Mental illness stigma in healthcare

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Mental illness stigma in healthcare: What can mental health professionals do about it?

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Overview

- Stigma in health care
- The evidence base for reducing stigma- and we hope, discrimination
- Applying the evidence base in practice and in education

N.B. you will notice you do a lot of this already!

Thought Exercise: Miracle question

- *You go to bed tonight as normal. It was a hard day and you fall deeply asleep straight away and sleep soundly. In the morning you wake up and can hardly believe it: a miracle has happened! Stigmatisation and discrimination have disappeared overnight – they simply do not exist anymore. You, however, do not know anything about it as you were asleep. What happens now? What will be different? And how do you notice at work that a miracle has happened?*

- What would make you notice that there was no more stigma and discrimination?

- What do you notice about yourself/your own behaviour?

- What are your thoughts and feelings on this?

- Who else will notice?

- Does the fact that stigma and discrimination no longer exist have any effect on the behaviour of others towards you?

Ackowledgements: Lena Friemüller and Wolfgang Wölwer

The effects of stigma on our service users

- Feeling they have to try and conceal the illness
- Social withdrawal and/or isolation- loss of social and economic opportunities
- Depression
- Social anxiety
- Exacerbation of illness
- Non engagement with mental health services and with treatment
- Poor access to health and other public services

The impact of stigma-the bottom line

Stigma makes everything more difficult for all concerned- whether

experiencing a mental illness,

caring for someone with a mental illness, or/and

working as a mental health professional

Manifestations of stigma: a four level model

Map 1: Exclusion from the right of political participation in the European Union

Note: An EU Member State can be represented in more than one map, as persons with mental health problems and persons with intellectual disabilities can be treated differently according to the national law of the respective Member State.

Source: FRA, 2010

Evidence for disparities in primary care

Family physicians: less likely to believe that patients with previous depression have serious medical conditions causing physical symptoms

→ more reluctant to investigate such symptoms.

(Graber MA, Bergus G, Dawson JD, Wood GB, Levy BT, Levin I. Effect of a patient's psychiatric history on physicians' estimation of probability of disease. Journal of General Internal Medicine 2000; 15: 204-6.)

Mental health stigma and primary health care decisions

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Viewpoint survey of mental health service users
Top 10 discrimination life areas 2008 and 2014

2008	2014	
1 Being shunned (57.9%)	1 Being shunned (47.2%)	(-10.7%) Signif
2= Friends (53.3%)	2 Family (43.3%)	(-9.8%) Signif
2= Family (53.1%)	3 Friends (39.7%)	(-13.6%) Signif
4 Social life (43.2%)	4 Mental health staff (31.6%)	(-2.7%)
5 Mental health staff (34.3%)	5 Social life (29.6%)	(-13.6%) Signif
6 Dating (30.9%)	6 Physical health staff (28.0%)	(-1.6%)
7 Physical health staff (29.6%)	7 Benefits (23.4%)	(+4.4%)
8 Neighbours (25.3%)	8 Neighbours (20.0%)	(-5.1%) Signif
9 Finding a job (24.2%)	9 Safety (18.2%)	(-1.4%)
10 Privacy (21.6%)	10 Keeping a job (15.6%)	(-1.3%)

Interviews of mental health service users: Coding framework

1. Mistreatment	1.1 Verbal stigma	
	1.2 Physical abuse	
	1.3 Tormenting	
	1.4 Taking advantage	
2. Social distance	2.1 Social distance by others	
	2.2 Social distance by self	
3. Judging	3.1 Judging competence	
	3.2 Judging character	
	3.3 Judging credibility	
	3.4 Over-protectiveness	*3.4.1 Exclusion from decisions* *3.4.2 Intrusive questioning*
4. Organisational decisions	4.1 System-based	
	4.2 Individual-based	
5. Lack of understanding	5.1 Lack of understanding/empathy	
	5.2 Not being heard	
6. Lack of support	6.1 Lack of support	
7. Dismissiveness	7.1 Dismissive of MH	
	7.2 Silencing of MH	

Discrimination: physical health care

- Unnecessary/unhelpful use of security
- Avoidance and consequent neglect
- Isolation on ward
- Inadequate pain relief
- Not giving prescribed psychotropic medication
- Transplant selection decisions
- Poor history taking for liaison psychiatry referral

Sources- liaison psychiatrists

Discrimination: health and mental health

- Privacy: correspondence and both types of inpatient unit
- Diagnostic overshadowing
- Verbal abuse
- Lack of involvement, respect, ignoring early relapse

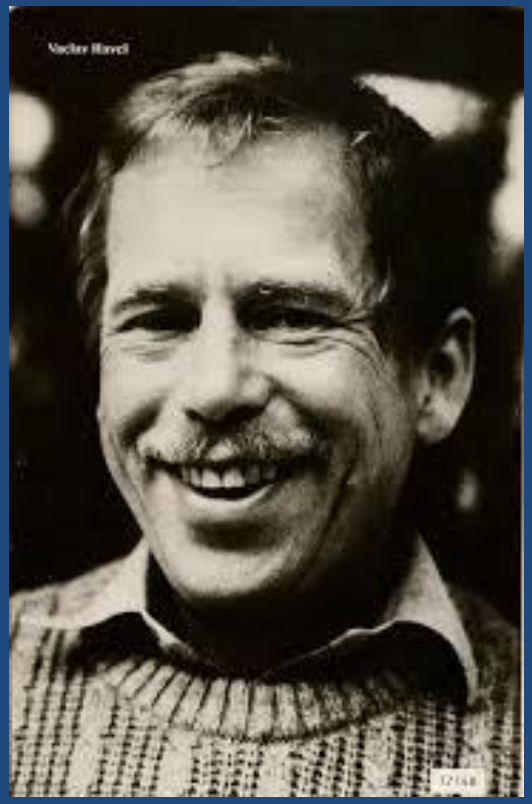
Discrimination: mental health care

- Focus on symptoms, medication, and risk vs. the person
- Coercion
- Involuntary disclosure due to medication side effects
- Therapeutic pessimism

Before applying the evidence base we need to consider our role in stigma

- We are part of the solution and part of the problem
- We will always be part of the problem
- We can shift the balance

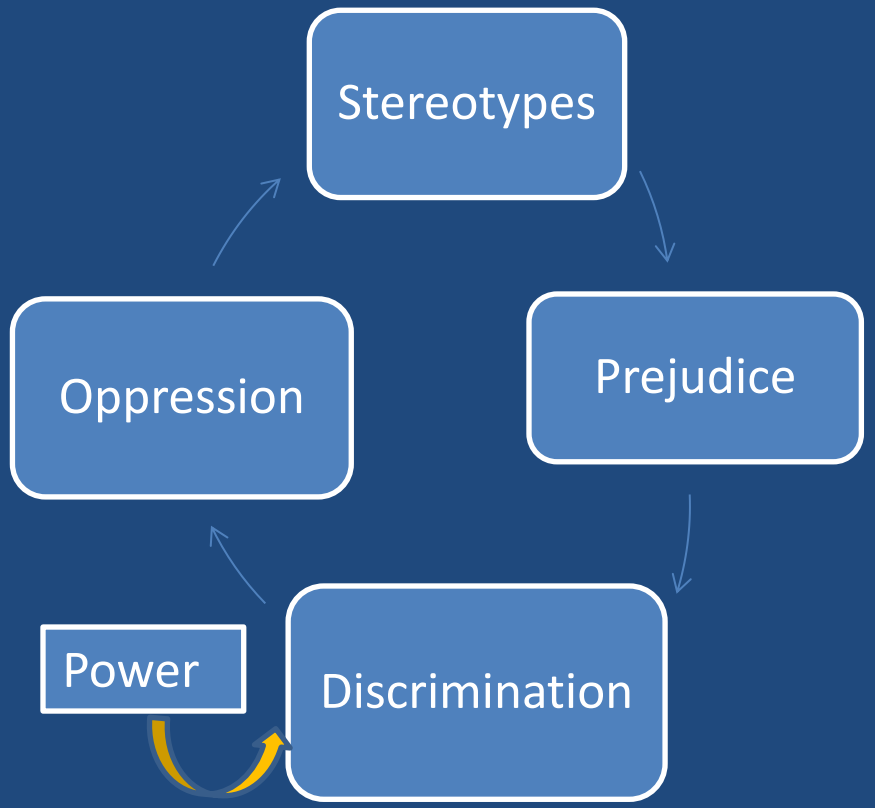
"The exercise of power is determined by thousands of interactions between the world of the powerful and that of the powerless, all the more so because these worlds are never divided by a sharp line: everyone has a small part of himself in both" Vaclav Havel



The evidence base for reducing stigma- and we hope, discrimination

- Education- traditional approach but best for youth or in combination with contact
- Contact- best for adults, can be combined with education but also highly applicable in practice
- Protest- can be counterproductive at individual level but can work at organisational level

The cycle of oppression- via F. Otitoju



Modified labelling theory- Link and Phelan

Labelling
Stereotyping
Emotional reactions
Separation
Status loss
Discrimination
Effects of discrimination
Context- power differential

Education

	Part of the problem	Ways to address these
Education	Stereotypes of mental illness learned by age 7-8 Stereotypes of psychiatry during training Disparities not challenged 'Treatments don't work, patients don't get better'	Good student experience of psychiatry and psychiatrists Contact

Contact (1) Key conditions

- Collaboration between the groups- working together on a common goal
- Opportunities to get to know more than one person from the other group (one person may be thought of as an exception so that prejudice regarding the group to which they belong does not change)
- Stereotype disconfirmation
- Equalisation of the power differential between the two groups
- Official approval of the activity

Contact (2) How does it work

- **Increases empathy**
- **Reduces anxiety**
- Increases knowledge (overlap with educational approaches)

Contact (3) how does it need to happen

- Direct- face to face
- Indirect/Parasocial- through films etc
- Vicarious- seeing someone else have contact

Or even

- Extended- knowing someone who knows someone in the other group, even if you do not

The evidence base for reducing prejudice and how mental health professionals can apply it (1)

Northern Ireland:

As a Protestant, if you have a Protestant friend with a Catholic friend you are likely to be less prejudiced, even if you don't have any Catholic friends yourself -and vice versa.

This phenomenon is called the effect of **extended contact.** It means **you** are an anti stigma agent for those who know you (professionally and personally) but who do not have much familiarity with mental illness.

But this effect is not automatic- you need to know how contact works and doesn't work.

The evidence base for reducing prejudice and how mental health professionals can apply it (2)

As a source of **extended contact** you can use the **mediators** of contact:

- Increase **empathy** towards people who experience mental health problems
- Reduce the **anxiety** many people have
- Increase others' **knowledge** about mental health problems

The evidence base for reducing prejudice and how mental health professionals can apply it (3)

- Increase **empathy** towards people who experience mental health problems

Talk about the impact of stigma without accusing the person

Talk about the factors that contribute to mental illness- trauma, poverty, discrimination (e.g. racial/ethnic)

Talk about the person's recovery journey

NB all this without breaking confidentiality when relevant

The evidence base for reducing prejudice and how mental health professionals can apply it (4)

- Reduce the **anxiety** people have (will I say the wrong thing, will the person be violent)
- But obviously share risk information where needed
- Get risk in proportion – acknowledge as if not lose credibility, but use prevalence to reality test ideas based on stereotypes

The evidence base for reducing prejudice and how mental health professionals can apply it (5)

Increase others **knowledge** about mental health problems-

educate especially to reduce pessimism- your treatments can work, people get better, they can do things and participate

Tell people how they can help- as an informal supporter or formal e.g. emotional support, practical support, encouraging professional helpseeking when needed

Do not, as a mental health professional

Do not:

Focus on workplace incidents of violence/bizarre symptoms or behaviour etc. as this leads to stereotype reinforcement

Using the evidence base for contact in education

- Contact based education: ensure conditions apply, follow existing guidance
- Vicarious contact- model how to identify, acknowledge and respond to discrimination (experienced or anticipated by service user, or witnessed by you)
- Extended contact

Be a greater part of the solution

- Identify, acknowledge and respond to discrimination:
  - Experienced
  - Anticipated
  - When you witness it

Identify, acknowledge and respond: experienced discrimination

- Identification and acknowledgement- distinguish from delusion if present and possible
- Mistreatment- safeguarding, police action
- Social distance- prevention is easier; discuss disclosure; do educate and don't overwhelm people; don't blame self
- Judging and organisational decisions, lack of understanding, support, dismissiveness-
  - advocacy/education- by and/or on behalf of service user.
  - Equality legislation may apply e.g. in employment

Identify, acknowledge and respond: anticipated discrimination

- Identification- social withdrawal, not taking up referrals for social and vocational opportunities, concealment
- Acknowledge- anticipated discrimination is a common and understandable reaction
- Is there an intermediate step to boost confidence
  - Testing attitudes without disclosing
  - Doing something with mental health services before going outside them- e.g. research participation, peer support
- Prepare response to discrimination
- Reality test- does anticipation fit with prior experience?

Witnessing discrimination and difficult conversations: applying the evidence base for reducing stigma

Fellow professionals are a source of stigma- examples?

How did you react? Why? What was the outcome?

Practice

Part of the problem	Why?	Ways to address these
Privacy: correspondence and inpatient units Diagnostic overshadowing Verbal abuse Lack of involvement, respect, ignoring early relapse Focus on symptoms vs the person, medication, and risk Therapeutic pessimism Coercion Involuntary disclosure due to medication side effects	Knowledge gaps Stress can shift what drives behaviour from professional values to stereotypes Stress → blame of service users and routine role enactment Risk aversion Clinical bias	**Knowledge-** physical health, self-harm, substance misuse **Attitudes** Reflection on automatic thoughts- stereotypes can't be unlearned but personal beliefs can override Work to prevent/reduce stress Repeated positive contact to counteract clinical bias **Discrimination** Minimise practices experienced as discriminatory Align practice to support personal recovery not just clinical recovery- help service users live as full and meaningful a life as possible with or without symptoms

To sum up

- Stigma and health care- this is our job not that of NGOs
  - Minimise actions which may be experienced as stigmatising, use personal recovery model
  - Identify, acknowledge and respond to experienced, anticipated and witnessed discrimination
  - Use the evidence base for contact (empathy, anxiety, knowledge) in practice
  - Use the evidence base for contact in education for students, trainees and for CPD
  - Ensure excellent student rotations

Questions, reflections

Contact

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Further reading

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3. Knaak S, Modgill G, Patten SB. Key ingredients of anti-stigma programs for health care providers: a data synthesis of evaluative studies. Can J Psychiatry. 2014 Oct;59(10 Suppl 1):S19-26.