

The stigmatization of sufferers with mental disorders

RECORDS of ill people being stigmatized are centuries old, especially individuals with mental disorders and related mental health problems.¹ Ingredients often include the fear of contamination and breakdown of our own mental defences; beliefs that the disorder may be self-inflicted and, to a degree, egosyntonic; that communication is especially difficult and may be unmanageable; and that, sometimes, the individual is especially unpredictable and dangerous.² Such concerns can underpin abuse and social distancing, and the sufferers experience the consequent isolation and insecurity. Their personal lives and employment are further compromised; their search for help is made more difficult.

For a century or more, the public has been protected by the existence of mental hospitals. With their closure, and the emphasis now on community care, public concern seems to be mounting and stigmatization of those seriously afflicted worsening.³⁻⁵

As doctors, our diagnostic approach to mental disorders potentially involves the matrix of biological, social, and psychological assessments and interventions, but the public tends, negatively so, to perceive our approach as largely 'physical' in nature.⁶

It is therefore no accident that attempts to combat the stigmatization of the mental illnesses are proliferating. The Australian government, the World Psychiatric Association, the World Health Organization, and the UK organizations Mind and the Health Education Authority are among those currently mounting important campaigns.

In October 1998, the Royal College of Psychiatrists launched its five-year-long campaign, entitled 'Changing Minds; Every Family in the Land'. It aims to complement some of the existing, more socio-political, campaigns and to collaborate with other such groups when appropriate.

The campaign, supported by back-up information packages, is focusing on six categories of common mental disorder: anxiety related illness, depression, schizophrenia, dementia, drug and alcohol abuse, and eating disorders; hence the campaign's title. These disorders will be addressed in terms of the stigmas associated with each of them and the realities of the matter. This 'demythologizing' will be complemented by a brief introductory statement concerning the scope of our knowledge and ignorance about the nature of mental disorders in general, and the difficulties that they generate for us philosophically. Each group of disorders will then be examined specifically in relation to what is known about:

- the contribution of genes, physical insult, culture, lifestyle, relationships, work, life events, and their personal meaning to the development of mental disorders;
- the extent to which the sufferer is likely to be helped by various therapeutic approaches, e.g. the psychotherapies, drug treatments, other physical treatments, social help, self-help, befriending;
- the skills necessary for professionals and the public to understand others with mental disorders, offer help to them, and facilitate self-help;
- what society should be providing in terms of material and human resources to treat these disorders most effectively.

These statements can then provide a foundation for a wide-

ranging programme aimed at the public in general, including people with all types of social and cultural backgrounds and, more specifically, groups such as the media, healthcare professionals, teachers, schoolchildren, and employers.

Primary care is clearly at the heart of this matter. It is general practitioners and their teams who are confronted endlessly by the challenge of mental disorder and related mental health problems in their patients: new cases, ongoing cases that never reach specialist services but which the primary care team addresses, and those cases that the specialist services are also involved with or will sometimes have given up on. The primary care team often has the potentially precious advantage, diagnostically speaking, of knowing the ongoing psychological and social dynamics of the family background. General practitioners, psychiatrists, and others are still often confronted by baffling cases that defy attempts at diagnostic rigour and are unresponsive to simple treatment. Norton and McGauley⁷ have argued that such difficulty can be another source of stigmatization.

As already indicated, the Royal College of Psychiatrists is planning one project to tackle the stigmatization of mental illnesses by ourselves, as doctors and as members of the public. We are very pleased that the Royal College of Physicians of London, the Royal College of General Practitioners, and the British Medical Association are going to collaborate with us.

As doctors, we have traditionally claimed, and been invested with, the responsibility for caring for the mentally ill. The mind appears to have an apparatus and chemistry within the brain and body at large. Moreover, we are specifically licensed by the public to invade this body and, in the process, should be able to examine the mind as thoroughly as other bodily systems. The fact that it is by far and away the most complex of these systems is the challenge.

Such examination must be rooted in the communication skills that provide us with the best chance of somehow penetrating the complexities of the hurt mind. Only they can underwrite the ability to assemble a relevant history, as well as properly to assess the mental state. We may also cherish notions of free will and social responsibility and resist attributing everything to deterministic influences, such as the gene. If so, it will also remain crucial to hone such professional skills to determine, with or without further expert advice, when psychological or social treatment might prove helpful to our patient.

The more that we as doctors can develop and deploy our knowledge and skills in respect of the mind and the interpersonal processes that impinge on it, the more we shall be able to define the boundaries of the effectiveness of our interventions, and also properly value alternative caring systems and interventions. So long as we fall short of this we are more likely to remain defensive, even to the point of stigmatizing the patient, and correspondingly be less effective and professionally satisfied. Our training as doctors, whether we be GPs or psychiatrists, is sometimes patchy in some of these areas, to say the least. If we are to successfully combat stigmatization of mental disorders, or if society at large is to achieve this, then we must get our own house in order at the outset.

It might also be helpful if we could come to understand not only what drives some of us to distance ourselves from the mentally ill but also what enables others to empathize with and

'befriend' sufferers. If it is true that mental disorder touches 'every family in the land', it behoves us to ponder on the basis for the wide variety of reactions to that experience.

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'But they don't see the whole child ...' Health visitors may not welcome systematic reviews of child health surveillance

SYSTEMATIC reviews of the literature have become a key part of strategies to develop knowledge-based health services and to identify new areas for primary research. Beginning with demonstrations that traditional narrative reviews could be biased by the choice of papers for appraisal,¹ methods have been developed to limit subjectivity and allow the reproducibility of results to be established. Standards for the production of systematic reviews have been published² and national and international mechanisms for dissemination set up, such as new journals and the Cochrane Collaboration. A symposium, entitled 'Systematic Reviews: Beyond the Basics', to be held this month in Oxford, is further evidence of growing maturity in this area.

Alongside this surge of academic activity, the concept of evidence-based medicine has been developed to show how such reviews can be used by individual clinicians treating individual patients.³ Despite its intuitive appeal to the rational scientist, the true scope for this approach to improve medical practice in general has been questioned. The most frequently voiced concerns are the external validity of individual results, the impracticability of extending and maintaining the evidence base, and the costs of implementation.

Although the principles of systematic review and evidence-based practice are, in theory, applicable to all health care professionals, to date it is in medicine that the impact on grass roots practice has been strongest. Nurses and the professions allied to medicine have begun to undertake systematic reviews of specific areas of practice such as wound care, but until recently no such group has had a substantial part of its practice exposed to this type of scrutiny.

The recent launch of a series of systematic reviews of screening in child health⁴ will provide such a challenge to the United Kingdom's 13 500 whole time equivalent (WTE) health visitors. Their reaction to the reviews will indicate whether scepticism about evidence-based practice is confined to doctors, or extends to other health care professionals.

Health visiting began at the end of the last century, in order to address important public health problems of the time: high infant mortality rates and an insufficient number of fit young adults to meet society's needs for workers and soldiers. Although infant mortality rates have dropped, the health and normal development of children remains important to health visiting practice.

Screening is a key expression of this, although the proportion of time this occupies the average health visitor is unknown.

The NHS reform process has resulted in questions being raised about the effectiveness and cost-effectiveness of health visiting. With its goal of long-term prevention of ill-health and health promotion, outcome indicators are difficult to develop.⁵ In the recent past, the inability to demonstrate easily the benefits of health visiting, combined with financial pressures in some parts of the NHS, have resulted in cuts in health visiting being proposed in several health authorities. Further uncertainty about the future of health visiting was raised by the 1997 draft GP fundholding regulations, which proposed releasing fundholders from the restriction that they could only purchase health visiting from existing NHS providers. *Primary Care Act* pilots will offer similar flexibility. Hence, there is much 'organizational turbulence' around health visiting at present and an environment in which substantive change is conceivable.

If this were to be seized upon as a national opportunity to demonstrate knowledge-based reconfiguration of the service, what could be achieved? The systematic reviews launched last month broadly showed that vision screening and the hearing tests, performed by health visitors on all pre-school children, were ineffective. A conservative assumption that these constituted 10% of workload would imply that about 1300 WTE health visitors could be lost, or about £26 million released per year, for new initiatives such as the implementation of the new national health strategy. A Green Paper on this subject is out for consultation. Health visitors could take a lead role, and their numbers need not fall, providing that practice can be changed rapidly.

The main barrier to such change may well be the resistance of health visitors themselves. As one health visitor said at the conference which launched the reviews: 'But they don't see the whole child ...'. There is indeed a dichotomy between the health visitors' concerns with the wider social context in which children live, healthily or otherwise, and the detection and treatment of specific medical conditions.

If most or all child health surveillance were eliminated, it is arguable that some children with developmental or sensory problems might not be identified before entering school. However, as the usual age of school entry drops to between 3 and 4 years, this may assume less significance. Such newly diagnosed children

would have immediate access to remedial education as well as the health service.

However, there is one aspect of routine child health surveillance not mentioned in the systematic reviews which is of fundamental importance. Screening for child abuse and neglect is difficult to evaluate, but is of potentially enormous public concern if judged to be wanting. While individual components of a child health surveillance programme might be ineffective as screening for specific disorders, their combination does provide an opportunity for the 'whole child' to be seen by a professional worker. Pre-school children are not routinely seen by any other workers, and if surveillance by health visitors was withdrawn then some child abuse or neglect may go undetected. A tragedy could make the withdrawal of health visiting seem rash.

Before the results of these systematic reviews lead to reductions in levels of health visiting, further work is needed to establish the wider benefits, if any, of surveillance programmes, and to assess the contribution of health visiting to child protection. The establishment of Primary Care Trusts could provide an opportunity for a randomized controlled trial of the effectiveness of health visiting in child health surveillance and child protection.

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