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# Challenges and opportunities in stigma for psychiatrists: an analysis of effective coping mechanisms to reduce stigma associated with mental illnesses

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Stigma leads to discrimination of the patient, family, health care providers and services. A workshop-type qualitative analysis was conducted with a panel of 40 psychiatrists to attempt to apply evidence based anti-stigma strategies to five given hypothetical case vignettes. Various combinations of protest, education and challenge strategies were selected as effective by the panel. The analysis also revealed a number of stigmatising beliefs related to psychiatry as a profession and behaviour of patients. Psychiatrists themselves need to change such beliefs as part of reducing stigma related to mental illnesses.

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Brief report

# Challenges and opportunities in stigma for psychiatrists: An analysis of effective coping mechanisms to reduce stigma associated with mental illnesses

M Rajasuriya, SM Fernando, U Gunawardhana

**Abstract**

Stigma leads to discrimination of the patient, family, health care providers and services. A workshop-type qualitative analysis was conducted with a panel of 40 psychiatrists to attempt to apply evidence based anti-stigma strategies to five given hypothetical case vignettes. Various combinations of protest, education and challenge strategies were selected as effective by the panel. The analysis also revealed a number of stigmatising beliefs related to psychiatry as a profession and behaviour of patients. Psychiatrists themselves need to change such beliefs as part of reducing stigma related to mental illnesses.

**Key words:** stigma, beliefs, behaviour, discrimination, mental illness, psychiatrist

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## Introduction

Stigma is a mark of shame and is associated with mental illnesses, poverty, HIV and many other life conditions. It has been defined as a negative attribute that reduces the value of the person with whom it is associated with (1). Stigma in mental illnesses leads to discrimination in education, employment and leisure activities (2,3).

Stigma extends its effects towards medical professionals who treat persons with mental illness, in addition to its effects on persons with a mental illness, their families, and places where they receive care. As psychiatrists we face stigma in everyday practice, and we may be responsible for propagating stigma as well as mitigating it (4).

There are three recognised methods of reducing stigma: protest, education and challenge, out of which most evidence is available for education and challenge (5, 6). However, each strategy used to reduce stigma needs to be tailored to the particular situation. A mixture of coping strategies may be most effective for most situations. Psychiatrists are frequently at the receiving end of discrimination, which requires them to be skilled in applying these coping strategies in their daily professional and practical life (4).

## Aims and methods

Applying evidence-based effective coping strategies to counter stigma and discrimination in a given practical situation needs careful and skillful judgement. We felt that inviting a group of psychiatrists to analyse few hypothetical but realistic situations where stigma is expressed may lead to better practical recommendations on how to cope in such situations.

The participants (n= 40) were psychiatrists with different levels of experience, ranging from doctors who had recently entered psychiatry training to retired veteran psychiatrists. The moderator (first author) divided participants into five groups of eight members each by allocating each participant a number from one to five according to the seating order. On observation the five groups looked broadly similar in composition as far as age, gender and psychiatry experience were considered.

The moderator allocated case vignettes, one per group, which were applicable to daily practice in psychiatry and addressed various aspects of stigma and discrimination. This was followed by a focus group discussion on how to manage the situation. Each group shared their findings with other groups. Discussions within the group and between groups were structured to recognise aspects of stigma and discrimination related to the contents of the case vignettes, distinguish contributory beliefs and affect states, i.e. attitudes and best coping strategies. The discussions were carefully documented and framework approach was used to analyse qualitative data.

## Results

### Vignette 1

The ward sister of the psychiatry inpatient unit of a provincial hospital made a request to the medical superintendent (MS) for four new beds for the unit. The MS agrees to give old beds discarded from another ward.

#### Discussion on vignette 1

*Aspects of stigma/ discrimination*: Place that provides psychiatric services, namely the psychiatry inpatient unit in this case, was given lower priority.

*Contributory attitudes*: Psychiatry and psychiatric services were deemed to be inferior to other specialities and medical services.

*Best coping strategy or combination*: Protest is the best coping strategy in this case, demanding transparency and good governance. Policy of distribution of resources among the wards should be according to an agreed priority list that would be based on needs rather than prejudices. It is important for mental health professionals to liaise with other professionals in other medical specialities, caregiver groups and patient groups to promote this equality.

## Vignette 2

A middle aged woman enters the psychiatrist's room and quickly informs, before her son, the patient, comes in, that he does funny things, such as buttoning shirts wrongly, each time he misses his tablets. She pleads with the doctor to admit him to hospital, despite absence of acute symptoms, as a family wedding was coming up.

### Discussion on vignette 2

*Aspects of stigma/ discrimination*: There is stigmatisation within the family. There is high expressed emotion with low tolerance of behaviour of the patient. The patient, himself, may have internalised this stigma.

*Contributory attitudes*: Every odd action or behaviour of a patient with a mental illness must be due to the effects of that illness.

*Best coping strategy or combination*: Psychoeducation for the family is of critical importance. However the panel felt not obliging carers by seeing ''proxy'' consultation without the patient present (except when clinically indicated such as in risk assessment) was of higher effectiveness. Seeking the patient's view of this situation should be sought and respected. If he is found to have the same attitudes about himself, i.e. internalised stigma, this needs to be addressed as well.

## Vignette 3

As the consultant psychiatrist enters the consultant lounge of the hospital, a colleague, with a smile on his face, asks her: ''How are the pissas (lunatics) getting on? Have they kept everyone amused?''

### Discussion on vignette 3

*Aspects of stigma/ discrimination*: The stigma is directed towards the psychiatric profession and patients highlighting the stereotyping of persons with mental illness (that they are stupid comedians).

*Contributory attitudes*: Persons with mental illnesses have stupid comic nonsensical behaviour effectively rendering them clowns. Psychiatrists are the 'doctors' who control these 'clowns'.

*Best coping strategy or combination*: Angry protest or timid acceptance may be harmful. It was suggested that this comment could be used to highlight the unprofessional behaviour and contributory attitudes of the other consultant in a subtle but assertive way.

One suggestion was to reply, ''They are ok. How are your patients getting on?'' Challenging this stereotype is also possible by saying assertively that ''I do not like that comment because persons with mental illness are not comedians''. One participant, a trainee in psychiatry, shared the experience of a friend asking ''Why in the world did you select psychiatry?'' The participant had said in response: ''Why in the world did you select gynaecology and obstetrics?''

## Vignette 4

A 31-year old man who was diagnosed with schizophrenia recently during a one-week hospital admission, returns to work after a further two more weeks medical leave at home, to find out that he had been sacked. The management maintained that nobody with a 'problem in the head' (sheershabadha in Sinhala) should be employed in their organisation.

### Discussion on vignette 4

*Aspects of stigma/ discrimination*: The employer decides to take away employment from a person with a mental illness, violating human rights.

*Contributory attitudes*: The employer apparently stereotypes persons with mental illness perceiving them as irresponsible, unpredictable or dangerous individuals. Best coping strategy or combination: In this situation the treating clinician will have an additional role to play. She/he may involve the family and possibly the social worker in seeking help to educate the employer and reverse this decision. The employer would need to be educated on why it would be unfair to deprive opportunities from a recovered patient. Examples of leading successful persons who have mental illness may be used to emphasize this point. Another course of action would be to use the legal system to challenge this decision.

## Vignette 5

Brief transcript of the daily comedy drama of a popular Sinhala radio show: A new young doctor wants to marry a female patient of a psychiatric hospital. Meanwhile this patient saves another from drowning. Director of the hospital recommends her release allowing the marriage to take place as her heroic act proved she was 'normal'. Then the young doctor notes that the person saved by the female patient had apparently committed suicide by hanging himself using his sarong, for which

she gives an explanation: ''He was soaked when I saved him, so I hung him to dry.''

### Discussion on vignette 5

*Aspects of stigma/ discrimination:* The pivotal point of this joke is that ''the psychiatric patient'' is stupid to the level shown.

*Contributory attitudes*: The creators of this segment do not appear to have any knowledge about mental illnesses. There is a diverse range of mental illnesses and not just one illness. None of these mental illnesses have got stupidity as a diagnostic criterion.

*Best coping strategy or combination*: The ignorance, whether deliberate or not, of the media about the true nature of mental illnesses needs to be addressed by protest and education. Another suggestion that emerged was to use the words ''crazy'' and ''mad'' to indicate stupidity and one should avoid such terms to describe mental illnesses.

As an immediate practical step, protest with an attempt to educate, such as writing a letter to the relevant radio station, was also discussed. This scenario highlights the role of health professionals to educate the media personnel with a view to improving their attitudes towards mental illness thereby minimising mental illness being portrayed in a stigmatising way through media.

### Limitations

A limitation of this research is the fact that the interventions described above were not objectively evaluated. But the in-depth qualitative exploration of this theme, among specialists working in the field is a novel aspect and a strength of the study.

## Conclusions and recommendations

At the end of the discussion it appeared that a number of potential steps could be taken by psychiatrists, to mitigate stigma and discrimination. Some of them are acts of commission such as writing letters of protest, and some are acts of omission, such as not obliging third parties' request to see doctors without the patient except when clinically indicated. A majority of these interventions necessitated a change of attitudes, but not an excessive investment of time or other indispensable resources.

This research was completed as part of a pre-congress workshop for the Annual Academic Sessions of the Sri Lanka College of Psychiatrists.

### Declaration of interest

None declared

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