

Does psychiatry stigmatize?

Derek Summerfield BSc MRCPsych

J R Soc Med 2001;94:148–149

The published work on stigmatization notes recurring themes in the way people with mental disorders can be perceived—dangerous, unpredictable, difficult to talk to, having only themselves to blame and so on¹. A survey of the attitudes of 1737 British adults across the country has shown that these perceptions still have considerable prevalence, though varying with type of illness². The survey did not look at attitudes to ‘personality disorder’, though as many as 3 in 4 saw people with drug or alcohol addiction as blameworthy and a danger to others. The Royal College of Psychiatrists is running a five-year campaign entitled ‘Changing Minds: Every Family in the Land’ designed to reduce the stigmatization of those with mental illness. In this campaign stigmatization is attributed almost wholly to non-psychiatrists—i.e. society. This rather recalls the way that people once regarded ‘institutionalization’ as a psychological attribute of longstay psychiatric inpatients, ignoring the contribution of psychiatric practice itself to the culture of the asylum as a place from which not many were expected to move on. Here I point to some facets of the sociology of stigma that highlight psychiatry as something more than an innocent bystander.

The story of psychiatry in the 20th century reflected the spectacular rise in the power of medicalized explanations for the world. Psychiatrists increasingly acquired the authority to explain, categorize, treat, detain and prognose in situations where well-defined mental illness was not present, using the same conceptual terminology they applied to the mentally ill³. In some subspecialties—child and adolescent psychiatry, forensic psychiatry, drug and alcohol addiction—most patients are not mentally ill and are recruited primarily because their behaviour has been identified as problematic, often by others. Mental health systems can perpetuate the needs of those who enter, and to exit from them can be difficult⁴. One consequence of psychiatrists’ extending into territory that was formerly the province of lawyers, priests and others is that psychiatry has encountered difficulties in separating medicopsychological facts from social values and expectations.

Clearly the perceived differences between psychiatric patients and the rest of society has been lessened by the

shortening of hospital admissions for psychiatric treatment and the gradual move of psychiatric practice towards community settings. Moreover, in an individual case, a psychiatrist-attested sick role may confer a helpful validation for the patient who until then has been regarded by others as capable with a little effort of pulling himself together. This shift in attitude could be destigmatizing. But if contact with a psychiatrist can helpfully modify the way a person is perceived, can it do the opposite too? Insofar as the general public has come to associate such disagreeable features as lunacy, depravity and dangerousness with the day-to-day work of psychiatrists, it might be said that almost all psychiatric interventions carry a potential for stigmatization as a side-effect. One at least partial counter to this would be high cure rates: personality disorder (a diagnostic category with negative connotations even for many psychiatrists) would fare better in the public eye if there were specific medical antidotes. Those whom psychiatrists first label personality disorder and then deem untreatable—a common circumstance—are more stigmatized than if they had been left alone. With antisocial behaviour, can the knowledge that a psychiatrist has become involved with a case harden rather than dissipate negative attitudes? When mental illness seems to be absent, the entry of the psychiatrist might be perceived by the patient, the family, the legal system and potential employers as delivering a judgment on that person’s whole history, prospects and indeed basic worth as a citizen.

Healing systems in all cultures serve not only individual patients but also public purposes of harmonization and control. However, history shows that psychiatry has often been deployed to legitimize the handling of those whom society, or those in power, have *already* decided to stigmatize and exclude. Foucault argued that in France the development of psychiatry as a special science followed, not preceded, the massive resort to confinement from the mid-seventeenth century onwards, and was dependent on it⁵. In nineteenth century USA slaves who ran away from their masters were deemed to have a mental illness called ‘drapetomania’⁶. In Britain young women who had given birth to an ‘illegitimate’ child were admitted to asylums, and many were never discharged. In more recent times a diagnostic category called sluggish schizophrenia was used to explain and discount the opinions of political dissidents in the USSR, who were then incarcerated in asylums on medication. The current proposals for the indefinite

Department of Psychiatry, St George’s Hospital Medical School, London SW17 0RE, UK

Correspondence to: 55 Denman Road, London SE15 5NS, UK

detention in psychiatric facilities of people who face no criminal charge but are deemed to have severe 'antisocial personality disorder' can be seen in the same light.

It is noteworthy that the survey cited above found that stigmatizing attitudes could coexist with reasonable knowledge of mental disorders. But this is to define public knowledge in terms of its concordance with what psychiatry presents as official facts, morally neutral and positivistic, other understandings and imperatives being ignored. From its very origins the stigmatization of people with mental troubles has probably had a social regulatory function. In our society many issues begging these and other sociomoral questions are now medicalized via a psychiatric domain of technical experts and the idiom of mental pathology. The relationship between psychiatry and those suffering negative stereotypes and exclusion cannot therefore be straightforward.

In short, stigma may be age-old, but aspects of its modern form are a by product of the medicalization of society. Has psychiatry overextended itself, stretched too far from formal mental illness—its core remit and the main justification for the lengthy and expensive training, salary and status of its practitioners? Psychiatric models based on a

static, individual-bound biopsychomedical paradigm inevitably have limited explanatory power when applied to situations that are as much a product of social and situational factors as of individual ones. Thus psychiatry may have little specific to offer to many of those it has nonetheless deemed sick in one way or another. The intervention may be stigmatizing in its own right. Is the Royal College campaign thinking about this? If we look more closely at the effects of medicalization of society, we might begin to ask whether psychiatry should be 'smaller'.

REFERENCES

- 1 Hayward P, Bright J. Stigma and mental illness: a review and critique. *J Ment Health* 1997;**6**:345–54
- 2 Crisp A, Gelder M, Rix S, Meltzer H, Rowlands O. Stigmatisation of people with mental illnesses. *Br J Psychiatry* 2000;**177**:4–7
- 3 Richman A, Barry A. More and more is less and less. The myth of massive psychiatric need. *Br J Psychiatry* 1985;**146**:164–8
- 4 Gerhard R, Marks A. Strategies for change: the balanced service system model. *J Psychiat Treatment Eval* 1980;**2**:179–84
- 5 Foucault M. *Discipline and Punish*. London: Allen Lane, 1977.
- 6 Fernando S. *Mental Health, Race and Culture*. London: MIND Publication, 1991