What else can we do to combat stigma?

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Stigma as a social phenomenon is exercised by groups of humans, one towards another, to fulfil psychological needs and to gain advantages, mostly economic. Stigmatizing groups derive psychological relief and even self-esteem from the mere knowledge that there exist individuals who are less able and less fortunate than they are (1). Also fierce economic competition, particularly on the background of scarce resources, has been associated with stigmatization. For example, by the end of the 19th century, the number of lynchings of blacks in the US was in inverse correlation with the price of cotton (2). Stigmatization of the eccentric and odd is justified by the stigmatizing groups as a tactic to avoid danger and protect the community (3).

Stigmatizing attitudes against mental patients are more prevalent among less educated and more competitive groups. However, mental health professionals, health insurers as well as patients themselves and the fiercely militant support groups are not immune from such attitudes. Furthermore, stigma is not only associated with behaviors related to mental illness per se, but also with everything else associated to it, such as diagnostic classifications, hospitals, doctors, nurses, drugs, rehabilitation counselors and support programs. This in turn prevents sufferers from seeking and receiving help, thus further perpetuating the illness and the stigma associated with it.

Corrigan and Watson quote evidence that stigma against mental illness is less frequent in the non-Western societies. Interestingly, it was also suggested that the outcome of severe mental illnesses is better in non-Western societies and that immigration from a non-Western country to Britain was associated with increased incidence of severe mental illness. Moreover, the immigrants who feel more discriminated and stigmatized by the hosting society are more likely to develop severe mental illness, underlying the complex bi-directional relationship between mental illness and stigma. It is conceivable that the less stigmatizing attitude in non-Western societies contributes to the better outcome, but the alternative hypothesis, that the better outcome is responsible for the lesser degree of stigma, must also be considered.

Not surprisingly, on the other hand, the most competitive Western societies are also at the forefront of the campaign to destigmatize mental illness. Compassion for the weak and love for the humankind in general are plausible drives towards destigmatization. However, protecting the weak and the stigmatized may serve additional societal purposes. By showing benevolence, society confirms its authority and promises protec-

tion to the strong but potentially vulnerable, hence increasing sense of security and cohesiveness. Whatever the impetus for destigmatization might be, the results of the destigmatization campaigns are far from satisfactory and much research and sophistication are still necessary.

Focusing on the stigmatizers, Corrigan and Watson advocate education of the public and contact between the public and mental patients as ways to combat stigma. However, a significant amount of evidence (4,5) indicates that education is not very effective and that its impact is not long-lasting. Much of the underpinning of educational campaigns focuses on providing 'correct' information and on emphasizing the social unacceptability of stigmatizing attitudes and behaviors. Hence campaigns tend to change cognitions and the resulting responses given in post-campaign surveys, rather than attitudes, emotions and long-lasting behavior (6). Similarly, contact with patients who do not fit the feared stereotype are often viewed as the exception to the stereotype rather than lead to generalization to the entire population of mental patients (6). For example, even successful contacts between patients living in a hostel and the neighborhood residents promoted by an anti-stigma campaign (7) failed to be translated into more tolerant behavior in the long run. On the contrary, even residents who reported positive attitudes after the contacts with mental patients tended to move from the neighborhood (6,7).

Focusing on the stigmatized should also be used as a strategy to combat stigma. While there is very little that can be done to change the circumstances of individuals and groups who are stigmatized because of the color of their skin, religious beliefs or ethnic origin, some of the circumstances which identify and make mental patients the target of stigmatization can be changed. Mental patients are identified as targets of stigmatization by their periodically odd behavior, by adverse effects of the medications they receive, and by their association with facilities and professionals providing mental health care.

Novel antipsychotic drugs have probably reduced the length and the frequency of active illness often manifested as odd behavior. Also the abnormal movements and posture induced by old antipsychotics and so closely associated with the appearance of severely ill mental patients are about to disappear as more patients are treated with the novel drugs. Since receiving care in psychiatric hospitals and psychiatric outpatient clinics are subjected to stigma, efforts should be made to provide care elsewhere. Without giving up any of the therapeutic advantages offered by neuroscience and modern medicine, as much care as possible should be provided outside of traditional medical facilities, i.e. in youth centers and community centers. When this is not feasible, the general rather than the psychiatric hospital should be utilized and even within the general hospital attempts should be made to provide care in general and not psychiatric wards. For example, elderly psychiatric patients could receive care in geriatric wards, children and adolescents in pediatric and adolescent wards and the less severely ill middle age patients in mixed neurological-psychiatric wards. Although manipulating the environment might not be the ultimate solution to stigma in mental illness, it might make mental health care more acceptable to those who need it.

In the end, the solution to stigma will come from more effective treatments of mental illnesses, rather than voluntary or cajoled benevolence. Until that happens, however, a combination of all reasonable means to combat stigma, including manipulation of the treatment environment, should be employed.

References

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