The tendency to stigmatise†

ARTHUR CRISP

This time-honoured propensity has probably served humankind and its ancestors well in the service of species and related personal survival. Such biological mechanisms as those subserving immediate survival, the quest for food, reproduction and related territorial needs are presumably its foundation. Moreover, the crudity of categorisation and labelling of related perceived possible threats needs, constitutionally, to be safely over-inclusive, before juggling the consequent options of relating to, coming to dominate, fleeing from or ignoring the source.

In recent social history such core matters as race and political persuasion, such diseases as leprosy, cancer and AIDS and various physical handicaps have all triggered this process. One can see with just these few examples how idiosyncratic are the concerns evoked (e.g. perceived immediate physical danger, excessive demands for change, death, infectivity). Many factors influence the natural history of such stigmatisations: changing familiarity, better general control over the perceived threat, assertiveness of the minority group concerned and changing societal and personal value judgements.

Throughout such time, the stigmatisation of people with mental illnesses has prevailed, with rare exceptions. Western humankind have brought their particular perception to bear. Mental illnesses have some unique properties. They express themselves primarily through cognitive, affective and behavioural symptoms and signs – those very dimensions that make us what we are as individuals. The afflicted person may be perceived as identified with, and not separate from, the illness (Alison-Bolger, 1999). Psychiatry itself adopts this perspective with many mental illnesses as it attempts to explain links between the illness and the individual's development, personality and relationships. This bio-psychosocial model may be widely applicable but it is often restricted, in the public's mind, to mental illness. Perceived negative aspects of the illness then readily attach themselves to the afflicted person, as also happens, for instance, with physical illnesses regarded as self-inflicted. Secondly, unlike many other stigmatised groups (e.g. the physically disabled, with their ramps, rumble strips, Olympic Games and back-up legislation), those with mental illnesses rarely fight their corner. The nature of their illnesses, whether characterised, for instance, by inertia, egosyntonicity or cognitive breakdown, militates against it. Meanwhile, one of the features of the recent College Campaign Survey (Crisp *et al*, 2000) has been its attempt to secure public opinion concerning six or seven mental illnesses. Sufficient numbers of the public clearly recognise differences between these illnesses and this is reflected in the differing negative opinions expressed concerning each of them.

The literature on this subject is patchy. It has tended to focus on schizophrenia and depression and much of the best has recently emanated from Australia, where related and well-organised anti-stigma campaigns have run through much of the last decade. A recent Department of Health commissioned literature review on public attitudes to mental health/illness (Department of Health, 1999) concluded that the experience "does not bring a strong sense of understanding, but rather of acknowledgment – that we do think of those with mental health problems in this discriminatory way". The authors suggested that "the origins of fear and dislike of those with mental health problems may well from a deeper spring in society". The report implies that greater understanding at this level may be a necessary next step if change is to occur. The ways in which we have come to apply our natural capacities and instincts to the tasks of relating or not relating to those of us with mental illnesses in our given and changing cultures and with our existential concerns would seem to provide the arena for this quest.

THE SELF-INTEREST HYPOTHESIS

In this month's *Journal*, Haghighat (2000) attempts to present a credible unitary theory to account for all these interactions. He reviews literature that reflects the breadth of vision he wishes to bring to bear. Within 'Constitutional origins', which oddly he distances from genetic influences, he cites the work of experimental psychologists that supports notions of the need, safely but broadly, to categorise potential threats and thereafter, if confirmed, to load them with other negative attributes. He considers 'Psychological origins', and the chosen literature consolidates the notion that, defensively, we need to identify scapegoats and thereafter to condemn and avoid them. He then proposes that stigmatisations, whether they be of another race, fellow competitors or people with mental illnesses, are weapons in socio-economic competition. He seemingly sees no biological substrate to this theme, but pauses briefly to present possible independent evolutionary influences, serving species rather than personal self-interests. Could our present-day attitude partly be fuelled by our ancient need to distance ourselves from "poor reproductive bets" and those who are "sexually unattractive" (Gilbert & McGuire, 1998)? More certainly, people with severe and chronic mental illnesses may be perceived as "poor economic bets" when it comes to considerations of reproduction and its more immediate social consequences. He concludes by advancing the plausible proposition that "the fundamental basis of all stigmatisation is pursuit of self-interest", which society naturally comes to enshrine.

If we propose that our repertoire of responses has evolutionary biological origins, we can then consider how they have been harnessed to serve humankind's present self-interest when confronted by those in their midst with mental illnesses. For instance, the College Campaign Survey (Crisp *et al*, 2000) shows that people with schizophrenia and the addictions in particular are perceived by the majority of people as dangerous and therefore are likely, directly, to evoke ancient considerations of control or

†See pp. 207–215, this issue

https://doi.org/10.1192/bjp.178.3.197 Published online by Cambridge University Press

flight. That perception is, of course, generally exaggerated and its fuelling is another matter for consideration. Adverse and selective media attention, lack of diagnostic clarity and comorbidity are some of the factors that have led people to perceive those with schizophrenia as being much more dangerous than they are. Sontag (1988), writing within the context of herself having cancer, stated ". . . diseases acquire meaning (by coming to stand for the deepest fears). . . . It seems that societies need to have one illness, which becomes identified with evil, and attaches blame to its 'victims'. . . Any disease that is treated as a mystery and acutely enough feared will [also] be felt to be morally if not literally, contagious". Finzen & Hoffmann-Richter (1999) suggest that schizophrenia, in recent years, has taken on this mantle to an ever greater extent, from the cancer and AIDS that Sontag was writing about. Haghighat's emphasis on self-interest expressing itself importantly in terms of economic exploitation can apply to all mental illnesses, although he does not identify any particular ones and may mainly have had schizophrenia in mind throughout much of his discourse.

In contrast, the College Campaign Survey (Crisp *et al*, 2000) reveals the theme of perceived self-infliction, especially in respect of the addictions but also in those afflicted with eating disorders, who, however, are not also seen as dangerous. Similar literature over the years has revealed this same association in the public's mind (Department of Health, 1999). It raises the problems of 'free-will' and 'choice', which Haghighat does not address. Perhaps we can only cope with this dilemma by not discussing it. Belief in it is often the cornerstone of our self-image, at least in the Western world; it is also the basis of law and order in society. Max Hamilton used to comment: "Free-will is something we believe we have, but we equally believe that we can predict how others will behave" (M. Hamilton, personal communication, 1970). In psychiatry we constantly seek determining explanations both for the form and the content of mental illnesses. At the same time, we usually operate as if our patients have choice, although we may also know that sometimes decisions such as whether to engage in the prospects of change will depend upon the context (experience of stigmatisation, legal constraints, transferences within therapy). Meanwhile, this dilemma may be at the heart of people's tendency to blame such groups of patients in particular. Haghighat considers that psychological mechanisms may be at work here, although he stops short of examining their relationship to the stigmatiser's own personality and its robustness or otherwise in respect of defenses against personal dysphoria (Hughes, 2000). Yet, as with responses to dangerousness, it accords with his self-interest hypothesis.

Two of Haghighat's main thrusts have to do with the view (e.g. Littlewood, 1998) that we may be prone to take advantage of the mentally ill by exploiting them economically. This could be linked closely to our ancestral origins and those commonplace natural behaviours of attempted territorial domination and its purposes. Haghighat himself examines causation categorically. Although ultimately he extols a monistic philosophy, he does not, for instance, seriously attempt to explore interactions between psychological and socio-political perspectives.

INTERVENTIONS

Haghighat concludes with an inventory of interventions that he hopes might collectively provide opportunities to mute the self-interest that drives our stigmatisation of, and distancing from, and our exploitation of those with mental illnesses. Several of these fit comfortably with the finding of the College Campaign's survey that the public overwhelmingly perceives people with all mental illnesses as difficult to communicate and empathise with. Such perceptions and expectations promote distancing, social exclusion and ignorance. An association between prejudice and ignorance has long been demonstrated, although the nature of that relationship is unclear. Haghighat commends educational programmes and is aware of their limitations in reaching out to people's deep fears. He sees the potential value of familiarity with people with mental illnesses, provided that it is accompanied by the necessary social skills. He applauds, although he is also sceptical of, the work of Wolff *et al* (1996) and Leff (2000), who have begun to develop and evaluate neighbourhood induction programmes. In this connection, a recent community psychiatric nursing initiative in Glasgow is also noteworthy (Kaminski & Harty, 1999).

But Haghighat's main hope comes through as being that humankind will grow up and adopt a more fraternal caring society, throwing off their biologically driven competitive nature and evolving along correct ideological lines. However, he describes also the chaos into which we are these days thrust through endless bombardment with information and our increasing geographical mobility, and acknowledges that under such circumstances we may become defensively prone to ever coarser negative compartmentalising and labelling processes. Humankind has always had the capacity to be more cruel than nature requires. Along with his belief that fraternal ideologies will triumph over the law of the jungle, Haghighat identifies the need to curb undue competition and freedom to exploit others in the interests of the entire community. Much law and custom are designed to do just that, but justice and compassion in particular are not the prerogatives of the State. Such morality can also have other springs. Toleration of mental illness has occasionally been more evident in ancient civilisations. Theologians (Lewis, 1943) have sometimes equated social and scientific evolution with moral decline – cognitive development without the corresponding affective maturation and related increase in self-awareness that Haghighat reminds us is the key to personal growth. Befriending of people with mental illnesses today is importantly a voluntary activity, doubtless with origins as diverse as those fuelling social exclusion of those with mental illnesses. There is agreement that, above all, we need more than ever to search for and respect the uniqueness of the individual apart from his or her illness, yet also recognise the contributions to civilisation that have sprung from such associations. We should also remember the value of hybrid vigour and the awful sterile dangers of genetic standardisation.

The campaign 'Changing Minds: Every Family in the Land' strives to achieve this goal by opening up this inescapable agenda for public attention but we shall still need to try to empower people with mental illnesses to test out the relevance to their own potential self-interests of the current Disability Discrimination Act (DDA) and the soon-to-emerge UK human rights legislation. We may also need to acknowledge our biologically driven behaviours before we can more effectively shape and curb them, and also become more knowledgeable and comfortable about ourselves, before we become more at ease with mental illness in others. Apart from good protective

https://doi.org/10.1192/bjp.178.3.197 Published online by Cambridge University Press

legislation, greater public self-awareness is probably now essential for significant and enduring change. Meanwhile, Haghighat's contribution deserves recognition as an early building block and social prompt in our efforts to penetrate and mute this unattractive and tenacious human trait of unfairly labelling and seriously disadvantaging others.

REFERENCES

Alison-Bolger, Y. Y. (1999) The original sin of madness – or how psychiatrists can stigmatise their patients. *International Journal of Clinical Practice*, **53**, 627–630.

Crisp, A. H., Gelder, M. G., Rix, S., *et al* (2000) Stigmatisation of people with mental illnesses. *British Journal of Psychiatry*, **177**, 4–7.

Department of Health (1999) General public attitudes to mental health/illness. COI Ref: RS4206. London: Central Office of Information.

Finzen, A. & Hoffmann-Richter, U. (1999) Mental illness as a metaphor. In *The Image of Madness* (eds J. Guimón, W. Fischer & N. Sartorius), pp. 13–19. Basel: Karger.

Gilbert, P. & McGuire, M. (1998) Shame, social roles and status; the psychobiological continuum from monkey to human. In *Shame: Interpersonal Behaviour, Psychopathology and Culture* (eds P. Gilbert & B. Andrews), pp. 99–125. New York: Oxford University Press.

Haghighat, R. (2000) A unitary theory of stigmatisation. *British Journal of Psychiatry*, **177**, 207–215.

Hughes, P. (2000) Stigmatisation as a survival strategy: intrapsychic mechanisms. In *Every Family in the Land* (ed. A. H. Crisp). www.stigma.org.

Kaminski, P. & Harty, C. (1999) From stigma to strategy. *Nursing Standard*, **13**, 36–40.

Leff, J. (2000) Contemporary images and the future: stigmatisation of people with schizophrenia. In *Every Family in the Land* (ed. A. H. Crisp). www.stigma.org.

Lewis, C. S. (1943) *The Abolition of Man*. Oxford: Oxford University Press.

Littlewood, R. (1998) Cultural variation in the stigmatisation of mental illness. *Lancet*, **352**, 1056–1057.

Sontag, S. (1988) *Aids and its Metaphors*. London: Penguin Books.

Wolff, G., Pathare, S., Craig, T., *et al* (1996) Public education for community care: a new approach. *British Journal of Psychiatry*, **168**, 441–447.

ARTHUR CRISP, FRCPsych (Hon.), Chairman, Royal College of Psychiatrists' anti-stigma campaign 'Changing Minds: Every Family in the Land'. Psychiatric Research Unit, Atkinson Morley's Hospital, 31 Copse Hill, London SW20 0NE

(First received 9 August 2000, accepted 15 August 2000)

https://doi.org/10.1192/bjp.178.3.197 Published online by Cambridge University Press