Stigma in Mental Health Care

Carol I. Ping Tsao, M.D., J.D., Aruna Tummala, M.D.
Laura Weiss Roberts, M.D., M.A.

Stigma marks someone as different from others, leading to devaluation of that person. A social construction, stigma occurs within relationships. In his classic 1963 description, Goffman (1) defines stigma as "an attribute that is deeply discrediting," where a person is diminished "from a whole and usual person to a tainted, discounted one." Shifting from a focus on individual traits, subsequent formulations have identified certain psychosocial processes that lead to stigmatization. These include labeling, stereotyping, separating, status loss, and discrimination in a context of power imbalance (2). Stigma affects people adversely. Academic achievement is lower for members of stigmatized groups as compared with nonstigmatized groups, and members of stigmatized groups are at greater risk for both mental and physical diseases (3).

Patients with mental illnesses are stigmatized and suffer adverse consequences such as increased social isolation, limited life chances, and decreased access to treatment (4–6). In addition to poorer social functioning as assessed by housing and employment status (7), those with the stigma of mental illness also encounter a significant barrier to obtaining general medical care (8) and to recovery from mental illness (9). As stated by Chin and Balon (10), "The added burden that stigma imposes on the struggle to recovery can alter behavior, generate anxiety, and ultimately cause isolation from the mainstream culture."

In this issue, several manuscripts make a case for increasing familial involvement in the care of patients with mental illnesses with the aims of improving social and health outcomes for patients and providing support to family members. Suggestions range from managing confidentiality while increasing family engagement in the treatment of distressed adolescents (11) to optimizing the benefits of family money management (12) to inclusion of family across the spectrum of psychiatric clinical care (13) to more formalized reintegration of family therapy training in psychiatry residency programs (14) to making after-death calls to family members (15).

Stigma also affects family members of persons with mental illness. Referred to as "courtesy" (1) or "associative" (16) stigma, its psychological impact can be quite deleterious. In a Swedish study, 18% of relatives of patients with severe mental illness reported that the patient would be better off dead (17). This figure increased to 40% in relatives who felt that the patient's mental illness caused mental health problems in themselves (17).

In this issue, two articles report literature reviews on stigma of families with mental illness (18) and stigma associated with suicide (19). In the first article (18), parental stigmatization of children with mental illnesses and the stigmatization of children with parents who have mental illnesses are explored. Parents are often blamed for causing mental illness in their children through poor parenting. Children are often perceived as being somehow tainted by their parents' mental illness. In the second article (19), three survivors of suicide report their experiences and make suggestions to further diminish stigma associated with suicide. Survivors of suicide, as compared with other bereaved persons, experience more guilt and less social support. Candid disclosure about the decedent's struggle with mental illness and suicide being the cause of death, having someone to talk with openly about the loss, and/or participation in a suicide support group can provide significant comfort to familial survivors of suicide and may go some distance in decreasing stigma.

As a group, mental health professionals are no less susceptible to stigmatizing beliefs than the general population (20–22). And medical education has only a very limited benefit with regard to reducing stigmatizing beliefs (23). In a study of resident physicians from an array of medical

Received November 28, 2007; accepted December 12, 2007. Drs. Tsao, Tummala, and Roberts are affiliated with the Departments of Psychiatry and Behavioral Health at the Medical College of Wisconsin in Milwaukee, Wis. Address correspondence to Carol I. Ping Tsao, M.D., Psychiatry and Behavioral Health, Medical College of Wisconsin, 5000 W. National Ave, Milwaukee, WI 53295; ctsao@mcw.edu (e-mail).

specialties, neither greater education nor additional experience nor choice of specialty exerted a positive influence on attitudes toward mental illness (10). Instead, stigmatizing attitudes were only lower when the resident physicians had family members with a psychiatric illness (10).

In this issue, several articles explore medical students' attitudes toward psychiatry in general and a career in psychiatry specifically. The psychiatric clerkship appears to have equivocal impact on changing medical students' views toward psychiatry (24). Medical students from the University of Nairobi, Kenya, generally had fairly favorable attitudes toward psychiatry, but few would consider psychiatry a viable career choice (25). Even fewer medical students from Pakistan, where there is a shortage of psychiatrists, identified psychiatry as their career of choice (26).

Interestingly, a recent article describes iatrogenic stigma, that is, stigma caused or perpetuated by mental health professionals (27). The author argues that certain actions on the part of the psychiatrist themselves perpetuate stigma (such as diagnosing a person with mental illness, which in turn leads to labeling; cosmetic side effects of medications, which make a person easily identifiable as mentally ill). On the contrary, we believe that psychiatrists have a duty to reduce the stigma of mental illness at the individual, family, societal, and structural levels. Stigma involves problems with knowledge (ignorance), attitudes (prejudice), and behavior (discrimination). Of the three, reduction of discrimination against people with mental illness is most pressing (28). Anti-stigma programs use three broad approaches: protest, education, and contact (29). Protest campaigns work to have stigmatizing media messages withdrawn. Media has a powerful role to play in influencing public opinion as exemplified by the recent Virginia Tech shootings. Psychiatrists and mental health professionals need to collaborate actively with the local media to ensure that an appropriate social message is passed on. Education provides accurate information to the public about mental illness. Contact entails positive social interaction with persons with mental illness. All three approaches have been shown to reduce stigma (30).

In this issue, two articles suggest that certain exposures, akin to contact, decrease stigma. Adolescent standardized patient training in psychiatric conditions reduces stigma in adolescent simulators (31). Advocacy groups have more positive impact on clinical as compared to preclinical medical trainees (32).

In addition to actively engaging in the proven methods to decrease stigma, psychiatrists also need to actively combat structural discrimination. Structural discrimination is unjust treatment perpetuated by a social, political, and/or legal institution based on stigmatizing attitudes. A chief example of structural discrimination is the inequitable distribution of resources, resulting in poor quality of mental health services based on the stigmatizing belief that mental illness is incurable or that mental illness is not a real illness.

Finally, psychiatrists need to work within the medical community to bring about more candid dialogue about impaired physicians, including psychiatrists, psychologists, and nurses. Kay Redfield Jamison (33) writes:

> There is a very large group that I think of as the silent successful—people who get well from psychiatric illness but who are afraid to speak out. This reluctance is very understandable, very human, but it is unfortunate because it perpetuates the misperception that mental illness cannot be treated.

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