Mental Illness, Stigma, and the Media

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Society is ingrained with prejudice toward mental illness, and sufferers are often widely perceived to be dangerous or unpredictable. Reinforcement of these popular myths through the media can perpetuate the stigma surrounding mental illness, precipitating shame, self-blame, and secrecy, all of which discourage affected individuals from seeking treatment. Efforts aimed at countering stigma in mental illness are faced with the challenge of centuries of discrimination and must, therefore, replace existing stereotypes with coverage of positive outcomes, as a first step in achieving the daunting task of overcoming these negative stereotypes. Long-term anti-stigma campaigns that encompass human-rights–based, normalization, and educational approaches are needed. The involvement of the media is essential for success, but, in order for the media to be used effectively, its motivations and limitations must first be recognized and understood.
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Society is ingrained with centuries of prejudice toward individuals with mental disorders.[1] Indeed, stereotyping and discrimination toward the mentally ill now feature daily in our newspapers and on our television screens. In today's "blame culture," a common outcome is self-stigmatization. Feelings of shame or self-blame lead to secrecy, reluctance to seek help from health care services, isolation, and social exclusion.[2] At times, even psychiatrists are affected, their own profession marginalized and tainted by the stigma of mental illness.

Humor is often used as a means of coping with the social discomfort that surrounds mental illness. Stigma in mental illness may arise from fear, with laughter serving as the socially acceptable first sign of fear and discomfort. Moreover, the widely held perception that people with mental disorders are dangerous and unpredictable is upheld by stereotypes that are both generated and reinforced by the media, whether through biased portrayal of the psychiatric profession in cinema or the sensationalist reporting of violent news stories that touch on the mental health of those involved.

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This article will discuss stigma in mental illness and explore its causality. The merits of various efforts to counter stigma will be debated using the experience of previous anti-stigma campaigns. Finally, the role that the media can play in achieving destigmatization—public acceptance of mental illness, without shame—will be discussed.

DEFINING STIGMA

The *Oxford English Dictionary* defines *stigma* as "a mark or sign of disgrace or discredit." Perhaps more accurate to the setting of mental illness is the dictionary's definition of *stigmatize*: "to describe as unworthy or disgraceful"—in this sense, stigma is not a natural mark of inferiority, but a product of social labeling.[3]

As part of the Royal College of Psychiatrists' 5-year campaign to destigmatize mental illness, Changing Minds: Every Family in the Land, Porter[1] described stigma in mental illness as a creation of spoiled identity. He wrote:

> Stigmatizing involves projecting onto an individual or group judgments about what is inferior, repugnant, or disgraceful. It translates disgust into the disgusting, apprehensions of danger into the dangerous. It is thus the creation of spoiled identity; first it singles out difference, next it calls it inferiority, and finally blames those who are different for their otherness.[1]

This perception of difference or "otherness" is a key step in the process of events that lead to the formulation of negative opinion. Instinctively, both human and animal groups rely on predictable behavior to confirm identity and therefore to ensure safety.[4] The ability to recognize a difference is intimately related to our cognitive style and enables us to make snap decisions based on the default

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assumption that, if something is strange or unpredictable, it may be dangerous—essentially stereotyping enhanced by arousal.

THE ROOTS OF STIGMA IN MENTAL ILLNESS

For centuries, people believed that all illness was related to original sin and was a punishment from God. Scientific advances and the determination of causality have enabled us to rationalize the existence of physical illness. Nevertheless, poorer understanding of the processes underlying mental illness has meant that parallel advances in thinking have occurred much more slowly in this field. Indeed, some of the approaches used to treat individuals with mental illness, including social exclusion and detention, act to further reinforce this "sinful" theory.

The media are guilty of perpetuating stigma. The depiction of psychiatrists in cinema and television is particularly illustrative of this. Examining the way in which psychiatry had been presented to the public through cinema from the early 1900s onward, Schneider[5] revealed that movie psychiatrists could be categorized into 3 distinct types: "Dr. Dippy," "Dr. Wonderful," and "Dr. Evil." These categories also revealed enduring stereotypes of patients with mental illness, which have undoubtedly shaped public perception of the disease.

The first movie psychiatrist category identified by Schneider—Dr. Dippy—emerged in the early years of silent cinema and was portrayed as a comical figure.[5] His patients were also depicted as figures of fun—essentially clowns on the edge of society. With the emergence of the "talkies," cinema was better able to portray the "talking cure" of psychiatry and Dr. Wonderful arrived—a warm, modest psychiatrist available at all times and in all places, riding to the rescue of tragic patients who were completely unable to cope, helpless, and devoid of responsibility. The most common portrayal of the psychiatrist in movies is, however, Dr. Evil. Dr. Evil manipulates his patients for control, power, or financial gain using techniques such as institutionalization, heavy medication, and hypnosis. In turn, Dr. Evil's patients are dangerous and unpredictable—the psycho killer/maniac stereotype.

Clearly, movie psychiatry has projected a distorted view of not only the psychiatric profession, but also patients with mental illness. This view has shaped public opinion and reinforced the common stigmas associated with these conditions today.

TYPOLOGY OF STIGMA

Hayward and Bright[6] determined 4 themes of stigma in their review and critique of the published medical literature. Their research showed that dangerousness, attribution of responsibility, poor prognosis, and disruption of social interaction were commonly attributed public attitudes toward individuals with mental illness. The concept of "dangerousness" surmises that stigma arises from fear and the widespread perception of the mentally ill as violent. Current mental health legislation, such as the U.K.'s Reform of the Mental Health Act 1983, may even perpetuate these fears.[7] The objective of the reformed Act to offer the public "better protection from dangerous severely personality disordered people" can only fuel the fear and apprehension directed toward sufferers of this mental illness.[7] The concepts of "attribution of responsibility" and "poor prognosis" are based on the notion that mental illness is self-inflicted and untreatable. Notably, studies have shown that medicalization of mental illness is associated with more favorable opinion than psychiatric labeling.[8] Indeed, psychiatric labels are widely believed to be associated with poorer outcome and more unpredictable behavior.[8] Finally, "disruption of social interaction" describes the common preconception that it is difficult to communicate with individuals with mental illness, and the associated discomfort arising from this situation.

PREVALENCE OF STIGMA IN MENTAL ILLNESS

The 4 underlying themes of stigma identified by Hayward and Bright[6] formed the basis of a public opinion survey conducted by the Office of National Statistics in the United Kingdom and Republic of Ireland.[9] A representative sample of 1790 adults were interviewed about the subjects' perceptions of 7 different mental disorders (severe depression, panic attacks, schizophrenia, dementia, eating disorders, alcoholism, and drug addiction). Subjects were asked to rate their opinions of 8 topics according to a 5-point severity scale for each disorder. Topics included danger to others, unpredictable, hard to talk to, feel different, selves to blame, not improved if treated, and never recover.

Negative opinions of mental illness and stigmatization were prevalent (Table 1)[9]; however, perceptions varied according to different mental disorders, revealing an interesting prejudice profile. Schizophrenia and addictions (both alcoholism and drug addiction) were regarded most negatively, with 65% to 78% of study participants perceiving affected individuals to be dangerous or unpredictable. Approximately 60% of respondents thought that individuals with addictions only had themselves to blame for their condition; however, this opinion was not shared for schizophrenia, depression, or panic attacks. Similarly, patients with depression or panic attacks were not generally viewed as a danger to others and were considered to be less unpredictable than those with schizophrenia.

The findings of the public opinion survey are somewhat encouraging, despite the prevalence of negative opinion. The majority of individuals interviewed recognized that differences exist between mental illnesses like schizophrenia and depression or anxiety. It was also widely

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Table 1. Attitudes Toward Mental Illness by Type of Illness: Proportion (%) of Respondents (N = 1737) With Negative Opinions[a]

Attitude	Type of Mental Illness: Severe Depression	Panic Attacks	Schizophrenia	Dementia	Eating Disorders	Alcoholism	Drug Addiction
Danger to others	22.9	25.7	71.3	18.6	6.7	65.2	73.9
Unpredictable	56.4	50.2	77.3	52.9	28.9	70.8	77.8
Hard to talk to	62.1	32.6	58.4	59.9	38.2	58.8	65.3
Feel different	42.6	39.2	57.9	60.6	48.9	35.1	47.7
Selves to blame	12.8	11.4	7.6	4.0	34.5	59.6	67.6
Pull selves together	18.6	22.3	8.1	4.2	38.1	52.4	46.9
Not improved if treated	16.0	13.6	15.2	56.4	9.4	11.0	11.8
Never recover	23.2	21.9	50.8	82.5	11.3	24.3	23.2

[a]Reprinted with permission from Crisp et al.[9]

recognized that depression and anxiety could improve if treated appropriately. Stigmatization was, therefore, not only associated with a lack of knowledge.

EFFECT OF STIGMA IN MENTAL ILLNESS

As a society, we are now more aware than we have ever been of the prevalence of mental illnesses such as depression and anxiety, the impact of these conditions on the individual, and the availability of effective treatment options. Nevertheless, the European Study of the Epidemiology of Mental Disorders (ESEMeD)—a recent cross-sectional population survey conducted in more than 21,400 individuals in 6 European countries—reported low rates of help-seeking and high rates of undertreatment among individuals with mental illness.[10,11] The project found that, each year, only 1 in 4 individuals (25.7%) with a mental disorder consults health care services because of his or her condition, despite significant associated morbidity.[12] Worryingly, the project also revealed that 21% of those presenting to health care services because of mental illness did not receive any form of treatment.[10] Furthermore, only 21% of patients who were actually diagnosed with depression each year were prescribed antidepressants.[11]

The stigmatization of mental illness affects health care utilization and treatment rates, exerting its effects at every level in the management process from presentation and diagnosis to treatment outcome, and affects patients, physicians, and caregivers. Indeed, stigma can affect the decision that mental illness exists at all and is a major factor confounding willingness to consult. The actual threshold for presentation will often depend on how an individual responds to his or her illness. For example, the point at which day-to-day stress becomes neurosis differs for each individual according to his or her own levels of stigmatization and self-denigration. His or her susceptibility to the influence of the "pull yourself together" mentality is key.

Even at consultation, the stigmatization surrounding mental illness can make discussion of emotional or psychological symptoms uncomfortable. Indeed, both physicians and their patients are affected by the stigma of mental illness. A patient's shame in admitting to mental illness and a physician's reluctance to inquire about it can potentially result in a double barrier. For individuals who have difficulty verbalizing emotional symptoms because of the fear of the stigma attached to them, the physician's response is a critical determinant in whether or not these problems are disclosed. A general practice survey of 83 patients with high scores on the General Health Questionnaire found that 64 patients did not mention their emotional problems to their physician.[13] When questioned, 45% revealed that they felt too embarrassed or did not want to trouble the physician, while 19% had been put off by the physician's behavior/body language or felt that the physician did not have enough time. In primary care, where consultation times are frequently short, this apprehension of patients can result in emotional problems not being discussed, which in turn can lead to misdiagnosis and undertreatment.

COUNTERACTING STIGMA IN MENTAL ILLNESS

Efforts to counter stigma in mental illness are faced with the challenge of overcoming centuries of prejudice. In 1997, the National Association for Mental Health (Mind) published the findings of a survey of "not in my back yard" (nimby) opposition to community mental health facilities, experienced by key service providers in England and Wales.[14] The results of the survey were published as part of the charity's campaign, Respect: Time to End Discrimination on Mental Health Grounds. More than two thirds of respondents had encountered opposition to mental health facilities over a period of 5 years. Fear—predominantly for children's safety, violence, or falling house prices—was the root cause of the opposition. Notably, the media was consistently cited as the principle source for these concerns.

On the basis of their findings, Mind proposed a series of recommendations to reduce discrimination aimed at various target groups, including the sufferers themselves, mental health care planners and providers, and the media.

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Mind's recommendations parallel 3 themes of stigma intervention that were proposed by Smith[4]: a human rights–based approach centering on use of the law to prevent discrimination, a normalizing approach that stresses the frequency of mental illness in society, and an educational approach that relies on balanced coverage by the media to shape social attitudes.[4]

Protest: Challenging Discrimination

The human rights–based approach to the destigmatization of mental illness relies on protest to counter discrimination.[4] Even the word *stigma* could be construed as stigmatizing in this context. The approach strives to achieve equal opportunities for individuals with mental illness in terms of practical outcomes (i.e., access to adequate health care, housing, employment, and legal protection) through the enforcement of rights. Similar approaches have been employed to counter discrimination based on gender, race, sexual orientation, or disability. The approach is underpinned by moral authority and need not depend on sympathy or understanding. It stresses the "right to be different," with no need for persuasion or concealment; thus, it is not necessary for there to be a change in public attitudes.

Scottish mental health law is moving in the direction of a human rights–based approach. The Mental Health (Care and Treatment) (Scotland) Act, which was passed by the Scottish Parliament in March 2003, strengthens the rights of individuals with mental illness to receive appropriate care and treatment, based on the principle of least restrictive intervention.[15] The legislation also strengthens the provisions for the Mental Welfare Commission to ensure that people with mental illness and learning disabilities are properly protected and have a right of access to independent advocacy. Notably, the Bill was amended to include a new appeal right against excessive security to ensure that "entrapped" patients can move on to a setting suitable to their needs.[15] The legislation is supported by the anti-stigma campaign *see me*.

Contact: Normalization

The Royal College of Psychiatrists' anti-stigma campaign, Changing Minds, epitomized a normalization approach to destigmatization, stressing the ubiquity of mental illness through initiatives that included the *1 in 4* short cinema film and the *Every Family in the Land* book (available online at www.stigma.org/everyfamily).[16] This type of approach aims to increase public sympathy and understanding, building a more tolerant society through slogans that insist that mental illness affects us all and mental illness is just like any other illness. In contrast to the protest-based approach to destigmatization, this effort promotes contact and acceptance, rather than equal rights.[4]

One of the risks associated with the normalization approach is the trivialization or medicalization of mental illness. In reality, acute mental illness cannot be normalized; some patients may have severe cognitive impairment, and others may require special support during specific periods. Promoting these conditions as normal is not a true reflection of the actual situation or the needs of affected individuals.[4] While normalization is certainly a means of creating understanding—particularly for depression and anxiety disorders—there is a need to address differences between mental illnesses, and to further acceptance of these differences.

Education: The Role of the Media

The concept of public education to reduce stigma in mental illness is not simple. Perceptions of mental illnesses have shifted many times over the past 50,000 years according to culture and context.[1,4] In addition, 3 in 4 people will never suffer from a mental illness at any point in their lives. For these individuals, the media is their prime source of information about mental illness.

Despite much media interest in mental illness, its potential to educate the public about mental illness and promote destigmatization is largely wasted, and the media's representation of mental illness is overwhelmingly negative. The underlying reason for this is obvious: scare stories and horror stories make compelling television and news articles. Indeed, the media cannot be expected to act as educators to counter stigma unless the story itself is newsworthy.[4] Therefore, in order to address stigma in mental illness through the media, it is necessary to understand what makes a good story and what the media's agenda is.

What makes a newsworthy story? The media's primary aim is to sell newspapers or increase viewing figures. As such, a newsworthy story needs to contain a striking headline, a powerful introduction, and a good story. Stories are often biased toward the adverse; credibility, accuracy, and human interest may not suffice. It is useful to remember that stories are subject to intense competition for placement. Several factors will determine whether they are included at all: timing—is it new? significance—are many people affected? proximity—can the audience identify with the story? prominence—does it affect someone famous?

In general, stories relating to mental illness can be categorized into 5 types according to their focus: cure stories, scare stories, stories about money, human-interest stories, and stories about ethical/profit-related issues (Table 2). Human-interest stories, in particular, appeal to an audience's emotions. They aim to evoke a response, such as amusement or sadness; in this context, science cannot compete.

Television is capable of reaching a large and diverse audience. Importantly, different programs and the timing of their broadcast enable distinct audiences to be reached. Television is, therefore, a vital tool in any anti-stigma

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Table 2. Five Types of Stories About Mental Illness Commonly Portrayed in the Media

Story Type	Example Headline
Cure stories	"Magic Bullet for Depression"
Scare stories	"Killer Drug"
Money stories	"New Drug Will Bankrupt Health Service"
Human interest	"My Struggle With the Side Effects of Antidepressants"
Ethics/profit	"Pharmaceutical Firms Conspire to Delay Release of Generic Drug"

campaign. However, a stark comparison exists between the subtlety of meaning that is innate to psychiatry and the bluntness of television. Vivid imagery will always have a role in this media format, and stereotypes are used extensively.

Using the media to destigmatize mental illness. The media is an immensely powerful machine. In order for it to change opinions toward the mentally ill, it needs to be used in all its forms (i.e., newspapers, television, magazines, cinema, giveaways, etc.). The key is to concentrate on the media's agenda by creating good human-interest stories with powerful images and striking headlines. These kinds of stories can easily create positive opinion if successful outcomes are stressed.

If media campaigns to reduce stigma in mental illness are to work, they must be long-term. Different sections of the public must be targeted—not just physicians or individuals with disease. A local focus is essential, and young people are particularly important; by the age of 12 years, an individual has generally formulated most of his or her opinions.

The secret to changing attitudes toward mental illness is to harness the power of stigma itself. Stereotypes of the mentally ill are deep seated and unlikely to be overcome quickly; therefore, they should be enriched rather than challenged. Highlighting successful outcomes within stereotypes is key, and using well-known individuals is one approach that can achieve this through the media. Indeed, a dramatic change in attitude toward acquired immunodeficiency syndrome (AIDS) patients was observed when Diana, Princess of Wales, was pictured shaking hands with AIDS patients during the late 1980s.

CONCLUSIONS

Stigma remains highly prevalent in mental illness, affecting patients, physicians, and caregivers. Although a change in attitudes toward some mental disorders, such as depression and anxiety, has recently been observed, individuals with mental disorders are still widely regarded as dangerous and unpredictable. Stereotyping and humor directed at the mentally ill are merely manifestations of a more serious undercurrent of fear. The result is discrimination.

The stigma surrounding mental illness is not simply a product of ignorance. It has evolved from thousands of years of folklore and prejudice and is now deeply rooted in society. Negative imagery and stereotypes of the mentally ill are constantly reinforced by the media in its quest for an emotive story that will "sell." The results for the patient with mental illness are shame and self-blame, which lead to secrecy and isolation, and eventually social exclusion. Indeed, stigma is known to be a major determining factor in unwillingness to consult, contributing to the low rates of help-seeking seen among patients with mental illness.

Numerous regular, sustained campaigns are required to work around stigma in mental illness, rather than trying to overcome it. The power of all aspects of the media will be essential in achieving this. Highlighting successful outcomes within mental health stories is vital to begin changing attitudes toward mental illness.

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