

‘Like a friend going round’: reducing the stigma attached to mental healthcare in rural communities

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Abstract

Traditionally, stigma is seen as something that is the fault of the mental health system, and that involves an individual suffering social disapprobation and reduced life chances as a result of having been given a diagnostic label and an identity as a patient as a result of their contact with psychiatric institutions. The present study, based on focus group discussions conducted with users and mental healthcare workers in a rural setting, suggests that this classic conception of stigma does not readily apply to care in the community. First, workers described themselves as actively trying to challenge stigma at an institutional level, as well as being apt to change their own practice to reduce the stigmatizing effect of mental healthcare on their clients and make their presence less conspicuous. The ideal was to be ‘like a friend going round’. However, this view included a somewhat passive notion of clients. By contrast, the present investigation showed that clients described themselves in much more active terms as being aware of possible sources of stigma and being inclined to challenge negative attitudes themselves. Future mental healthcare practice could draw upon professionals’ stock of knowledge as to how their practice could lead to less stigma and could build upon clients’ own strengths to achieve stigma reduction.

Keywords: clients and patients, focus groups, mental health, stigma, users

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Introduction

The present paper describes an investigation into the concept of stigma as it applies to the care of clients with mental health problems living in rural areas in the UK. The idea that stigma might be experienced by the clients of mental health systems was first formulated 40 years ago, when a far greater proportion of mental healthcare was undertaken in hospital settings. It is the present authors’ intention to describe here how the meaning of the concept has come to be reformulated in a contemporary community setting. As a result of the movement toward care in the community, sufferers of severe and enduring mental health difficulties, who were once institutionalized for periods of years, have increasingly been released into the community. Moreover, newly

identified clients are being hospitalized for brief periods of time and shortly released (Herman 1993, Edwards 2000). Thus, as the nature of mental healthcare has changed, so too might the experience of stigma. Therefore, the present paper maps out some of the contours of how the phenomenon of stigma has been formulated classically, and shows how it has undergone some dramatic changes as the locus of care has shifted from the clinic to the community.

The concept of stigma: classic formulations

Within the social sciences, and in the literature on mental health, the issue of stigma has taken its cue from Erving Goffman’s (1967) classic formulation. This relies on two constructs. First, the actor – in the present case

someone who might have a mental health problem – and second, an audience – usually the rest of society, personified in the form of neighbours, employers, family members, significant or powerful individuals, institutions, and so forth. The question of stigma arises when a person's actual social identity falls short of some societally defined ideal identity. This may occur if a person's health, ability or status is not what would normally be expected in that role; for example, when it is discovered that a police officer has prior criminal convictions, a doctor is a drug user or a priest has an unprofessional relationship with a choirboy. Anyone who suffers from a 'gap' between their actual and ideal identities is a potential candidate for stigma. The widely noted negative connotations of 'mental illness' mean that those who are distressed or have engaged with mental health services are likely to suffer stigma if their status is disclosed to others in their community. Because mental health difficulties are often not obvious to the casual observer, the sufferer may be very wary of anything that might give away or 'leak' their status. Moreover, when their status is made obvious to their neighbours or employers, perhaps as a result of a crisis, they subsequently face the task of managing the tension produced by the fact that the audience knows of the problem.

From the 1960s, when attention was initially drawn to the negative effects of having a 'psychiatric patient' identity (Goffman 1961, Scheff 1966) to the present, there have been a number of attempts to explore what stigma means for psychiatric service users and survivors. From an early stage in this body of work, it was noted that seeing a psychiatrist himself could be stigmatizing (Bar-Levav 1976). Over the past 40 years, a whole raft of findings has accumulated which emphasize the difficulties faced by current or former clients. For example, researchers have addressed public attitudes toward the mentally ill (Whatley 1959, D'Arcy & Brockman 1961, Nunnally 1961, Farina & Ring 1965, Lamy 1966, Bord 1970, Trute & Loewen 1978, Taylor *et al.* 1979, Cochrane & Nieradzick 1985), as well as the role that the media play in informing the negative public attitudes which are sometimes disclosed (Philo 1996). In addition, scholars have tried to discern correlates of societal acceptance or rejection of ex-psychiatric patients (Rabinowitz 1982), and family acceptance or stigmatization of former mental patients (Kreisman & Joy 1974, Doll *et al.* 1976, Clausen 1981). Stigma is also noted to affect the relatives of former patients (Freeman & Simmons 1961, Segal *et al.* 1980), the client's access to housing (Goldmeir *et al.* 1977), and her or his employment (Miller & Dawson 1965, Webber & Orcutt 1982).

Overwhelmingly, the notion of stigma in the above work was as something that was attached to clients by the mental health system itself. The system was seen as

being concerned with containment, control, medication or therapy, and its unfortunate clients suffered stigma as a result of their often compulsory engagement with it. Survivors such as Chamberlin (1994) or radical mental health practitioners such as Burstow (1992) have been at pains to emphasize this: practitioners 'give us drugs that make us look like mental patients' (Chamberlin 1994). To simplify the view of radical critics, stigma is imposed on reluctant clients by the system and by practitioners. It is then something that clients struggle to dispel or challenge, if they are sufficiently able (Herman 1993, Herman & Musolf 1998).

Whereas there have been many calls for the public to be enlightened about the nature of mental health problems in an attempt to reduce stigma, it is clear that the obstacles faced by those with a history of engagement with mental health services may be formidable (Barry *et al.* 2000).

To explore the meaning of stigma within the circumstances of everyday interaction in communities and workplaces, let us elaborate a little more of Goffman's (1967) account of face-to-face interaction. He argued that ritual actions in everyday life centre on protecting 'face', or 'territories of the self', expanding the ethnologists' concept of territory to include 'areas' of visual, verbal and informational privacy (Roth 1995, p. 317). In Goffman's (1967, p. 19) words, 'one's face is a sacred thing, and the expressive order required to sustain it is therefore a ritual one'. The self is 'a ritually delicate object' (p. 31). 'When a face has been threatened, face-work must be done' (p. 27). Therefore, by extending this to the situation of mental health clients, we can imagine that they would be very keen to protect 'face' in the light of the negative view of 'mental illness' which prevails in many sections of society. This protection of face may involve trying to conceal one's status as a 'patient' or, if the status has been disclosed, managing the possible negative reactions of the rest of the community and minimizing their impact on one's well-being. This protection of face may take up a great deal of energy or personal resources. Classically, the literature on stigma in mental health has seen this to be a solitary effort on behalf of the clients themselves and researchers have not generally explored the possibility that the management of stigma might be undertaken jointly; certainly, the role of health professionals as helpers in the client's struggle against stigma has scarcely been touched upon.

The transition from care in hospitals to care in the community has led to a paradigm shift (Edwards 2000) in the way in which many workers see their clients. An increasing emphasis in policy and training of professionals has encouraged a view of clients as people whose views matter and has stressed the desirability of

including clients as active participants in their own care (Audit Commission 1994, Edwards 2000). In addition, the importance of taking clients' views seriously has been forced on the mental health professions because, rather than having a captive audience in hospitals, they must perforce make needy clients wish to use the services. They are, like Arthur Miller's tragic hero in *Death of a Salesman*, 'Way out there in the blue riding nothing but a smile and a shoeshine.' The relocation of care to the community has fostered a collaborative ethos amongst mental health workers so that they increasingly rely on the interpersonal rapport that they are able to foster with clients.

This has implications for how the process of stigma may operate in practice. In as much as professionals enter into clients' subjective worlds, they will have to confront the everyday problems with living which clients face. Mental healthcare, as Wainer & Chesters (2000, p. 141) remind us, is increasingly seen as involving helping clients to have enough money to live on, to have a home, a job, relationships and friends, and to be free from violence and stigma.

There are a number of issues unique to the provision of mental health services in rural areas. According to Roberts *et al.* (1999), there are particular challenges in preserving patient confidentiality, and boundaries between caregivers, patients and families may be significantly different from those that one might find in an urban setting. Rural areas are believed to be particularly prone to yield stigma for mental health service clients (Buckwalter *et al.* 1993, Rathbone-McCuan 1994, Hoyt *et al.* 1997, Fuller *et al.* 2000). On the other hand, some authors have highlighted how communities in rural areas may be particularly tolerant of deviance (Sommers 1989), especially when the individual's dwelling is extremely remote (Fuller *et al.* 2000).

Thus, as care has shifted in location and emphasis, it is particularly timely to investigate the concept of stigma as it applies to mental health service delivery in the community, to see how the concept and experience may have changed as a result of changes in the location of care, the changes in professionals' orientation, and a growing awareness that the social circumstances in which clients live have a bearing on how they fare in a sometimes hostile community.

Subjects and methods

The present research formed part of an exploratory, qualitative study to investigate that nature of provision of mental health services in a rural area in the north Midlands in the UK, comprising mixed arable and live-stock farmland, villages and market towns, as well as areas which bordered on large conurbations.

Participants

The data presented below were yielded from eight focus group discussions involving a total of 33 mental health personnel from statutory and non-statutory services, and 15 users of mental health services and supports.

Following ethical approval for the project, the recruitment of suitable participants was approached in different ways depending on whether they were users or professionals. Once the sampling area had been identified, the user participants were first contacted by their responsible medical officer or keyworker, who sought initial confirmation of their willingness to participate. Whereas potential participants might have suspicions of a study that appeared to be initiated by the service providers, it was felt that an approach from a health professional with whom they had a good working relationship might be more productive than 'cold calling'. It would also help to establish the sense that they were in control of the research process by asking them at the outset rather than their receiving an unexpected phone call or visit from a stranger. Once the idea had been suggested, those interested in participating were invited to attend the focus groups and subsequent interviews by means of a letter outlining the rationale for the project and also explaining their rights in relation to participation.

In line with the policies of the local research ethics committee who scrutinized the work, and to facilitate candour, participants were assured of anonymity and confidentiality, and transcription was undertaken so as to prevent any participant from being identified. Following transcription, the audio-tapes were destroyed. Participants in interviews were given the choice of having their views recorded by either the means of audio-tape or an independent observer. Professionals and representatives from voluntary agencies who had worked with the identified group of users were contacted initially via their line manager or senior management. If they agreed to participate, they were sent a letter outlining the rationale of the study and their rights regarding participation. The group of workers contained psychologists, community mental health nurses, volunteers, psychiatrists, social workers and employees of charity and service organizations. In the present report, these participants will be referred to as 'professionals', even though not all of them were in paid posts.

Focus group strategy

The focus groups took place in a variety of settings depending on whereabouts in the catchment area participants originated. Efforts were made to select times and locations which were convenient for participants.

Settings included offices belonging to health trusts, drop-in centres and mental health charities. The arrangement of the rooms and the atmosphere were deliberately kept informal, refreshments were served, and wide-ranging discussion, informal interaction and exploration of issues was encouraged.

The composition of the groups varied. Two out of the eight groups exclusively contained users, and a further group contained predominantly users with a social work assistant and community mental health nurse. Two of the users in these groups had coordinating roles in a mental health charity. A further group consisted of an equal number of users and workers, including a rural mental health coordinator, a community mental health nurse and a support worker. Four groups exclusively contained professionals, including: a group of assertive outreach workers consisting of three occupational therapists and a clinical psychologist; a group from a multidisciplinary team including psychiatrists, community mental health nurses, a psychologist, a support worker and a student; a further group from a different multidisciplinary team consisting of social workers and a rural mental health coordinator; and finally, a group of professionals working at a unit offering day centre activities and outpatient services to a rural clientele.

Whereas the presence of users and professionals in the same discussion groups could be argued to reduce candour on the part of the users, the researchers' impression was that, perhaps because the professionals involved were not intimidating and were predominantly nurses and support workers, the users were well able to express criticisms of the way they were treated, despite the presence of workers in the group. In addition, because two of the users also had experience as voluntary workers, the sharp distinction which is sometimes observed between staff and 'patients' in mental healthcare was not apparent in this case. Indeed, with the well-established pattern of interdisciplinary working in this area, it was not always immediately apparent what professional group the worker participants represented.

With people who use or have used mental health services, the questions for the focus group sought to empower them as advice-givers in the following way:

- How would they go about advising someone who, for example, had started hearing voices and was becoming distressed?
- What services would they suggest that the person should use?
- What would be the likely obstacles or barriers which could prevent such a person getting the help that they need?

- What would the ideal services and support for that person look like?

With the professionals and representatives of voluntary agencies, the focus group addressed the following:

- How do they contribute to the pathway into services for people with severe and enduring mental illness in rural settings?
- What are the barriers or 'gaps' in service provision which prevent such people from accessing services?
- What other influences or problems affect either client-to-service or service-to-client access?

The precise order of the discussions was deliberately kept informal so as to allow opportunities to follow issues raised by participants and to facilitate the production of longer, anecdotal narratives if the participants so wished. The audio-taped discussions were transcribed and checked for accuracy by two researchers.

Analysis and interpretation

For the purpose of the present paper, the transcripts of both the users' and professionals' discussions were read by the researchers for mentions of stigma, as well as being electronically searched using this term and other related terms which the researchers felt were cognate, such as prejudice, attitudes, friends and neighbours. This yielded a sub-corpus of material relating to stigma that was then further categorized in terms of whether it was a description of the problem, or a strategy for reduction or resistance, which forms the basis for the presentation of the data in the 'Results' section below. The latter two themes, i.e. stigma reduction and resistance, were allowed to emerge from the data in a bottom-up manner, similar to that advocated in B. G. Glaser and A. Strauss' 'grounded theory' approach to qualitative material (Glaser & Strauss 1967, Strauss & Corbin 1998).

Validity and reliability was further advanced by interdisciplinary triangulation (Denzin & Lincoln 1994), so that researchers' local knowledge, remarks made before and after the formal recordings were made, and convergence between the accounts presented by different participants in different discussions were all taken as further checks on the integrity of the data set.

Results

The results are presented under several sub-headings corresponding to different aspects of the phenomenon of stigma which were identified by the participants. For ease of exposition, the present authors deal with the narrative of stigma produced by the clients and workers in a sequence which moves from initial definitions of

the problem, through to cautionary tales of how it might be inadvertently increased by the mental healthcare workforce, and finally, to strategies for minimization and challenge.

Defining the problem

First, it is a testament to the pervasiveness of social science knowledge in popular discourse that the notions of stigma and labelling – once esoteric ideas of interest only to sociologists – were present in the discussion generated by both worker and user groups. Characterizations of the ‘problem’ appeared in the following terms:

If you can imagine to the younger male generation, that’s within your age range and from what I hear from the town that I live in, they’re more than willing to label someone – a friend as well – ‘slightly not in’. It’s actually the thing to be, from the aspect of the young male generation that is coming through. That’s what I have just heard. (User, p. 72)

When I became ill, really ill about 20 years ago, everybody scattered. I was living in the country, and had a flat in town. My employer ... ran a mile as well, everybody just scattered, everyone runs away, my family, everybody. People in the village and the town, I didn’t detect any real difference ... (User, p. 72)

Users’ experiences were sometimes of a self-imposed isolation because of fear of stigma. It sometimes was seen as an issue demanding considerable resources to overcome:

... [I]n the club where I’ve been a regular member I’m a bit wary of going in there, if they treat me any different I don’t know. But I’m going to find the courage to go. (User, p. 52)

Amongst the participants with a background in the professional or voluntary sector, the question of stigma was one which was seen as involving special difficulties for the potential service user in rural areas:

And a lot of the times it can lead to the actual person accessing services at crisis point rather than earlier because they’ll try and cope with it or family will be so frightened of the consequences of releasing this information, asking for help, that they’ll let it go on and on and on. There was a difficult case in [village name] where the young lad wasn’t well went on and on, and there was a drug habit involved, but it led to psychosis anyway and, but it went on and on and on till crisis were called and suddenly there was this massive influx of professionals coming in, so they stuck out like a sore thumb anyway. But that was, when speaking to them, that was the sheer fear factor of releasing that information. And also the lack of support from the GP [general practitioner] in recognizing that there was possibly a mental health problem other than the obvious drug issue at that moment in time. (Professional, p. 42)

This quote encapsulates a number of themes in the stories of stigma elicited during the investigation. First, there is something specific about rural communities which means – in the view of participants – problems being hidden because of the fear of what will happen. The second theme, which will be seen again in these results, is one of denouement, where the crisis becomes so acute that the problem is obvious to the entire neighbourhood. The third theme is that there are other bodies and individuals in positions of authority which the speaker feels could be doing more. In particular, workers in the area were apt to single out GPs as one source of obstacles to vulnerable individuals receiving services:

We do not do an awful lot out there to publicize it and again it is the stigma when you are looking at the rural villages, the GP surgeries, there’s still sort of a lot of stigma about mental health. So they don’t make the referrals at the appropriate time so we tend to get them a crisis point, which can be disastrous, you know. People have already have a negative opinion of different professions, because you talk about sectioning people and taking all their liberty away, and it is really negative. You can really struggle to get through to the GPs as well. If you try and sort of say, you know, I want to come and see you, and they say we don’t have mental health problems here at all, which isn’t true, because I am already seeing five people from your village, so you have. But it’s like completely over their heads. (Professional, p. 37)

In the UK, research on treatment for mental health difficulties shows that the overwhelming majority of this is performed by GPs (Freeling *et al.* 1985, Freeling 1990, Kendrick *et al.* 1991, Tylee 1999). Currently, over 90% of such clients are managed in primary care and it is likely that more services will be provided in primary care settings in the future (Jenkins *et al.* 1992). Furthermore, the above authors argued that services provided via primary care would be preferred by clients and their families because they allow easy access to services, facilitate early diagnosis of problems, and prompt interventions in a person-centred, non-stigmatizing environment.

Despite this idealized picture of GP’s surgeries as places of psychic repair for clients, it is equally clear that not all practitioners wish to provide mental healthcare at their surgeries (Hausman & Le Grand 1999). Indeed, GPs may not recognize mental distress in their clients (Shepherd *et al.* 1966, Arve *et al.* 1999). This is partly because of a lack of education on the part of GPs (King *et al.* 1994, Gask 1999) and the fact that they have a ‘low therapeutic commitment’ to these clients (Cartwright 1980). Thus, the present informants’ observations chime in very well with the rather pessimistic picture painted by a good deal of the research literature.

In addition to GPs, further obstacles were seen to be placed in the way of providing effective services by

other bodies who might be involved in providing venues, facilities or other support. These bodies (e.g. parish councils and churches) were sometimes described as reluctant or obstructive:

P1: It is only, like, when you look, for example, the [name of village] group, and the location, we have the group there, the amount of problems we had initially like you know, 'What do you mean there will be people with mental health problems coming in here, we do not want people with schizophrenia coming in here, they are not from here, there's kids around.' There was a lot of stigma and anger that we dare to make it sort of more public and actually have this group in a public place.

P2: They even went down the line of once they had tried that and tried to stop it that way and failed, they then tried to put more barriers in front, like you cannot eat here, you cannot make drinks here. Which you could before. Health and Safety say this and Health and Safety say that. So we would continually, instead of being supported, we would be continually narked and we were continually having to challenge the boundaries.

I: Can you give me any ways how you overcame that?

P2: Challenge it, just challenged, direct challenging. We challenged the parish council, we challenged the administration. (Professionals, p. 38)

The problem then, from the professionals' point of view is that other people or groups are stigmatizing or presenting barriers to services or to clients' access. The tone is one which emphasizes the heroism of the workers in the face of backward GPs and obstructive public bodies. Largely then, the stigma came from elsewhere, not from the mental health system itself. This is a little different from the classic formulation of stigma as being something that originates from within the mental health system.

The theme of stigma coming from the community itself was one which was further elaborated in anecdotes concerning what clients felt they had to face in resuming their lives in rural communities. Speaking of one client who was dealing with the consequences of her previous unusual behaviour one of the professionals said:

P: ... [F]or her there was like the issue of like everybody in the village knows that she's been in [hospital], so she'd kind of want you to park round the back and not look like you were coming from [hospital] because other people in the village, she didn't want, she wanted to put that behind her because she felt that everyone felt that she was just mad and that, kind of, if she could keep it limited, you know, 'Well like that's behind me now, perhaps people'll forget about it,' but she still wouldn't, there was a bus, but she wouldn't catch the bus because she got an issue that everybody on the bus knew that she'd been in [hospital] and that people'd, maybe wouldn't want to sit with her.

I: Is this a minibus phenomenon?

P: No, no, it was just a public service bus, she felt everybody in the village knew all the business. When she'd been unwell, she'd done quite, she had done quite bizarre things in the village, sort of been round the village with no clothes on and been quite disinhibited. So for her, she was like well, 'I don't want to go out because I'll just remind people, people will see,' and I think that, for her, there's no, I think if you're in an urban area I think you can either move like a few streets away and perhaps people know less about you, you can kind of be more ... or move to a different part of town.

I: Anonymity. (Professional, p. 17)

In addition to this awareness of the role of stigma in the lives of clients, the professionals in the present study were, as can be seen from the above extract, apt to describe the countryside as a place where privacy and anonymity are difficult to achieve. Thus, they are particularly keen to alert the researchers to the difficulties which may develop for clients once the identity as a 'mental patient' has been leaked to other members of the community. In these extracts, one of the features, to which we shall return later, is that the nature of the clients' problems – like this woman described above, or the young man with the drug problem – is such as to make their status as mentally ill individuals unavoidable to those around them. The mental health problem then is itself the agent of leakage and it is, by implication, the professional's job to help the hapless victim deal with the ensuing social difficulties. Again, this enables the worker to be innocent of creating stigma themselves and to emphasize their helping role in tackling it.

Interestingly, in many of the accounts, clients are seen as the passive victims of stigma, and it is something that they are not described as resisting or challenging – at least in the eyes of the mental health workers. They are, like this woman and the young man with the drug problem, described as remaining prisoners in their own homes after such an incident. Thus, despite being many miles from the institutional certainties of a hospital, the 'defensive social structures' (Goodwin 2000) which emphasize professional competence and client passivity remain undisturbed.

On the other hand, passivity was much less apparent when clients themselves described their responses to stigma. There were a number of cases where users reported successfully challenging experiences of stigma and negative attitudes from others:

I came back from the toilet once and this bloke making a nice comment about how I looked. Then this other bloke went, 'Oh no, she's a nutter, you don't want to go there!' and I heard them say it, and I said, 'Oh, I'm a nutter am I?' I said. 'Well, how come I can have a serious conversation with you then?' I've done this, I've done that. I really pointed him up on it,

what it was really like to be labelled a nutter. He was so sorry afterwards, and he comes over and talks to me now. It's the fear of the unknown. Once you get a label. (User, p. 72)

Here, the user reports doing the kind of repair work mentioned by Goffman (1967) to salvage a threatened identity or threatened 'face':

... [S]o you're sat at home on high tranquillisers. [Laughter] You try and go out up the club for a drink, and you have one drink with your medication and you're sat in the pub like this. [Laughter] I think everyone thought I was a junky because I used to act weird in the pub. Because I'd go in the pub and have one drink, and I'd be all floaty and happy. And they'd say, 'Hey, she is off her head.' Very few people will come up to you and be up-front, they're not two-faced. They will come up to you and say, 'I have heard this about you, is it true?' I'm thankful for people like that, because you get a chance to say things back to them. I don't want to admit that I have got schizophrenia because people don't know much about it, it has had such bad press. You hear about these people who have murdered, because they thought they would go to heaven if they killed these people. It is very hard to live with it especially in a small community, because everyone else knows everyone else's business. (User)

This quote discloses a number of the key issues surrounding the experience of stigma. First, we can see the sense that one's status as a deviant – a junky – will be obvious to everyone. Secondly, we have the sense that acquaintances who deal directly with the issue are valued more than those who remain silent but (she suspects) may typify her negatively when she's out of earshot. She seemed to be welcoming the opportunity to challenge negative stereotypes. However, it is difficult for service users to regain the personal resources necessary to mount these challenges and some may meet with even more negative reactions when trying to inform acquaintances about their situation (Herman 1993). Nevertheless, users' accounts were redolent of an active process of challenging stigma or attempting to rise above it. This account of users' action was not visible in workers' accounts of users' responses to stigma. Users – like the patients in traditional hospital psychiatry – were passive, whereas the workers were active in making changes to their practice and the community around so as to reduce the perceived likelihood of stigma, as we shall see in the next section.

Cautionary tales: the insensitive practitioner

One of the ways in which the mental health workers highlighted the problems which could arise from the insensitive application of mental healthcare practice was through the telling of cautionary tales. The descriptions of the problem were sometimes embellished by

means of narratives concerning staff who had somehow violated the implicit norms of good practice:

... [A] woman who was having regular visits from a CPN [Community Psychiatric Nurse], who was female and that wasn't a problem, because it was like a friend going round. Then one day, a man actually turned up with a depot injection in his hand, so that everybody was looking out, and they could see the injection, so it was quite clear that there was something wrong, with you know suitcase, syringe in one hand, you know big nice [healthcare trust] badge, no sort of attempt to cover it up. And after that injection, she said well forget it, I'm not having any more injections, you know. Everybody now knows what these people are doing. Before this, she'd kept it quite quiet. And it took us weeks, I think she missed it for about 8 weeks, and it was only on the basis that it would always be a female and it would always be sort of very confidential. You know, briefcase wouldn't come out, just a bag, and nobody would know any different. But it's in the rural communities that people notice that more than the urban communities because comings and goings are sort of less in the rural communities and like everyone's watching out from the net curtains a lot more because they're keeping an eye on each other. (Professional, p. 41)

In this vein, the workers were able to describe a number of cases where clients had been reluctant to engage with services, or even been physically violent. Therefore, the cautionary tale – always about someone else, never the teller her or himself – can serve to convey important local knowledge about good practice as well as present the teller in a favourable light, as someone who would not make these mistakes themselves and is sensitive to issues surrounding stigma. Allied to this sensitivity, there was a further stock of storytelling where a set of specific strategies were presented for protecting clients from stigma.

Strategies of secrecy: stigma avoidance

The avoidance of stigma could take several forms. Mental health workers described a variety of strategies to ensure that their identity or the purposes of their visits were not obvious to clients' neighbours:

P: Sometimes we see people here [at the clinic] rather than at home, because they actually don't want us visiting at home in case the neighbours see. So we make arrangements for them to come here.

I: So they don't want you coming looking like someone from mental health ...

P: That's right.

I: When you're going out on visits though, do you adopt any strategies for improving your access and the acceptability of your access to these people, I'm not suggesting you dress up

in rustic uniform, but do you take any actions yourselves to go incognito?

P: Some of us wear uniforms and, erm, carry briefcases, I'd probably leave that in the car.

I: So you tend to look ...

P: Scruffy.

I: Non-important. You could be anyone.

P: Yeah, yeah.

I: But you actually make a conscious effort there to do that.

P: Sometimes if you've got two in the same street, I'd perhaps leave my car round the corner and walk round. (Professional, p. 32)

Alternatively, another professional group responded in this way:

P1: Think about what you're wearing according to what client group you're going to, not sort of walking around carrying a briefcase or looking conspicuous. Think about what car you might go in, you might think about whose car you might go in.

I: Do you think about sort of carrying diaries and a pen sort of thing?

P1: You wouldn't carry that on show, no badges really. I mean you've got your badge with you for some policy.

P2: You have it hidden in a pocket somewhere so that people can't ...

I: Do you think that works? Do you sense that works?

P1: I think it does to a certain extent. (Professionals, p. 19)

Thus, in line with Goffman's (1967) notions of stigma, where potentially discreditable information might leak out concerning the actor with something to hide, the workers here are concerned to minimize the sources of leakage which might lead to stigmatizing experiences for their clients. On the other hand, some clients identified even more subtle sources of this leakage. One user mentioned the postal service as a possible source:

'[Gossip] ... goes like wildfire ... you know with local people, neighbours, letters you get through the post ... they've got the name of the hospital ... letters what you get, hospitals, see, they've got the hospital on. The postman, the temporary ones, as well ... in villages ...' (User, p. 66)

Thus, users are particularly sensitive to features of care which might disclose their identity as a patient. Retaining a sense of control over who knew what was important to them. In addition, contrary to classical conceptions of patients as people who lack social awareness and impulse control, some formulated these acute and meticulously observed accounts of village life, which

exceeded the subtlety of the workers' descriptions of their current practice.

Discussion

Towards community mental healthcare with a human face: 'just like a friend going round'

The classic formulation of stigma within the sociological study of mental health issues tends, as the present authors have argued, to see the stigma as something that the service users have thrust upon them by a psychiatric system that imposes the stigma of patient identity on them. Once they have been labelled, the stigma is something that they have to deal with on their own. However, as the present data tentatively show, the issue of stigma is something that those working in community mental health are concerned with too. Whereas users can relate their own experiences of stigmatization, the professionals readily relate accounts of how their colleagues or other individuals or institutions have been instrumental in causing problems, and are able to challenge local prejudices and exclusionary practices. This is at odds with traditional formulations of the concept of stigma where professionals are often seen as the 'bad guys'. Thus, it may be that, in order to grasp clients' subjective concerns and keep them out of hospital, professionals in rural areas must deal with the issues which prevent clients living a fulfilling and supported life in a community setting. This involves facing with clients their anxieties about going out in public, visiting shops and pubs, or simply making friends. Therefore, it appears that the notion of stigma is a well-established part of both the users' and professional's lexicons when it comes to making sense of the experience of mental health difficulties in a social context.

What is more, even amongst this small sample of professionals, there is a rich stock of anecdotes concerning how the stigma of their interventions and their presence may be reduced. Thus, the control of stigma is very much the business of the mental health professional with involvement in community care. These 'social representations' (Moscovici 1976) of stigma also represent powerful tools not only for making sense of existing experiences, but planning services and even everyday activity so that the disapprobation of the rest of the community is not visited upon the client. Interestingly, this transformation in the role of mental health workers, so that they are active in combating stigma, has recently been noted by other authors (e.g. Steele 1996). Whereas professional bodies concerned with mental health have attempted to educate the public in an attempt to reduce stigma (e.g. Britten 1998, Byrne 2000), what is far less well known is how professionals can help clients with stigma

on a day-to-day basis. The present paper has begun to map some of the contours of this daily effort on the part of users and professionals.

Whereas this study is small and the present authors cannot make claims as to the generality of the phenomena they have described, this paper has begun to identify these strategies on the part of professionals. Whilst the authors cannot even be certain that the good practices and sensitivities described here are implemented outside the focus group itself, the very fact that they are mentioned at all suggests that professionals are actively trying to construct a sense of what it is like to be a client, and that activists' and clients' concerns about stigma are at last finding their way into professional consciousness.

The strategies described in the present study constitute a valuable resource for training and education in community mental health. If effective and accessible services are to be planned for rural areas, it is vital that these considerations are taken into account. Therapy which leaves people's social relationships intact is much more likely to prevent relapse (Ostman *et al.* 2000). If professionals are able to help maintain a client's social relationships and social status rather than compromise it, this could be just as important a therapeutic manoeuvre as the drugs, cognitive behavioural therapy, anxiety management groups or outpatient facilities which they can provide. Moreover, users sometimes displayed an acute awareness of the signals which could be leaked about their identity such as hospital postmarks on letters. Again, it is possible to see this awareness as a resource of useful information to enhance workers' sensitivity. Whereas the present study is too small a basis on which to redesign mental health training, it perhaps might highlight the usefulness of exercises like this so that users and the workforce can express what they feel is needed.

As we have also seen, albeit only suggestively, the professionals have a blind spot when it comes to clients as active agents of challenge and change themselves. Whereas they are solicitous in managing stigma, they implicitly attribute a relative passivity to clients, who may become trapped in their homes by other villagers' twitching curtains, whispering and cold-shouldering. Again, the results are small in scale and merely suggestive, but the way professionals construct clients has a good deal in common with the idea of incapable patients which characterized the past two centuries of hospital psychiatry (Goodwin 2000). On the other hand, clients are active in detecting possible sources of stigma, such as postmarks on letters, and are sometimes even active in problematizing and confronting others' attitudes. It is apposite to take very seriously the way in which clients do this since it may well be therapeutically

advantageous for professionals to build upon clients' resources in this area if they are to survive successfully in rural community settings. This might need to involve further paradigm shifts on the part of the professionals. At the moment, the fact that the mental health practitioners are successful in concealing their identity and their visits to clients may reduce the stigma that can attach to those individual clients, but it does not challenge the stigmatizing attitudes on the part of other community members. In a sense, the bigots have won and those who suffer from mental health problems must remain in the closet. Whereas there are hopes that the public may become better informed about mental health and that this will lead to a reduction of prejudices (Barry *et al.* 2000), progress on this front may be slow. Perhaps it would be possible for professionals to recognize and build on the resources of clients to challenge and transform their own situation and the attitudes of others, as has been successfully attempted by other groups of clients elsewhere (Herman 1993, Everett 1994, Emerick 1996). It is through enhancement of their role in empowering clients that mental health professionals will make their visits much more 'like a friend going round'.

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