site.

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The Hearing Voices Network suggests that the following principles can help to prevent and challenge stigma surrounding mental illness.

First, seeing mental distress as human and ultimately understandable. Rather than seeing voices, visions, and extreme states as symptoms of an underlying illness, it is helpful to view them as meaningful experiences, even if we don't yet know what that meaning is. It's important to use human language when describing human experiences, rather than medical terminology. Given the role of trauma and adversity, we need to start asking, 'What has happened to you?' rather than 'What is wrong with you?'

Secondly, keeping the person in the driving seat, giving people the freedom to define their own experience. Support should be based on need, not diagnosis. Equally, people need to access a wide range of alternatives to understand and manage their experiences. Medication is just one way amongst many that people may choose. We need information about the pros and cons of each approach, true choice and collaboration, not coercion.

And finally, supportive communities. Mental distress is not just the domain of mental health services. Communities have an important role to play in supporting those who are struggling to cope. Community-based options can run alongside and as an alternative to psychiatry. Equally, these approaches must go hand-in-hand with greater awareness of the causal impact of social factors - such as poverty, gender and racial inequalities, unemployment, deprivation, and abuse - on mental distress.

Ultimately, a further key challenge is to identify which interventions will produce behaviour change to reduce discrimination against people with mental illness. To this end, it has been recommended that research would benefit from a refocusing of attention on mental health discrimination rather than stigma, and on actual, rather than intended, behaviour change. This would both strengthen evaluations of anti-stigma initiatives and enable people with mental illness to receive comparable benefit from relevant anti-discrimination legislation as those with physical disabilities.