



Mood Disorders Society of Canada

La Société Pour **Les Troubles de L'Humeur** du Canada

Stigma and discrimination – as expressed by mental health professionals

NOVEMBER 12, 2007

RESEARCH REPORT

Dr. Manon Charbonneau, President of the Canadian Psychiatric Association:

“But stigma is not solely the domain of others. As professionals we need to be conscious of our own stigma-prone behaviours or the internalized stigma we may perpetuate.”

Summary of Brief

Anecdotal reports of consumer and family experiences of stigma and discrimination are numerous. At the Mood Disorders Society of Canada's (MDSC) October, 2006 Stigma Research Workshop (supported by the Institute of Neurosciences, Mental Health and Addiction (INMHA), the Public Health Agency of Canada, and Health Canada) the focus was on identifying top research priorities. **Almost 100 attendees representing consumers, patients, families, caregivers, researchers, professionals and policy makers, identified stigma and discrimination as expressed by health and mental health professionals as their number one priority.** An emerging body of research shows that mental health professionals can hold the same – or even more deeply – stigmatizing attitudes toward people with mental illness and their families. This research implicates psychiatrists, and reports that they hold the most pessimistic views of peoples' chances of recovery. Other mental health care professionals and service providers are also implicated. Fighting stigma begins at home. MDSC acknowledges that psychiatrists and other mental health care professionals can, themselves, be the targets of stigma. At the same time, MDSC calls upon all health care professionals to confront the stigma that exists within its own ranks and develop an action plan to deal with it.

Table of Contents

Introduction	4
Workshop results	4
Stigma towards people with mental illness and their families	5
Stigma as expressed by health professionals	6
Stigma towards mental health professionals	7
Stigma as expressed by mental health professionals	8
Emerging research	10
In conclusion	11
Resolution	12
Appendix Executive Summary: Stigma: The hidden killer (2006)	

Introduction

As part of its mandate to support those with mental illness and offer leadership in strategies to address mental illness in Canada, the Mood Disorders Society of Canada (MDSC) convened a national workshop in 2006 to discuss stigma and develop a report that would form the foundation for scientific research questions that would facilitate the development of an evidence based agenda to deal with stigma and discrimination.¹ Stigma causes serious economic, health and social consequences to consumers, patients, families and caregivers, as well as to society at large. The experience of stigma, and its resultant discrimination, is a profoundly personal one and best understood by those who have experienced its effects.

Advice on the development of a pan-Canadian stigma and discrimination research agenda was requested by the sponsors of the research workshop - Institute of Neurosciences, Mental Health and Addiction (INMHA), Public Health Agency of Canada and Health Canada.

The goals of the workshop were:

1. To develop a comprehensive researcher and consumer/family focused research agenda.
2. To develop materials to inform the research agenda of the Institute of Neurosciences, Mental Health and Addiction and, subsequently, the Mental Health Commission of Canada.
3. To encourage an exchange of ideas and build collaborative research teams and networks.
4. To develop national and international partnerships among funders, researchers and stakeholders.

Workshop results

The workshop brought together almost 100 individuals representing consumers, patients, families, caregivers, health care providers, researchers, government policy makers, and non-profit organizations. They spent two days addressing the goals of the workshop through large and small group structured discussion.² Of the 16 priorities identified, number 1 and number 3 were:

¹ See Appendix 1 for the Executive Summary of the background paper that formed the foundation of the workshop.

² Report on proceedings prepared by Paula Stanghetta (2006). Stigma hurts: Stigma and discrimination research workshop hosted by the Mood Disorders Society of Canada. Note that the second highest ranked research priority was: "There are a

1. What are the most effective strategies to reduce stigma and discrimination associated with mental illness and addictions among health and social service providers?

3. What do mental health professionals do or do not do that consumers experience as stigmatizing and discriminatory?

The priority findings of this workshop – that consumer and families experience stigma and discrimination emanating from health and mental health professionals - is extremely difficult for professionals to confront. Stigma and discrimination, in general, is an under-researched topic, but stigma among mental health professionals is even more neglected. However, reports of experiences of stigmatizing attitudes and behaviours abound in consumer and family literature.³

Some authors are beginning to think about how mental health professionals can be, at one and the same time, stigmatizers, the objects of stigma and powerful actors in anti-stigma campaigns.⁴

Stigma against mental illness appears so entrenched in society that it must be examined from multiple perspectives:

- Stigma towards people with mental illness and their families,
- Stigma as expressed by healthcare professionals in general,
- Stigma towards mental health professionals, and
- Stigma as expressed by mental health professionals.

number of consumer-led anti-stigma campaigns that look promising. How effective are these? For the full report, see:

http://www.moooddisorderscanada.ca/Stigma/pdfs/FinalReportMDSC_StigmaWorkshop_Jan07.pdf

³ As only two examples, see: Edwards Karmazyn, J. (2007). Stigma and discrimination and the mental health consumer/survivor movement. See: <http://72.14.205.104/search?q=cache:1exkrvVILROJ:www.ccamhr.ca/papers/Stigma%2520and%2520Discrimination%2520-%2520Karmazyn.pdf+stigma+and+discrimination+from+mental+health+professionals&hl=en&ct=clnk&cd=15&gl=ca>

Wahl, O. (1999). Telling is risky business. Chapel Hill, NC: Rutgers University Press.

⁴ Schulze, B. (B. (2007. Stigma and mental health professionals: A review of the evidence on an intricate relationship. International review of Psychiatry. 19(2), p. 137 – 135.

Stigma towards people with mental illness and their families

Most well documented are the experiences of stigma and discrimination against people with mental illness and their families. They say that the stigma associated with their own (or their family member's) diagnosis was more difficult to bear than the actual illness. Stigma is all-encompassing. It affects the ability to find housing and employment, enter higher education, obtain insurance, and get fair treatment in the criminal justice or child welfare systems.⁵

In recognition of the deleterious effects of stigma, the Canadian Psychiatric Association joined with 11 other professional groups of the Canadian Collaborative Mental Health Initiative to endorse and sign a Charter of Principles and Commitments related to collaborative mental health care.⁶ The commitment related to stigma is as follows:

Develop and implement strategies for reducing stigma and discrimination associated with mental illness that can be applied across various settings (e.g., health, community, workplace, school)

Stigma as expressed by health professionals

People with mental illness also experience discrimination in the Canadian health care system. Their views are dismissed. They feel ignored in emergency rooms and treated disrespectfully by family physicians. Once known to have a mental illness, they report that their legitimate physical health concerns are disregarded.⁷

The existence of stigmatizing attitudes among health professionals has been well documented. As only a few examples:

⁵ Everett, B. (2006) Stigma: The hidden killer (2006). Background paper – Stigma Workshop prepared for the Mood Disorders Society of Canada. See: http://www.mooddisorderscanada.ca/Stigma/stigma_hiddenkiller_present.htm

⁶ The full text of the Canadian Collaborative Mental Health Initiative Charter (March 2006) is available at: <http://www.ccmhi.ca/en/products/charter.html>

⁷ *ibid*

- 28% of medical students stated that psychiatric patients were “not easy to like.” As graduates and practicing physicians, that figure rose to 56%.⁸
- Medical practitioners hold a “range of attitudes towards individuals with a psychiatric diagnosis similar to those held by the general public (p. 74).”⁹
- The presence or the mere suspicion of a mental illness in a patient in a general hospital led to reactions among staff that ranged from silence, disbelief (they are not genuinely ill), to invalidation of the patient’s experiences.¹⁰
- In the UK, 44% of people with mental illness reported experiencing stigma from their primary care physician, and 32% reported stigma from other health care professionals.¹¹

This last finding is especially troubling because, overwhelmingly, people with mental health problems turn most often to their primary care physician for help.¹²

Stigma towards mental health professionals

Psychiatrists, themselves, are the subject of stigma from the general public and from medical colleagues.

“Psychiatrists are not “real” doctors.”¹³

⁸ Bryne, P. (1999). Stigma of mental illness: Changing minds, changing behaviour. *British Journal of Psychiatry*. Vol 174, p. 1 – 2. See: <http://psy.dmu.ac.uk/brown/dmulib/byrne.htm>

⁹ Gray, A. (2002). Stigma in psychiatry. *Journal of the Royal Society of Medicine*. Vol 95, p. 72 – 76.

¹⁰ Liggins, J. & Hatcher, S, (2005). Stigma towards the mentally ill in the general hospital: A qualitative study. *General Hospital Psychiatry*. 27(5), p. 359 – 364.

¹¹ Pull yourself together: A survey of peoples’ experience of stigma and discrimination as a result of mental distress (2000). Mental Health Foundation, London, UK. Available at:

<http://www.mentalhealth.org.uk/page.cfm?pagecode=PBUP0204>

¹² Mental health literacy in Canada: Phase 1 report (2007). Canadian Alliance on Mental Illness and Mental Health. See:

http://www.camimh.ca/files/literacy/MHL_REPORT_Phase_One.pdf

¹³ Persaud, R. (2007). Medicine’s unsung heroes: why does psychiatry have such an image problem? *Canadian Psychiatry Aujourd’hui*. 3(6). See: <http://publications.cpa-apc.org/browse/documents/262>

“People feel like they are giving up “real” medicine to do psychiatry.”¹⁴

“Some doctors are still prejudiced against patients with mental illness and I have been told, ‘you work with loonies.’ If one doctor can say this to another, what hope can we hold out for the rest of society?”¹⁵

Film characterizations of psychiatrists and therapists portray them as either evil or bumbling.¹⁶

In addition, psychiatrists are regular targets of the most scathing attacks not typically aimed at other medical specialties.¹⁷

Stigma against mental health professionals (of all types) and mental health researchers has also been identified as a barrier to the free flow of scientific knowledge that could lead to better treatment, improved policies and greater investment in the Canadian mental health system. This stigma is seen as endemic in the scientific, political and medical communities.¹⁸

Stigma as expressed by mental health professionals

Perhaps one of reasons why stigma among mental health professionals is so difficult to acknowledge is because of the strong emotion contained within consumer’s criticisms.

Consumers’ views have ranged from...

Angry and harsh:

“It’s all very well to acknowledge that many people come from abusive families but who’s going to acknowledge that abuse goes

¹⁴ Collinson. K. Specialty questions: Psychiatry. University of Alberta.

¹⁵ Priory Group, Roehampton Health Care, (South London) UK (August 2007). *Crying shame*. Dr. Natasha Bijilani, Consulting Psychiatrist, as quoted on pg. 12. See: <http://www.prioryhealthcare.co.uk/webfiles/news/crying%20shame.pdf>

¹⁶ Byrne, P. (2003). Psychiatry and the media. *Advances in Psychiatric Treatment* Vol 9 p. 135 – 143. Available at: <http://apt.rcpsych.org/cgi/content/full/9/2/135>

¹⁷ As only one example, see the Coalition against Psychiatric Assault at: <http://capa.oise.utoronto.ca/links.html>

¹⁸ Strategic Initiative – Meeting the national challenge: Putting mental health and addiction knowledge into practice (2006). A report produced by the Institute of Neurosciences, Mental Health and Addictions in collaboration with the National Collaborating Centre for Aboriginal Health. See: <http://www.cihr-irsc.gc.ca/e/31322.html>

on in institutions and by professionals. Are we going to acknowledge that when you're in a disproportionate power relationship, disproportionate things happen? Whether you're a kid or an adult, when you're driven crazy by an abusive situation in your family, you are likely to be forced into an abusive situation in an institution. And if you get your act a bit more together and you go looking for an "alternative" therapist -- although I've got a lot of respect for what a lot of people do -- I don't see any more quality assurance mechanisms in place in a community agency than I see in the run-of-the-mill big, bad institution." ¹⁹

To inconsolable loss:

"Something began to die in us. Something way down deep began to break. Slowly the messages of hopelessness and stigma which so permeated the places we received treatment, began to sink in. We slowly began to believe what was being said about us. We found ourselves undergoing that dehumanizing transformation from being a person to being an illness: "a schizophrenic", "a multiple", "a bi-polar." Our personhood and sense of self continued to atrophy as we were coached by professionals to learn to say, "I am a schizophrenic"; "I am a bi-polar"; "I am a multiple". And each time we repeated this dehumanizing litany our sense of being a person was diminished as "the disease" loomed as an all powerful "It", a wholly Other entity, an "in-itself" that we were taught we were powerless over. The weeks, the months or the years began to pass us by. Now our aging was no longer marked by the milestones of a year's accomplishments but rather by the numbing pain of successive failures. We tried and failed and tried and failed until it hurt too much to try anymore." ²⁰

To unflattering observances of mental health professionals' own struggles with mental illness and their contempt for their own helping profession:

¹⁹ Hugh as quoted in Everett, B. (2000). A fragile revolution: Consumers and psychiatric survivors confront the power of the mental health system. Waterloo, ON: Wilfrid Laurier University Press. (p. 120)

²⁰ Excerpts from Recovery and Conspiracy of Hope: A speech by Patricia Deegan (2002). Available at: <http://www.namisc.org/newsletters/February02/PatDeegan.htm>

As an inpatient following a suicide attempt, Jane says: "I recall one nurse telling me about her sad life and she said, 'I'm seriously considering committing suicide myself but, let me tell you, Jane, I'd never put myself in the position you're in.'"²¹

These critiques are aimed at professionals who originally chose their careers in order to help and heal those they serve.

A recent and new voice has been added to those of traditional consumers and that is the voice of mental health professionals who have themselves, experienced a mental illness and, as a result, have become the target of stigma and discrimination from colleagues.

Cheryl Peever, manager and social worker at the Centre for Addiction and Mental Health (CAMH) and one of the 2006 recipients of CAMH's Courage to Come Back awards reported what can happen when a mental health professional reveals her experiences with mental illness and addiction – in a workplace dedicated to helping people with exactly these problems.

"The truth came out awkwardly. An announcement was posted on the staff bulletin board... The dominant (reaction) was silence. People didn't know what to say so they didn't say anything. As she expected, there were a few hurtful comments. What surprised her were the furtive congratulations. 'I really respect you, but I didn't want anyone to see me talking to you,' one colleague told her. 'I'm proud of you' said another making sure no one was in earshot."²²

In a second example,²³

"When Nigel Bart decided that his experience reigning in his demons made him ideally suited to fill a counsellor opening at a Winnipeg public mental health agency, it had been seven years since he had been tormented by the voices in his head. That he was a local man with a university degree and a passion for mental health issues had him sailing through the interview, he

²¹ Jane as quoted in Everett, B. (2000). *A fragile revolution: Consumers and psychiatric survivors confront the power of the mental health system*. Waterloo, ON: Wilfrid Laurier University Press. (p. 124)

²² Goar, C. (Monday, Oct 15, 2007). *Mental illness in the workplace*. The Toronto Star.

²³ Andreatta, D. (Tuesday, November, 2007). *Struggling against stigma*. The Globe and Mail.

recalled – until he mentioned his schizophrenia.’ I could see them just brace themselves a little bit,’ said Mr. Bart, 32, an artist who now runs a studio to benefit mentally ill artists. ‘They called me later to tell me that I didn’t get the job and when I asked them why, they said it was because I made an unhealthy disclosure. That’s what they called it.’ ”

Emerging research

Anecdotal evidence tends to be overlooked in academic circles. However, there is an emerging set of findings that lends credence to consumers’ and families’ lived experiences.

For example, in a survey of 1073 mental health professionals and 1737 members of the general public, researchers found that psychiatrists held more negative attitudes toward people with mental illness than the general public. Mental health professionals of all types were three times more likely to support restrictions for people with mental illness than the general public. The authors concluded that better knowledge of mental illness did not reduce stereotyping nor did it enhance willingness to interact with people with mental illness.²⁴

In another survey of 226 mental health professionals, it was found that they were less optimistic about long term outcomes for people with mental illness than the general public. Psychiatrists were the most pessimistic of all the professions surveyed, with nurses being less so.²⁵ These findings have been replicated.²⁶

In a further example of recent research, 50% of 567 psychiatrists surveyed by the Michigan Psychiatric Society said that they would treat

²⁴ Nordt, C. Rossler, W. & Lauber, C. (2006). Attitudes of mental health professionals toward people with schizophrenia and major depression. Schizophrenia Bulletin. 33(4), p. 709 – 714. See:

<http://schizophreniabulletin.oxfordjournals.org/cgi/content/full/32/4/709>

²⁵ Hugo, M. (2001). Mental health professionals’ attitudes towards people who have experienced a mental health disorder. Journal of Psychiatric and Mental Health Nursing 8 (5), 419–425. For abstract, see: <http://www.blackwell-synergy.com/doi/abs/10.1046/j.1351-0126.2001.00430.x?journalCode=jpm>

²⁶ Mental health literacy in Canada: Phase 1 report (2007). Canadian Alliance on Mental Illness and Mental Health. See: http://www.camimh.ca/files/literacy/MHL_REPORT_Phase_One.pdf

themselves in secrecy rather than have mental illness recorded on their medical chart.²⁷

In conclusion

On the face of it, it is not surprising that mental health professionals can also hold the same range of stigmatizing attitudes as the general public. However, it still comes as a shock in that these are the very people the mentally ill and their families turn to when they need treatment and understanding. Expressions of pessimism from those who there to help are of great concern to consumers and families, given that hope is one of the most valued ingredients in the professional/client relationship and the strongest predictor of positive outcomes.

However, courageous professionals are beginning to speak out. Dr. Manon Charbonneau, President of the Canadian Psychiatric Association says: "But stigma is not solely the domain of others. As professionals we need to be conscious of our own stigma-prone behaviours or the internalized stigma we may perpetuate."²⁸

It is possible that the fight against stigma begins at home.

MDSC has a commitment to collaborate with professional associations and NGOs which share its goal of improving the lives of Canadians living with or suffering from mental illnesses as well as the lives of their families and caregivers. All mental health care professional associations and providers are valued collaborators and partners in this regard.

Consumers and families have spoken. They are experiencing stigma and discrimination at the hands of some mental health professionals whose role is to help - not hurt. Emerging research shows that psychiatrists and other health care professionals are implicated.

MDSC respectfully requests all Canadian mental health care professional associations and provider associations, in their roles as

²⁷ Myers, M. (2001). Presidential address to the Canadian Psychiatric Association. New century: Overcoming stigma, respecting differences. Available at: <http://www.cpa-apc.org/publications/archives/CJP/2001/December/president.asp>

²⁸ Charbonneau, M. (2007). Identity, humanity, generativity. A year in review. *Canadian Psychiatry Aujour'hui*. 3(5). See: <http://publications.cpa-apc.org/browse/documents/262>

national leaders and as partners and collaborators with MDSC and other consumer and family organizations, confront stigma and discrimination within their own ranks and to join with MDSC and others in the development of a National Action Plan for the elimination of stigma and discrimination by healthcare professionals and service providers towards consumers and patients dealing with mental illnesses.

Appendix 1

Stigma: The hidden killer (2006)

Available at:

http://www.moooddisorderscanada.ca/Stigma/stigma_hiddenkiller_present.htm

Executive Summary

People who live with mental illness and their families often state that the stigma associated with their diagnosis was more difficult to bear than the actual illness. Stigma is all-encompassing. It affects the ability to find housing and employment, enter higher education, obtain insurance, and get fair treatment in the criminal justice or child welfare systems. Stigma is not limited to the attitudes and actions of others. Self-stigma relates to internalized negative stereotypes that lead people with mental illness and their families to adopt attitudes of self-loathing and self-blame leading to a sense of helplessness and hopelessness.

Stigma is dangerous because it interferes with understanding, obtaining support from friends and family, and it delays getting help (sometimes for years). Stigma is:

- An inhibitor of primary prevention,
- A fundamental cause of disease (marginalization, oppression and denial of opportunity),
- A factor that limits early detection,
- A factor that interferes with positive treatment outcomes,
- A contributor to a drain on health resources and on the Canadian economy,
- An impediment to recovery,
- Multi-faceted and creates a multiplier effect (stigma piled upon stigma).

Theories about why people stigmatize involve ideas about humankind's natural protective responses to perceived threats and social processes that tend to identify and categorize human difference, leading to decisions regarding which individuals or groups are valued and which are not. The exercise of power is central to stigma - overtly to reject and exclude or covertly to devalue and discredit.

New directions for health-related stigma research suggest initiatives that document the burden of stigma, compare stigma among health problems, define the determinants of stigma, develop measurement tools and implement research methods that include consumers and families in research.

Consumers and families value research but tend to focus on research as it relates to action. Having experienced stigma first hand, they are interested in what, exactly, to do about it.

Research regarding anti-stigma interventions offers mixed results. Public attitudes and behaviours are extraordinarily resistant to change. In addition, most anti-stigma campaigns are un-evaluated, time-limited, piecemeal, depend on volunteers and are mounted with limited budgets. Some anti-stigma approaches that have potential:
Counteracting self-stigma

- Empowerment (self-help and peer support groups, economic development programs, Mad Pride parades, advocacy)
- Recovery (personal growth and healthier choices leading to improved quality of life)

Changing public attitudes

- Anti-stigma campaigns that involve positive contact with people with mental illness and their families (print ads, television, films, seminars and presentations),
- Media-watches to expose biased reporting or negative stereotyping,
- Laws and policies that prevent discrimination,
- Tests and surveys that encourage people to self-identify and get help,
- Self-expression through the arts which celebrate people's talents while, often, providing educational or advocacy messages.

This overview paper concludes with recommendations for future Canadian research directions that have particular resonance for consumers and families:

1. Self-stigma is the enemy within. It renders a person complicit with the injustice of externally imposed discrimination and stereotyping. Yet the processes by which people come to believe that they deserve ill-treatment and ostracism are ill defined. As result, mechanisms to counteract self-stigma are less well articulated. There is a rich source of ideas in the recovery movement that require further thought and, perhaps, re-framing

in terms of the mechanisms that address the effects of self-stigma. Recovery, along with self-empowerment, may be among the premiere antidotes to self-stigma because they change one's own ideas about self and the world. **Self-stigma is an important area for further research.**

2. Anti-stigma campaigns are aimed at changing others' attitudes and beliefs. The sheer amount of activity offers many useful examples about what works, and what does not. In Canada, there is no need to re-invent the wheel. The time has come for action. Consumers and families are less concerned with measuring the extent and impact of stigma (they already know that). **Research attached to action would be highly valued.**
3. **Consumers and families must be involved**, not only in defining the actions to be taken and delivering the resulting campaigns, but also in the complete research process. They must participate in developing the research questions, collecting data and in analyzing results. No one cares more than they do about outcomes. As a result, they are the funders' best allies because they, too, want to ensure that investment pays off.
4. Often research, like many of the anti-stigma campaigns, can be piecemeal and unconnected. People don't hear about results and thus, are unable to make use of what has been learned. **Consumers and families have active organizations that can be utilized for the dissemination** of both the campaigns and the research findings.

Consumers and families recognize all too clearly that stigma can kill. They have a sense of urgency driven by personal experience that can be used to fuel change. However, changing attitudes and behaviours is extraordinarily difficult. While there is a lot of activity focused on anti-stigma campaigns and, while there is some evidence that beliefs are shifting, there is much work left to do.