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Mental-health stigma: expanding the focus, joining forces

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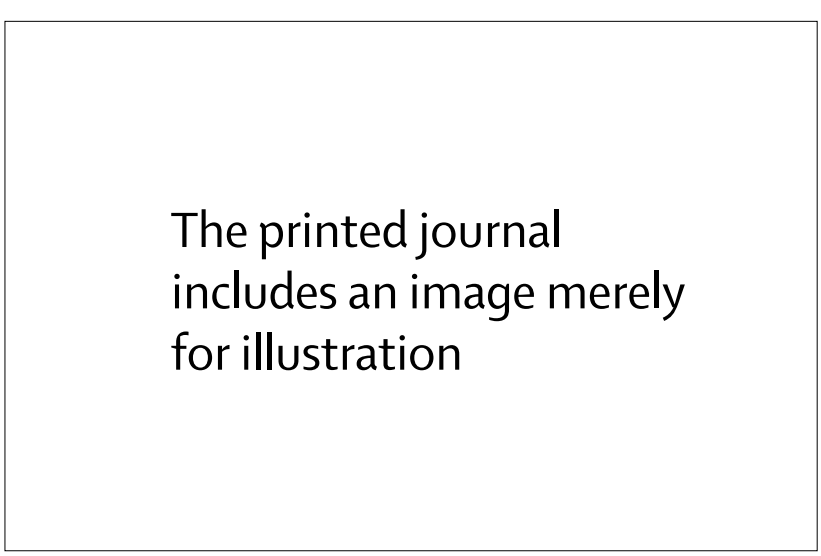
See Articles page 408

Despite ample international efforts, stigma against people with mental-health problems persists. This finding is underlined by Graham Thornicroft and colleagues' INDIGO study, in *The Lancet* today.[1] The results reveal high rates of discrimination on a global scale and show that many mentally ill people anticipate negative reactions even in the absence of discriminatory behaviours. This landmark study encourages us not only to continue fighting stigma in a global coalition,[2] but also to step up our efforts.

So far, we have tackled stigma mainly from a wide-angle view—attempting to create more favourable environments for mentally ill people. But we also need to look closer to home. First, clinical interventions must include strategies to enhance patients' self-esteem, and to replace self-stigma with self-efficacy expectations.[3] These programmes must appreciate the complexities involved when a person decides whether or not to disclose their diagnosis, and value existing coping resources. Further, we should continue to strive to improve the quality of psychiatric treatments. Treatment success depends on therapeutic optimism. Recent research in neuroscience tells us that treatment expectations have a strong effect on outcome.[4] To take advantage of these psychobiological mechanisms, we will have to start examining health-care professionals' own attitudes and refute fatalistic notions about prognosis and treatment.[5]

Increasing attention on fighting self-stigma should not detract from efforts to tackle structural barriers to social integration. The INDIGO study shows that discrimination is predicted by treatment duration and experience of coercive measures. To counteract this kind of "side-effect", mental-health policies need to be reviewed to find ways of ensuring that people who need treatment receive it, with less reliance on compulsory treatment. This development could be aided by enhancing psychiatrists' skills for cooperative clinical decision making.[6] In challenging stigma and discrimination, we must bear in mind that stigma can only be deployed in contexts of unequal power. In addition to protecting the civil rights of mentally ill people by antidiscrimination legislation, we should empower them to actively pursue their rights and challenge discrimination through education and protest.

For antistigma measures to take effect, we must continue to confront negative public attitudes. We should be encouraged to take a preventive view, and dispel stereotypes before they arise. School projects against stigma have been successful in improving



PA Photos

Art against stigma
Art exhibit by psychiatric patients, London, 2006.

attitudes, including multiplier effects on teachers and parents.[7] By making mental-health issues personally relevant for the young people, these programmes prevent the distinction between "them" and "us" as a precondition for discrimination to occur. Many people who live with a mental illness find it difficult to find or keep a job, with unemployment rates of up to 95% for those with severe mental illness.[8] Although stigma-management programmes could develop their skills and encourage them to apply for work, this is often not enough. We have to acknowledge that people with mental illness have illness-related deficits while facing an increasingly competitive labour market. Beyond courage, people with mental illness therefore need support to realistically assess their potential, to find a job, and to keep it. A promising model is individual placement and support, which emphasises continuing support to patients and employers by a job coach working with the mental-health team and has proven more effective than vocational services for both employment and clinical outcomes.[9,10]

To successfully fight stigma and discrimination, we need to know what we are talking about. Much research on stigma, discrimination, and prejudice fails to clearly define the concepts involved.[11] Conceptual clarity becomes more important when targeting antistigma interventions. To this end, we should refine the methods for measuring stigma and discrimination, because efforts to fight stigma will only have a lasting effect if we can document progress. In particular, we need compact validated instruments to measure "felt" stigma and qualitative studies for understanding stigma from within specific cultural contexts.

The INDIGO study is breaking new ground, pointing to the kind of research we need to more fully understand stigma and discrimination. By investigating actual discrimination and self-stigma, the study brings together the structural and cognitive perspectives that have not previously been combined. Furthermore, this study combines quantitative and qualitative data on discrimination experiences of people with schizophrenia from 27 countries. However, what remains to be done is to determine the effect of discrimination on health and social outcomes and translate these findings into effective public-health strategies.

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Trade agreements and health in developing countries

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See Series page 416

Politicians champion free trade for bringing an era of high and stable growth, although the evidence supporting such claims is ambiguous. Studies that associate increases in trade with increases in gross domestic product often leave open questions of causality: high growth, the result for instance of strong industrial policies, typically leads to more trade. China and India's growth spurts preceded trade liberalisation. A study by UN Development Programme showed little relation between trade liberalisation and growth.[1]

But trade liberalisation is associated with growing inequality in most countries of the world (although there are other contributing factors). Especially in conjunction with liberalisation in capital and