

Where has all the stigma gone?

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There has been a dramatic increase in recent years in the number of people diagnosed with mental disorder. For example, in USA the NIMH estimates that, in any given year, 25% of the population has a diagnosable mental disorder. A prospective study found that, by age 32yrs, 50% of the general population had qualified for an anxiety disorder, 40% for depression and 30% for alcohol abuse or dependence. Fifty-one percent of boys and 49% of girls aged 13-19 have a mood, behaviour anxiety or substance abuse disorder. The World Health Organisation projects that by 2020 depression will be the second leading cause of worldwide disability. In South Africa psychiatric disorder has already knocked backache of its perch at the top of the disability log.

It is of course possible that brain dysfunction has become more common. However, a few voices have dared to question the actual figures and even, heretically, the methodologies and tools of the epidemiological surveys from which they are derived.

Other, persuasive possible reasons for the reported increases in psychiatric illness have been suggested. Here are a few:

- a. The boundaries of normality are shrinking and are very porous. Widespread traits, feelings and behaviours, which were previously regarded as well within a normal spectrum of the rich tapestry of life, or as normal reactions to life experiences and situations, now fulfill the criteria for psychiatric disorder in current psychiatric nosologies. This may become even more problematic under the influence of the emergent DSM V.
- b. Massive propaganda exercises have encouraged everyone to identify patients, work colleagues, friends and family members who may have unrecognised psychiatric disorder and need help. Undoubtedly many previously unrecognised patients have benefited from treatment in this new therapeutic atmosphere. Twenty-five years ago I was interrupted during a lecture to a group of non-psychiatric doctors. A surgeon, a gynaecologist and a general practitioner sitting together felt that they had to share aggressively with the audience that in all their years of practice they had never seen a case of this thing called "Depression". They were suspicious of the psychiatric

message of the time. This could never happen now, which is good.

- c. There has been an extraordinary increase in prescriptions for psychotropic drugs. The role of the main beneficiaries, the pharmaceutical industry, and its motives, in persuading us to participate in the expansion of diagnoses and prescribing has been questioned. Some of the heretics have dared to suggest that Disease Awareness Campaigns are not always good.
- d. The industry, which also invests in and sponsors patient and family support groups, has been accused of manipulating them towards its own ends. Naturally, the emphasis is on increasing the sales of psychotropic medication. This may not be all good. In the background barely camouflaged advertising direct to patients has crept in, which certainly is not good.
- e. Meanwhile, non-psychiatric mental health colleagues as well as armies of lay or semi-lay counsellors, therapists and motivationalists militantly, in many cases evangelically, trawl and scour the community for customers for their services. The heretics wonder if all the offered treatments are really effective. Could it be that some individuals would be better off if they remained under the radar of those who would turn them into clients? Could it be that this vast energy source could be mobilised and directed into more conventional, and perhaps less potentially iatrogenic, psychiatric territories where the need is great?
- f. And, like a great unseen miasma enveloping us all is the Internet. The jury is out on whether or not it is good. But in reality we all know that undesirable elements can mobilise the wondrous facilities accessible on line, and they can increase their efficiency and impact in the same way as we, the good guys, try to do.

These issues do generate debate, although it is mindboggling how many psychiatrists apparently do not want to participate in that debate or, sadly, do not even know that it is taking place.

But there is one aspect which deserves urgent attention. As part of the above mental health scenario, and perhaps even because of it, increasing numbers of patients welcome their new psychiatric disorder labels, go out of their way to obtain them, and bask in the secondary gain which, in many circumstances, being labelled as a psychiatric patient can bestow.

Hold on a minute you say. Surely the stigma attached to mental illness makes that scenario impossible. Yes, we have

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all spoken against stigma and most of us have worn the twists of coloured ribbons on various mental disorder days. But, sadly, the strategies we have employed to persuade people that DSM derived mental illness is just like any other illness, merely a chemical imbalance of the brain, and probably genetic, and not something a patient can be expected to cope with or even survive without treatment, have to a remarkable extent been incorporated uncritically into modern thinking.

Too many people appear to think that the plethora of psychiatric rating scales already places psychiatry at the cutting edge of science. For example, I am led to understand that, in the right hands, the Bipolar Spectrum Diagnostic Scale is like a finely tuned Stradivarius unerringly plucking "Bipolar Affective Disorder" from the ambient noise of comorbid irritability, aggression, narcissism, victimhood, grief, dissatisfaction and a host of negative counter-transference producing symptoms. In the wrong hands though, it is perhaps less of a boon to modern psychiatry. In real life of course, we increasingly encounter patients bringing readily available rating scales with them, already ticked off, perhaps to save precious consultation time. Such is the desire to have a psychiatric disorder label in a sizeable group of individuals.

Not surprisingly if you think about it, there is a group of people, not the intended targets of the propaganda, for whom the secondary gain of being labelled as suffering from a psychiatric disorder is as manna from heaven. Obviously there are cases of frank malingering, particularly when financial gain or mitigation of sentence is at stake, as there are in other disciplines. But most of the claimants are genuinely persuaded (dare we say subconsciously?) into a disability mindset when the psychiatrist pronounces that all the noxiousness of the workplace, as well as previous failed expectations and messed up relationships, anger and hours when mood was low, were in fact due to an identifiable psychiatric illness and the associated disequilibrium of brain chemicals. Sadly, nowadays, this major social problem is

compounded by the interventions of a myriad of alternative psychiatric diagnosis allocaters and rating scale aficionados such as general practitioners, psychologists, occupational therapists, counsellors and women's magazines. In this group of patients, traditional healers would do less harm with their more reality based stories of bewitching and troubled ancestors.

Post traumatic Stress Disorder and Treatment Resistant Depression (aka Bipolar Disorder Type II) have become commonly sought after diagnoses in more sophisticated patients and those who treat them. But "Stress" (reportedly the number one diagnosis on sick notes in UK) and "Burnout" (a local favourite) are useful standbys. A limited range of diagnoses which qualify for secondary gains is often specified on one or other administrative list. Increasingly, what seems to be in a patient's short term financial interests determines the selection of the diagnosis rather than the phenomenology of the presenting condition.

Meanwhile, powerful lobbies are motivating for "sub-syndromal" mood and anxiety disorders to be recognised as major causes of lost working days. This, in itself should be a clarion call for an urgent review of the societal implications of psychiatric labelling. Already pension fund administrators and insurance agencies are wrestling with the actuarial challenges in attempting to underwrite what seems to be in danger of becoming universal illness.

It would be unthinkable to suggest that we need to bring back stigma to deal with these problems. But, surely then we must avoid colluding in practices which contribute to a significant and increasing minority of patients almost proudly wearing their labels of often spurious psychiatric disorder.

Psychiatric illness may elicit new forms of stigma. These practices may have more influence than well intentioned curls of ribbon in places that matter.

References are available from the author.

INSTRUCTIONS FOR AUTHORS

African Journal of Psychiatry (AJP)

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