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Eradicating Stigma in Health Care Systems

Introduction

Stigma against persons with behavioral health histories is, among other things, damaging to the effective delivery of health care services.¹ Health care professionals, like people generally, are influenced by prevalent stereotypical notions about people with psychiatric histories. Endorsements of biased thinking by highly educated health care providers damage the therapeutic relationship by impairing trust and the potential for honest self-reporting. It is imperative that health care professionals' contribution to perpetrating stigma be acknowledged and addressed as part of health care reform. Training in the recovery model of behavioral health care is necessary for all professionals and will tend to reduce stigmatization, as providers come to see the potential for persons with psychiatric histories to live productive lives and become less likely to view them in a pejorative way. However, long-term collegial contact between health care providers and individuals with lived experience in recovery, e.g., certified peer specialists and other peer workers, holds out the most promise for curbing bias against people with psychiatric histories.

¹ D. Sadow, *et al.*, *Is education of health professionals encouraging stigma towards the mentally ill?* 11 Journal of Mental Health 6, at 657-665 (2002).

Attitudes of Health Care Professionals

Stigma towards persons with psychiatric histories is pervasive. Physicians, psychiatrists, nurses, other mental health professionals, and medical/mental health students alike manifest stigmatizing bias.² In one study, for example, nurses were found to act as “stigmatizers,” carrying negative attitudes founded on the belief that individuals with mental health issues are dangerous, weak and to blame for symptoms.³ These attitudes are most often directed toward individuals with previous hospital admissions, those who are actively presenting symptoms, or those who are diagnosed with what is perceived as a long-term illness, such as schizophrenia, as opposed to individuals who do not exhibit florid symptomatology.⁴

Stigma also can be attributed to the incorrect assumption that mental illness is necessarily a life sentence.⁵ Health care professionals’ often have negative and pessimistic views toward recovery.⁶ In fact, they tend to be even less optimistic than the general public about the ability of

² A. Llerena, *et al.*, *Schizophrenia stigma among medical and nursing undergraduates*, 17 *Eur. Psychiatry* 298-9 (2002); A. Smith and C. Cashwell, *Stigma and Mental Illness: Investigating Attitudes of Mental Health and Non-Mental Health Professionals and Trainees*, 49 *J. Humanistic Counseling, Educ. and Dev.* 189-202 (Fall 2010); H. Rao, *et al.*, *A Study of Stigmatized Attitudes Towards People with Mental Health Problems Among Health Professionals*, 16 *J. Psychiatric and Mental Health Nursing* 279-284 (2009); M. Hugo, *Mental Health Professionals’ Attitudes Towards People Who Have Experienced a Mental Health Disorder*, 8 *J. Psychiatric and Mental Health Nursing*, 419-25 (2001); L. Nordt, *et al.*, *Do Mental Health Professionals Stigmatize Their Patients?* 113 *Acta. Psych. Scand.* 51-59 (Suppl. 429, 2006).

³ C. Ross and E. Goldner, *Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature*, 16 *J. Psychiatric and Mental Health Nursing* 558-567 (2009).

⁴ H. Rao, *supra* note 2. (Health care providers exhibit less bias toward persons with brief episodes of psychiatric difficulties or towards persons with addictions who are in recovery and more toward persons who had been institutionalized and with active addictions.)

⁵ A. Llerena, *supra* note 2.

⁶ See, e.g., *id.*; C. Ross and E. Goldner, *Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature*, 16 *J. Psychiatric and Mental Health Nursing* 558-567 (2009) (“attributing mental illness solely to biological or inherited determinants ‘appears to increase stigma and social distance, perhaps because the illness is perceived as fixed and chronic.’”); J. Horsfall, *et al.*, *Stigma in Mental Health: Clients and Professionals*, 31 *Issues in Mental Health Nursing* 450-455 (2010).

persons with behavioral issues to recover and lead productive lives.⁷ Further, many psychiatrists believe that persons who use mental health services are incapable of making decisions. They do not respect them to the same extent as other patients, and communicate this perception, which is likely to be internalized by the persons receiving services.⁸

Addressing and Reducing Stigma

According to a majority of the evidence, health care providers are most free of bias when they have contact with persons with psychiatric histories who nonetheless have achieved success.⁹ Direct contact is more likely to produce “greater improvements in attitudes” than educational and training programs.¹⁰

Educational and training programs are most effective when providers that have friends with psychiatric histories¹¹ and when they incorporate persons with lived experience.¹² A study of undergraduate classroom interventions found live and recorded theatrical presentations performed by people with mental health issues to be effective in reducing bias, with live performance having the greatest impact.¹³

⁷ M. Hugo, *supra* note 2.

⁸ J. Chamberlin, *Consumer involvement in mental health service delivery*, 14 *Epidemiologia e Psichiatria Sociale* 1 (2005).

⁹ L. Stromwall, *et al.*, *Peer Employees' and Clinicians' Perceptions of Public Mental Illness Stigma and Discrimination*, 35 *Psychiatric Rehabilitation Journal* 406-408 (2012); A. Llerena, *supra* note 2 (students who had exposure to persons with schizophrenia less likely to view them as violent).

¹⁰ P. Corrigan and B. Gelb, *Three Programs That Use Mass Approached to Challenge the Stigma of Mental Illness*, 57 *Psychiatric Services* 393-398 (2006); *see also*, G. Thornicroft, *et al.*, *Reducing Stigma and Discrimination: Candidate interventions*, 2 *Int'l J. Mental Health Systems* 3 (2008).

¹¹ D. Sadow, *et al.*, *supra* note 1.

¹² N. Rusch, *et al.*, *Mental Illness Stigma: Concepts, consequences, and initiatives to reduce stigma*, 20 *Eur. Psychiatry* 529-539 (2005).

¹³ D. Faigin and C. Stein, *Comparing the effects of live and video-taped theatrical performance in decreasing stigmatization of people with serious mental illness*. *Journal of Mental Health* December 2008; 17(6): 594-606.

The attitudes of health care providers, however, are most likely to improve from daily interaction with persons with lived experience who are in recovery. Professionals' attitudes tend to be formed on the basis of dealings with patients when they are at their most needy, and a more balanced and beneficial outlook can arise from contact with a broader range of persons with lived experience than they may see in their daily practice, including persons in recovery from psychiatric issues.^{14, 15} Meta-analyses of 515 studies substantiate that such contact can reduce anxiety generated by interactions with stigmatized individuals.¹⁶

By contrast, limited contact with persons with psychiatric histories does not produce dramatic attitudinal changes. Rather, engaging in activities with persons with lived experience could reduce stigma.¹⁷ But persistent contact with persons with psychiatric histories in shared work settings yields the best results, as context of the contact, including the characteristics of the persons with whom contact occurs, are crucial.¹⁸ Peer specialists enable providers to witness successful, "normal" functioning of recovered individuals with behavioral health histories.¹⁹

¹⁴ M. Hugo, *supra*, note 2.

¹⁵ T. Pettigrew and L. Tropp, *How does intergroup contact reduce prejudice? Meta-analytic tests of three mediators*, 38 Eur. J. Soc. Psychol. 922-934 (2008) (also suggesting that reduced anxiety resulting from intergroup contact may be a prerequisite to increased knowledge of and empathy for the stigmatized population).

¹⁶ *Id.*

¹⁷ A. Smith and C. Cashwell, *supra* note 2 (suggesting that medical students engage in practicum involving persons with lived experience to reduce stigma).

¹⁸ M. Kolodziej and B. Johnson, *Interpersonal Contact and Acceptance of Persons with Psychiatric Disorders: A research synthesis*, 64 J. Consulting and Clinical Psychology 1387-1396 (1996) (finding positive relationship between contact and reduced stigma, but finding that prolonged contact in institutional settings did not increase effect because "institutions often do not promote a comfortable atmosphere for psychiatric service providers and recipients" making it difficult to have "positive experiences."). *See also*, A. Smith and C. Cashwell, *supra* note 2 (Study found that differences in stigmatizing attitudes between a mental health students and a mental health professionals were not significant, indicating that experience treating the population may be insufficient to reduce stigma and that exposure to "successful" persons with psychiatric histories may be essential.)

¹⁹ P. Solomon, *Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients*, 27 Psychiatric Rehabilitation Journal 392-401 (Spring 2004).

Conclusion

Research supports the premise that long-term contact with successful persons with psychiatric histories is necessary to significantly reduce stigma. If health care professionals are playing a role in making their patients feel stigmatized or contributing to a societal stigma against persons with lived experience, then it is important that health professionals and those delivering health care improve their attitudes.²⁰ It is also important because such stigma can negatively the quality of health care delivered.²¹ Ensuring that peer workers are a significant presence in the delivery of health services will benefit recipients of services directly²² and indirectly by helping to reduce stigmatizing attitudes of other health care professionals.

For more information, please contact Susan Fendell, 617-338-2345 x 129.

²⁰ L. Nordt, *et. al.*, *supra* note 2.

²¹ See, e.g., G. Thornicroft, *Discrimination in health care against people with mental illness*, 19 Int'l Rev. of Psychiatry 113 (2007) ("There is strong evidence that people with a diagnosis of mental illness, for example, have less access to primary health care and also receive inferior care for diabetes and heart attacks. . ." (citations omitted)); M. Graber, *et al.*, *Effect of a Patient's Psychiatric History on Physicians' Estimation of Probability of Disease*, 15 J. Gen. Internal Med. 204 (2000); E. Koranyi, *Morbidity and Rate of Undiagnosed Physical Illnesses in a Psychiatric Clinic Population*, 36 Arch. Gen. Psychiatry 414-419 (1979) (In a study of 2,090 psychiatric patients, 43% suffered from at least one major medical illness, of which, almost half or 46% remained undiagnosed by the referring physician.); S. Parle, *How does discrimination affect people with mental illness?* 108 Nursing Times 28:12-14 (2012); R. Hall, *Physical Illness Manifesting as Psychiatric Disease*, 37 Arch. Gen. Psychiatry 989-95 (Sept. 1980) (One hundred patients were intensively evaluated for the presence of unrecognized medical illnesses that might have affected their hospitalization. Forty-six percent of these patients suffered from physical, medical illnesses previously undiagnosed by their physician and which physical, medical illnesses either directly caused or greatly exacerbated their psychiatric symptoms. An additional 34% of patients were found to be suffering from at least one other undiagnosed physical, medical illness requiring treatment though unrelated to their psychiatric symptoms.).

²² Peer specialists can be used to empower and assist those with psychiatric challenges. L. Nordt, *et al.*, *supra* note 2. From the perspective of a person receiving services, peer specialists help them to navigate the system, make better health care decisions and give them the ability to "direct their own recovery and advocacy process and to teach and support each other." A. Llerena, *et al.*, *supra* note 2. In addition, peer specialists can assist their mental health professional colleagues by providing health care professionals a "unique insight into mental illness" and the recovery process. L. Davidson, *et al.*, *Peer Support Among Adults With Serious Mental Illness: A Report From the Field*, 32 Schizophrenia Bulletin 3, at 443-450 (2006).