Psychiatria Danubina, 2013; Vol. 25, Suppl. 2, pp 200–202 *Conference paper*

STIGMA IN CLINICAL PRACTICE

Slađana Štrkalj-Ivezić

University Hospital Vrapče, Zagreb, Croatia

SUMMARY

Much more is known about attitudes toward mental illness and social stigma, the viscious cycle of its consequences and how to fight the social stigma in public, but much less is known about how to combat the stigma and self stigma in clinical practice. Stigma theories have not been enough to understand the feelings and experience of people with mental illness. Conceptual framework that understands stigma as consisting of difficulties of knowledge (ignorance or misinformation), problems of attitudes (prejudice), and problems of behaviour (discrimination) have not o been enough to understand stigma dynamics in the patient therapist interaction. Understanding the psychodynamic aspects of internalized stereotype of mental illness in the patient- therapist relationship may improve our competency to deal with stigma and self stigma in clinical practice.

Key words: *stigma – schizophrenia - psychodynamic aspects*

* * * * *

INTRODUCTION

Stigma of mental illness leads to a chain of consequences that hamper recovery from mental illness, leading to a vicious cycle of self stigma, disability, social isolation and lack of services based on recovery (Sartorius et al. 2005). Studies of attitudes toward mental illness, repeated in intervals of several decades, show that the social stigma of mental illness is difficult to change (Pescosolido et al. 2010), especially in a clinical setting (Crocker et al. 2013). The majority of people with mental illness are continually perceived as incompetent, weak, dangerous, with recovery being difficult to achieve, this being especially associated with schizophrenia. About half of the patients treated because of schizophrenia suffer internalized stigma (Brohan 2010). Internalized stigma or self stigma is related to the process of accepting negative attitudes of the public associated with mental illness, by a person with a mental illness, as being personally relevant (Corrigan et al. 2006). Self stigma leads to a decrease in self-esteem and self-efficacy (Corrigan et al. 2006); it damages identity (Yanos et al. 2008) leading to a series of negative consequences related to recovery (Sartorius et al. 2005). A literature review of self-stigma reduction programs for patients with schizophrenia revealed a small number of successful programs (Mittal et al. 2012) suggesting that psychiatry is still searching for solutions to treat self stigma and its consequences in clinical practice.

MEHANISMS INVOLVED IN STIGMA AND SELF STIGMA

While there is an extensive knowledge base concerning which stigmatizing attitudes toward the mentally ill exist, much less is known about why these attitudes develop and how to combat them and their consequences in clinical practice.

Contemporary theories on the mechanisms involved in the development of stigma are based on social-psychological models (Link & Phelan 2001) and cognitive models for self stigma (Corrigan & Watson 2002). Stigma exists when elements of labelling, stereotyping, separating, status loss, and discrimination co-occur in a power situation that allows these processes to unfold (Link & Phelan 2001). To experience self-stigma, the person must be aware of the stereotypes that describe a stigmatized group, agree with them and apply the stereotypes to one's self (Corrigan & Watson 2002).

Stigma theories have not been enough for understanding of feelings and experience of people with mental illness. Although results of the recent evaluation of the Time to Change anti-stigma campaign in England show some promising change such as a 5% positive shift in positive attitudes towards mental health problems, and a 5% reduction in discrimination (Henderson & Thornichroft 2013), disappointingly, Crocker et al. (2013) found no significant change in discrimination by mental health professionals experience by people using mental health services. The conceptual framework that understands stigma as consisting of difficulties of knowledge (ignorance or misinformation), problems of attitudes (prejudice), and problems of behaviour (discrimination) (Thornicroft 2006) has not been enough to understand stigma dynamics in the patient therapist interaction. Unfortunately mental health professionals remain an important source of stigma but its origins and especially how to handle it in clinical practice have not been studied well.

Such findings as increased internalized stigma among people with schizophrenia (Brohan et al. 2010) and existence of stigmatized attitudes among mental health professionals (Croker et al. 2013) suggest that we should shift our attention to understand the dynamic relation between self stigma and stigmatized attitudes of mental health professionals in order to combat negative consequences of stigma in clinical practice.

Although we know from clinical practice with persons with mental illness that the majority of their

feelings relating to stigma is unconscious, psychodynamic understanding of the unconscious processes contributing to the mechanisms involved in stigma and self stigma is neglected.

PSYCHODYNAMIC THEORY OF STIGMA

Combining the social psychology theory with psychodynamic theory could be a significant step forward in clinical practice working with negative consequence of stigma, especially with self stigma.

The psychoanalytic theory of self (Kohut 1978) combined with the theory of social self (Cooley 1956) can broaden our understanding of these processes. The self concept is how we think about and evaluate ourselves, it is associated with self esteem and self-worth. The development of self is the result of complex psychological interactions with the environment through processes of mutual mirroring (Kohut 1978). Looking glass hypothesis (Cooley 1956) suggest that self is a social construct and that we develop self through our observation and interpretation of the responses received from others. Other people are a mirror in which we see self-reflecting images, and internalize these reflections in our own experience of the self. To some degree self-worth depends on the evaluation of the social group to which one belongs or with which they identify and the values that one and others attribute to this group.

A variety of stressful situations, such as a diagnosis of mental illness can threaten or challenge the positive image of self and its stability.

To understand the effect of stereotypes of mental illness on people diagnosed as having a mental illness we must understand the relationship between stereotypes of mental illness and self concept before and after the diagnosis of mental illness. Before persons have become mentally ill, they, as well as other members of their social environment, have internalized collective stereotypes about mental illness seeing the person with mental illness as weak and incompetent, different from image of strong personality. So definition of strong personality, or our positive evaluation of self is partly conditioned by the absence of the characteristics associated with the stereotype of mental illness. This definition is largely unconscious and non-conflicting to our personality and bears no consequence up to the point of one's own encounter with mental illness. From this point of view stigma has an important unconscious psychological function in maintaining the idea of strong self, so it is maybe this psychological process which makes stigma of mental illness difficult to change.

Being diagnosed with a mental illness reactivates the collective internalized stereotypes of mental illness which threatens the patient's definition of self, the perception of their own personal value. In order to protect the stability of self the patient needs to redefine or re-evaluate the image and perception of self. This will help to restore the largely positive experience of self and separate it from the threatening stereotypes. Rejection of the stereotype of mental illness by the patient as being personally irrelevant, or unjust according to Corrigan (Link & Phelan 2001) may prevent self stigma.

This process must be supported by professional help during all phases of treatment. In every treatment, especially in the beginning, it is necessary to talk about the meaning attached to the diagnosis to help the patient so that the stereotype of mental illness does not become relevant to them personally. Offering a recovery perspective on treatment and outcome of illness will be helpful in this process. Unfortunately, despite optimistic research on the course of schizophrenia showing a favourable long term outcome in about 50% of cases (Harrison et al. 2001) and advances in treatment methods that help many people with schizophrenia to recover, mental health professionals often see the outcome of the disease in accordance to the stereotype and they do not offer enough optimism for recovery. This can be related to an activation of internalized stereotypes, on the part of the professionals, which they are not aware of. As it said before, mental health professionals also share the same collective stereotypes about mental illness, and this might influence their work with patients, especially when attention is not paid to this fact. Mental health professionals should as well as patients reject the stereotype of mental illness and make it irrelevant to the patient whom they treat. In doing so the stereotype becomes irrelevant to the specific patient they are treating, allowing them to treat any aspects of mental illness, even those resembling a stereotype, solely as a problem related to the mental illness which can be solved through an individualized treatment plan. Paying attention to these processes can help professionals to free themselves of the unconscious influence of the internalised stereotype and see the patient's problems objectively. Breaking the connection between the diagnosis of mental illness and its stereotype and facilitating the identification with the empowered person should be the first step in clinical practice in order to break the vicious circle of stigma.

CONCLUSION

When mental illness is diagnosed, collective internalized stereotypes of mental illness, associating it with a weak personality, incompetence and danger, are reactivated leaving the person to face a devalued image of self. In order to prevent the negative consequences of this process, the person with mental illness should be offered recovery perspectives which will help the patient to separate the illness problem from its stereotype. To be able to help the patient reject the stereotype of mental illness as being personally irrelevant for him, mental health professionals themselves must be free of the influence of their own internalized stereotypes, which they share as members of society. This might influence offering to the patients the perspective of chronicity instead of recovery. Not recognizing the

impact stereotypes of mental illness have on the therapist-patient relationship as described above can lead to internalized stigma and chronicity. Viewing patients positively through the realm of recovery rather than cultural stereotypes can help combat the negative consequences of stigma. Awareness training of these processes should be an integral part of the standard and continuous education of professionals working in the field of mental health.

Acknowledgements: None.

Conflict of interest: None to declare.

References

1. *Brohan E, Elgie R, Sartorius N, Thornicroft G; Gamian-Europe study group: Self stigma, empowerment and perceived discrimination among people with shizophrenia in 14 European countries: the GAMIAN-Europe Study. Schizophr Res 2010; 122:232-238.*
2. *Cooley CH: Human nature and social order. New York: Free Press 19562. Corker E, Hamilton S, Henderson C, Weeks C, Pinfold V, Rose D et al Experience of discrimination among people using mental health services in England 2008-2011. Br. J Psychiatry 2013; 202(suppl 55):s58-63.*
3. *Corker E, Hamilton S, Henderson C, Weeks C, Pinfold V, Rose D et al: Experience of discrimination among people using mental health services in England 2008-2011. Br. J Psychiatry 2013; 202 (suppl 55): s58-63.*
4. *Corrigan PW, Watson AC, Barr L: The self-stigma of mental illness: Implications for self-esteem and self-efficacy. Journal of Social and Clinical Psychology 2006; 25:875–884.*
5. *Corrigan PW, Watson AC: The paradox of self-stigma and mental illness. Clinical Psychology: Science and Practice, 2002; 9:35-53.*
6. *Harrison G, Hopper K, Craig T, Laska E, Siegel C, Wandperling J et al: Recovery from psychotic illness: a 15- and 25-year international follow-up study. Br J Psychiatry 2001; 178:506-517.*
7. *Henderson C, Thornicroft G: Evaluation of the Time to Change programme in England 2008-2011. Br J Psychiatry 2013; 202(suppl 55):s45-s48.*
8. *Link BG, Phelan JC: Conceptualizing stigma. Annual Review of Sociology 2001; 27:363–385.*
9. *Kohut H, Wolf ES: The Disorders of the Self and their Treatment: An Outline. Int J Psychoanl 1978; 59:413-425.*
10. *Mittal D, Sullivan G, Chekuri L, Elise Allee E, Corrigan PW: Empirical Studies of Self-Stigma Reduction Strategies: A Critical Review of the Literature. Psychiatr Serv 2012; 23:262-269.*
11. *Pescosolido BA, Martin JK, Long JS, Medina TR, Phelan JC, Link BG: "A disease like any other"? a decade of change in public reactions to schizophrenia, depression, and alcohol dependence. Am J Psychiatry 2010; 167:1321-1330.*
12. *Sartorius N, Schulze H: Reducing the stigma of Mental illness: A report from Global Programme of the World Psychiatric Association. Cambridge: Cambridge University Press 2005: 1-12.*
13. *Yanos PT, Roe D, Markus K, Lysaker PH: Pathways between internalised stigma and outcomes related to recovery in schizophrenia spectrum disorders. Psychiatr Serv 2008; 59:1437-1442.*
14. *Thornicroft GJ: Shunned: Discrimination Against People with Mental Illness. Oxford University Press, 2006 p 182.*

Correspondence:
Prof. dr. sc. Slađana Štrkalj-Ivezić
University Hospital Vrapče
Bolnička cesta 32, 10000 Zagreb, Croatia
E-mail: sladjana.strkalj-ivezic@zg.t-com.hr