ORIGINAL ARTICLE

Panic disorder and stigmatization

Ján Praško [1], Barbora Mainerová [1], Tomáš Diveky [1], Dana Kamarádová [1], Daniela Jelenová [1], Aleš Grambal [1], Klára Látalová [1], Zuzana Sigmundová [1], Petr Šilhán [2]

[1] Department of Psychiatry, Faculty of Medicine and Dentistry and University Hospital Olomouc, Palacky University Olomouc; [2] Department of Psychiatry, University Hospital Ostrava, Czech Republic.

Correspondence to: Prof. Jan Prasko, MD., PhD., Department of Psychiatry, Faculty of Medicine and Dentistry, Palacky University Olomouc, University Hospital Olomouc, I.P. Pavlova 6, 775 20 Olomouc, Czech Republic; tel: +420 588 443 5030; e-mail: prasko@fnol.cz

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Abstract

The stigma attached to mental illness and psychiatry results in the discrimination of people with mental disorders which is the major obstacle to early and successful treatment. Many people which might have benefit from mental health services will not seek help or fail to fully participate. Patients with panic disorder are rather forced to concentrate on somatic aspects of anxiety. A lot of prejudicial beliefs, emotions, and behaviours cause the discrimination against people labelled as mentally ill. Unfortunately, public prejudice and self-stigma may provide equally large barriers to achieving and enjoying life opportunities. Families worrying from stigma often keep patient from early psychiatric intervention. Labelling mentally ill patients is quite often from health care workers, especially physicians, who can exaggerate or underestimate the level of problems. Individuals who have more information about mental illness are less prejudiced against the mentally ill. Destigmatization can be reached through educating the families and public about the realities and myths of mental illness.

Introduction

The epidemiological studies convincingly indicate that significant proportion of the population suffer from the mental disorders. Approximately 25% of population has so serious problems they seek professional attention. By estimation another 25% experience psychical problems sometime during their life, but do not seek any help at all. The majorities of disorders have temporary character and subside spontaneously or during the treatment. Nevertheless the social distance of the healthy population from the mentally ill individuals is significant. The mental illness may be both the scientific diagnosis and, outside the scope of the professional world and medicine, implicit social label. The disadvantages of the diagnosed ones arise at the time the diagnosis loses the function of the treatment manual and transforms into a social stereotype with the harm sealed in. The diagnosis becomes social stigma then (Praško & Grambal 2011).

The mental disorder is like a double-edged sword. It brings psychical problems and handicaps along and moreover it is limiting the individual in ways of life goals achievement and fulfilling. On the other hand the mental disorder impends its carrier by the public reaction when discovered. Numerous prejudices, emotions and behaviour lead to the discrimination of the individuals labelled as mentally ill. Unfortunately the general prejudices and autostigmatization may create similar barrier to life opportunities achievement and use (Corrigan *et al* 2002). Many people, who may have significantly benefited from the psychiatric care, refuse

to use it. The stigma connected with the mental disorder results in the discrimination of the handicapped ones, which is great barrier to early and successful treatment (Stuart 2008).

In anxiety disorders the patients may contend with both the labelling from the others and autostigmatization. The threat of the stigmatization often impedes the adequate psychiatric attention seeking. That's why the psychical aspect of the problems is often suppressed or denied and patients try to find a somatic explanation for their complaints and seek the somatic specialists for. Many patients feel excessively nervous, all the time control heir external manifestation of the nervousness (*"for others not to recognize he/she is a madman"*) and those often go out of their control and the patients behaves "nervous". They are usually afraid of going mad, but avoid the psychiatrist, because "he could discover their illness". In the panic disorder the attention of the patient and other focuses on the somatic symptoms of the fear and anxiety. The somatic symptomatology is better tolerated and arouses sympathy and need to protect rather than denial. The symptoms of the anxiety in the panic disorder are usually so dramatic, that the others easily believe it is a serious somatic disease. The patient and the family are disappointed by the psychiatric diagnosis. If the patient develops the agoraphobia his/her surrounding is usually tolerant and also the patient "forgives" him/herself even a significant avoiding behaviour. The avoidance is more often regarded as a "weakness", "lack of the courage" and is attributed to the personality of the affected individual and also patient him/herself feel it the same "I am incapable to fight it".

The weakness, lack of the courage and shyness are better tolerated in women than in men. The patients feel their problem similarly to the surrounding. Their autostereotypy impedes the treatment. They feel this is their character and personality and it can't be changed.

The general population may also stigmatize specific types of treatment or methods. The family and patient may have specific attitudes – labels towards the psychiatric treatment. They may regard the medicaments as poisons, which change the psyche, the psychotherapy as brain-washing. The ill individual should better get together, eat well and have enough of sex. The nerves coated with fat are considered to be immune against the mental illness development. Certain types of treatment are preferred and certain are rejected in the population. There are some regional differences. For example in Germany large sample of the population showed, that the majority accept the psychotherapy and the people treated this way well, while refusing the pharmacotherapy. Interestingly in the western Germany the psychoanalysis has highest reputation, while in the eastern part the group psychotherapy is in the lead (Angermeyer *et al* 1996).

The *stigmatization of the discipline* may be a problem of the treatment in a broader sense. Psychiatry has been misused by some systems (Nazism, Communism) in the past. In any society psychiatry has, except from the curative function, also the controlling function (deviant individuals' detention) and the psychiatrist is often regarded as an "control agent". Another general lay conviction, that the psychiatric disorders are not true illnesses when compared to the somatic ones, leads to the mistrust of the psychiatric treatment abilities. The struggle for the financial sources is much more difficult for the stigmatized discipline and as well is the development of the treatment methods. It is the Czech republic dishonour to spend only 3,9% out of its funds on the health on psychiatry, which is the second lowest percentage in the whole European Union (where the average is 8% and the most developed countries spend 12%). The general public often expresses displeasure towards psychiatrists. They are ironically labelled as "madmen as well" and may arouse mistrust in general, especially in less educated people. The mistrust in the potential help and the fear "they can see inside me too much" and "they could possibly find something on me" as well are the attitudes decreasing the feeling of security in the presence of the psychiatrist. One of the ways, how to fight the insecurity is to have a laugh of it. That's why the jokes about the psychiatrists are so rewarding. Psychiatrists are often presented as freaks and eccentrics in the movies.

The stereotype of mentally ill and stigmatization

The stigma of mental disorders is connected with lack of the knowledge, fear, prejudices and patient discrimination (Corrigan & Watson 2007). Our history is filled with tragedies related to isolation and social disqualification of people suffering from psychic disorders (asylums, torture, the ships of madmen etc.). The tendency to disqualify has partially survived up to now. That is connected with medical and social impact such as conflicts in close or occupational relations, homelessness, suicidal attempts etc.

In terms of social psychology the *Stereotypes* are rigid, passively accepted ways of assessment of people, based on traditions and prejudices (Hyhlík & Nakonečný 1977). The stereotype enables a rapid categorization and affects expectations and behaviour of other people, even in the situation when their own experiences are little or lacking at all. Stereotypes in assessment are related to groups of people, classes or certain representatives of the society (physically disabled, mentally ill), or entire nations and races (Jew, black, Gipsy etc.). The social psychologists differentiate between so called *autostereotypes*, i.e. the ideas and opinion members) of certain group possessed about themselves (e.g. the mentally ill about mentally ill), and *heretostereotypes*, that they possess about members of other groups (i.e. healthy about mentally ill). Using stereotypes certain groups are usually assessed in a simplified way and irrationally. Even the marked individual qualities and

differences of particular members of certain group are being erased.

One of the typical stereotypes is the *mentally ill stereotype*. Such a stereotype may bring both positive and negative consequences for the individual. The positive one may be the protection of the individual, empathy, placing less demand in performance and life roles on them. The positive consequences obviously do not predominate. The typical negative consequence is a stigmatization. The stigma generally signifies an devaluing attribute, that may cause its holder the discrimination. The term stigma originates from antic Greece and points out the physical features indicating something unusual, insufficient or wrong in the moral value (Clare 2000).

Sociologist Erving Goffman (1963) in his classical sociological publication analyzes the stigma and illustrates, that the individual with stigma is most frequently defined as a "worse than a man". That's why the stigmatization was often misused by the ideological purposes. The stigmatization may manifest both as a felling of inferiority of its carrier and as a devaluating attitude of the environment. Usually the illness is the only one deviation that is its carrier not responsible for and is not given sanctions for. However this not applies to the historically stigmatized illnesses (leprosy, tuberculosis, sexual transmitted diseases, mental disorders). In mental disorders the denial is theoretically connected with continuing different behaviour, which means certain degree of threat for the others. There is a question, why the stigmatization and thus the denial as well operate in disorders in which such an aberrant behaviour is not expressed (e.g. panic disorder and agoraphobia). Most likely there operates the label itself – in certain periods its effectiveness may prevail the other information about the individual over. Moreover the label of "mental disorder" or "mental illness" does not take in consideration the various types of those illnesses. Unfortunately even the information about the contact with psychiatric institutions, especially about the hospitalization, operates as a label itself. The labelled individual is under increased social control, that tends to interpret every deviation from the standard (even the presumed one) according to the label (Chromý 1990).

The response from the social environment, that results in the conclusion "mental disorder" is called *labelling reaction*. There are traditional labels used at general level (character, nervous breakdown, madness) at the professional level the diagnostic labels are used. The label may have both the corrective and stabilizing impact on the deviant behaviour. The corrective impact operates by the identification and treatment of the disorder. The mechanism of stabilizing impact may be various:

The patient changes his/her self-image and behaviour as a result of the label or to divest it

He/she retrospectively interprets their behaviour according to the deviation ("I've always been anxious")

It may act as a status for the others: not leaving any space or other qualities than the stereotype contains (the individual is reduced to the "hypochondriac")

In stigmatization of patients with mental disorder (there is often not distinguished between the disorders categories, the patient is "just" psychiatrically treated), there is often present the stereotypical anticipation of unpredictability and danger, irresponsibility, uncontrollability. The stereotype of the image of mentally ill appropriates the role of a deviant. The unusual behaviour, dangerousness, uncontrollability, irresponsibility and perhaps aggression is anticipated. According to these negative anticipations the behaviour of the environment to the patient changes and the remarking reaction is imminent. Therefore the general public as a group keep a *significant distance*. The patient becomes isolated with his problems. Once adopted image is resistant to the modifying effects, despite of it is often fictitious. Such a persistence of this fictitious image in time is also called *"a stereotypical image of the mentally ill"* in which the *"career of the mentally ill"* is expected (Janík 1987). Often is does not matter whether is it a psychosis or neurosis. The fact that the handicapped person is treated psychiatrically may lead to the automatic classification as "mentally ill" which is by the general public used for the severe and extreme psychic disorders. That's why people suffering from neurosis are so afraid of psychiatric diagnosis. The elemental behaviour to the labelled mentally ill is "keeping distance" and tendency to "observe" and eventually isolate him/her. The lay people especially pay attention to the external manifestation of the patient – countenance, movements, physiognomy, posture and language and register unusual features. When discover that the labelled one "behaves strangely" or "acting crazy" the labelling process begins and may lead to the permanent stigmatization. If the behaviour is found noticeable but still tolerable, the patient is usually labelled as "nervous" and a personality underlying cause or a situational "breakdown" is supposed. The personality underlying causes are also used to be negatively labelled, seldom the "breakdown". The lay population created a traditional peculiar taxonomy of the mental diseases. The dichotomic taxonomy is typical: genuine "madness" and on the other hand "nervous breakdown" (Chromý 1990). The image is also modified by the notion of the underlying cause of the disease. The intensity of denial of the labelled individuals depends on the lay interpretation of the etiology of the disease. The lay people attitudes to the underlying causes of mental illnesses could be simply divided into several groups: *the personality* (mental inferiority, weakness, perversity, immorality), *the organic* (genetics, brain disorder) or *the situational* (traumatic breakdown, shock, life misfortunes, worse

material situation, grief, sorrow). The attitude towards the handicapped individual may change according to the anticipated underlying cause. The more positive one is so called peristatic interpretation, which finds the cause in occurrences experienced by the individual. The other extreme there is an organic interpretation, discovering the cause in the "ill brain". In "personality" etiology the affected one should.

Mr. Vláďa is 36 years old. He is a successful businessman used to work 12–15 hours a day. He is living in a hurry. One year ago in the evening he suddenly got a fit of palpitation. His chest clenched and he had pins and needles in his fingers and lips, could not catch his breath. He was frightened and called the ambulance. The doctor hesitated for a while when scanning his ECG then took it again. The doctor said, there was nothing wrong with his heart, at least there is no pathology on the ECG. Vláďa got an injection. He was feeling better then, but was nervous because the ECG had been taken twice. Another fit came a week later. He woke up at night, sweating his heart beating like a bell, his chest was clenched. He could not catch his breath. He run to the window and was trying to breathe the fresh air. His wife was frightened and took him to the emergency. The same situation as a week before repeated, but with another doctor. During 6 months he visited the emergency 17 times. He went through numerous examinations – ECG repeatedly, lab tests, ultrasound etc. There was nothing wrong and the fits kept coming. He had his schoolmate a doctor, hospitalize him at the internal medicine ward. In the end he was tactfully recommended to visit a psychiatrist, which he rejected. Fearing another fit he reduced travelling. He was sending his subordinates at the meetings and goods purchase all over the Europe. He could only drive a car at the time the traffic was not so heavy – in the evening and early in the morning, He had the doctors to hospitalize him again, this time at the neurologic ward. Again he was after many examinations recommended to see a psychiatrist. He did not reject this time...

The family and fear from labelling

Because of the fear of the stigmatization relatives sometimes discourage the patient from the psychiatric treatment. As if there was a rule: "the person treated psychiatrically must be a madman". The family is afraid of both labelling one of its members as a mentally ill and that they all will be stigmatized and "*it will be a shame*". The family finds running such a risk for complaints they even do not consider so deviant (patients is phobic or neurotic) too excessive. They try to persuade the patient to "get together" eventually they help him/her with the security behaviour (dealing with the authorities instead of the patient, driving them everywhere, providing easements in issues patient is afraid of). Such a behaviour usually reinforces the symptoms of the disorder (Praško & Sigmundová 2010). The general lay definition of the mental disease if narrower than the professional one. The risk of mental disorder identification by the psychiatrist fulfils the family with concerns. In general public's point of view *"the psychiatrist often sees madmen in everyone"*. Moreover the family may possess peculiar attitudes towards the treatment and consider the psychiatric intervention to be useless: *"He /she should get married", "start their sexual life", "start to work hard", "put on a bit weight"*.

Self-labelling

Labelling a person as a mentally ill, often results in several forms of repression, social and existential threat. Not surprisingly those people defend against such a label and they avoid the psychiatrist or struggle to reduce the consequences of the *labelling process* if possible. The general lay approach, to the subjective experiencing of the mental disorders by the afflicted themselves, is peculiar as well. Patients suffering from neurotic disorders often succumb to the severe anxiety "not to go mad" or start believing "they have already gone mad". In many cases they do not want anyone to recognize their problem (then telling us they *"pretend feeling well"*). That's why they may isolate from the others *"to prevent others to detect their problems"*. The fear of stigmatization may be so serious, that some patients are even afraid to discuss their complaints profoundly and depreciate them in face of the professional (Praško 2001). Other times they try to suppress the anxiety inside or they understand it as a consequence of their somatic problems. Such a reaction enables the patient to escape from the stereotype of the mental illness subjectively and to infiltrate the socially more convenient stereotype of the somatic disease (unlabelled, well understood by everyone, as for example myocardial infarction, or a serious one such as cancer).

Patient (as well as his/her family) may refer to *their psychic problems* differently if those regarded as an "illness" (he/she is a "victim" of the illness and expects help from the others, especially the physician or the medication, is passive and waiting the illness "to cure by itself"), than as a "disorder" (he/she mostly understands it as a long-term "condition", which they must to adapt to and accept passively) or as a "response to the stress" (most often he/she expects to be commiserated, as long as the stressor is present someone arranges the elimination).

Labelling by the physician

The physician's and psychiatrist's attitude towards mental illnesses reflects opinions of their social group and their medical education. Compared to the normalizing reaction of general public the professionals are more prompt to labelling reaction. This is attributed to the inculcated rule, that to miss the disease is an extremely serious error, while the incorrect diagnosis is not so serious (Chromý 1990). That means there could be something about the general claim that *"the psychiatrist sees madmen everywhere"*. In professionals we can encounter both the overestimation of the severity of the

disorder (when the symptoms are less comprehensible) and the underestimation (both for the patient and his surrounding – "*You are just overworked*"). Individuals originating from lower social classes usually receive more serious diagnosis. The overestimation is usually connected with the belief in mainly biologic understanding of the etiology, the underestimation with the psychological one. When overestimating the severity of the disorder the physician often resigns from the possible curability, when underestimating he sometimes tends to disapprove patient's complaints or generally underestimates the therapy. The general practitioners sometimes face a peculiar situation when communicating with the patient at two different levels: *"it is a matter of nerves*" sounds less serious (*"you are not going to die from it"*), but at the same time this may be more threatening for the patient, because of the fear of stigmatization.

There is typical request for a psychiatric consultation in patients admitted to the somatic wards, whose history contains psychiatric treatment, even though they behave adequately at the moment and the examining physician has not find anything pathological.

The treatment of the patient significantly depends on the *therapeutic relationship*. The internal attitude is crucial for the involvement of the therapist. When the therapist presumes presence of the personality disorder, he may beforehand expect the insusceptibility to the therapy and his therapeutic endeavour is minimalized (Praško *et al* 2003). The patient is stigmatized from the therapist's point of view. The labelling occurs more often in the case physician anticipates *difficult treatment*. The individuals originating from lower social classes than the therapist are labelled more frequently. Those patients are less intensively treated as well (Janík 1987). The patients unpleasant to the therapist, those who he fails to establish an efficient cooperation with or they even criticize him, are more often labelled by the therapist as having *more difficultly treatable diagnosis* as well. The therapist often uses, even if face of the staff, pejorative synonyms of the label (she is a "Hysteric", "Psychopath", "Chronic complainer", "Paranoid", "Hypochondriac", "Borderline"). At the general practitioner the expression as "Neurotic" may sound the same. There the *pejorative labels* act as defences of the therapist, that justify his own failure or unwillingness to provide a more intensive care to the patient (Praško 2001). From my psychotherapeutic trainings and supervisions experience I found this inverse proportion: the more the therapist labels his patients, the less therapeutically successful he is and the smaller the group of patients he is able to help. Paradoxically the most labelling are those professionals, who have many neurotic maladaptive or personality characteristics themselves. The patients, who begin to complain, because they do not think they are treated sufficiently, have many difficulties. The labelling as "Querulant" or "Chronic complainer" is used frequently to discredit them and it arouses negative attitudes in the physician. The vicious circle results: The patient complains – than he/she is labelled – the physician does not pay enough attention to the treatment – the patient complains again.

The stigmatization may emerge *during the therapy* as well. In the course of the individual therapy the patient may be stigmatized by some therapists' direct non-therapeutic utterances or allusions (*"You are a hysteric*", *"Hypochondriac*", *"Everything originates from your character"*). The stigmatization very often arises during group psychotherapy, then the stigmatized patient becomes a "black sheep", especially if the insecure therapist joins the group.

The labelling of the patient by the psychiatrist (or other health professional) often results from the countertransference reactions and is maintained by the countertransference later on (Praško 2003). Typical psychiatrist's attitude enabling the label maintenance is a protective or "Samaritan" behaviour towards the patient. Such a behaviour easily removes all the sense of responsibility from the patient and situates him/her into a position, that no demands can be placed on him. This detachment of the patient from his/her previous duties is just confirming their peripheral position in a small social group (in the family, at the workplace). Sometimes this supports the general public attitudes that: mentally ill has to be spared, stay in peace, rest a lot and avoid any worriment. In case some of the patients profit from those situations, we discuss so called secondary benefits. On the other hand there is a "jovial approach", which the patient may experience as disrespect of their personal dignity or as depreciation of their complaints (Dušek 1988).

Another inappropriate approach of the therapist is the confirmation of supposed diagnoses to the family (*"She is a hysteric, hypochondriac"*). Such a diagnosis confirmation brings a stigmatizing label to its carrier. The family then does not have to seek cooperation in the treatment and patient's diagnosis is often misused in arguments with him/her (*"You're a hysteric, you're always playing comedies*") (Dušek 1988).

Labelling and reintegration

For a long time the family opposes the fact of presence of a mental illness in one of its members. That's why they often impede the treatment, discouraging him/her from it and sometimes, in order to hide his/her symptoms, taking their commonplace issues over. Even though the family later realizes the mental illness is really present, the majority of the families demonstrate a considerable effort to harmonize the handicapped member's behaviour, which means their reintegration into the group (so called integration reaction) (Chromý 1990). When those efforts are not successful the interaction restraint and hostile attitudes ensue (so called elimination reaction). The interest in treatment may emerge both in the integration and elimination reaction. If this emergence

comes in the elimination reaction and the hospitalization is the formal help, the patient is usually regarded as being deviant and the reintegration problem follows after the treatment is finished.

After being discharged from the psychiatric care (especially hospitalization), the attitudes of people the patient is in contact with are often influenced by the stereotype view of mentally ill person. The negative attitudes are frequently boosted by the media, where the people suffering from mental illness are described as treacherous, aggressive, incompetent and unreasonable individuals dangerous or ridiculous to the others (Angermeyer *et al* 2003; Nawková *et al* 2008). The stigmatization also depends on the characteristics of the institution, where the patient has been treated in. The hospitalization in the mental hospital is usually linked with considerably more negative labelling than at the clinic or a specialized psychiatric wards (Janík 1987).

Also during the maintenance treatment the problems may emerge. Many of the general practitioners (unfortunately some outpatient psychiatrists as well) are convinced that psychiatric patients are taking too many psychiatric medicaments (Praško & Grambal 2011). This is especially true for patients suffering from neurotic symptoms, because *"after all, they are well"*, their complaints are depreciated and those patients are regarded as *"weaklings"*. Therefore after the patient admits not having any complaints anymore, he/she is advised to discontinue the medication, because it is *"harmful to their liver"* or he/she becomes *"addicted to it"* and in fact they do not need it any longer. Next time they fell the patient is not completely cured, thus *"the drugs are useless"*. Those attitudes are, except from the attempts to diminish the treatment costs, inspired by general beliefs about the chronic body drug intoxication, addiction to all types of psychiatric drugs and the belief that *"having to take drugs people are ill and when healthy they do not have to take them"*. Early drug discontinuation often results in the symptom recurrence.

The consequences of stigmatization in the treatment

The stigmatization may affect the *"path to help"* in several dimensions (Eisenberg et al 2006). The identified internal or surgical patient comes and is referred to sources of help directly. The self identification as a psychiatric patient is far more difficult. In this case the defensive mechanisms of denial and repression operate intensively, because of the concerns about stigmatization. The handicapped person is trying to find another underlying causes, especially the somatic ones. Even after the patient or his/her surrounding identifies the complaints as psychical, the help is not necessarily achieved. Patient and the family tend to wait for the symptoms to disappear spontaneously, or if the holiday, relaxation or anything more "natural" may work. Even when this is not effective the waiting usually continues. Numerous patients suffering from agoraphobia rather learn to adapt their own life and life of their families than to seek for treatment. But the process of finding help may also be disabled by the health professionals themselves. Many of the GPs feel unsecure and uneasy when having to suggest the psychiatric care should be useful, it is because they fell the nature of complaints as a label as well and do not want the patient to be angry about them. Therefore they rather postpone the treatment or try it by themselves. Than it is questionable how adequate this treatment is. That is why numerous patients with panic disorder and agoraphobia start their treatment after many years of severe suffering (Praško 2005).

Destigmatization

The attitude of people to the patient is in contact with after discharge from the psychiatric ward towards them may possibly be changed by family education or family psychotherapy.

The self-helping groups are the other way how to facilitate the destigmatization. Their existence has an explicit aim – to provide psychological support for individuals suffering from mental illness and for their families. The self-helping groups are helping to cope both with the mental problems and the stigmatized position in the society. Those groups use almost all of the therapeutic methods of the group psychotherapy – especially altruism, congruency, universality, imitative behaviour, hope support and catharsis. There are much more empathetic reactions than in the psychotherapy group itself, because the interpretations and confrontations are almost missing (Yalom 1999).

Because the stigmatization of psychiatric patients is a severe issue discouraging many of them from the treatment, it is essential to think of the possibilities of destigmatization. The health education and enlightenment play the main role in this process of changing attitude towards the mentally ill. Awareness of the general population of the contemporary problematic of neuroses, anxiety disorders and somatophorm disorders is relatively low. This lacking information helps to maintain the negative stigmatized stereotype of the mentally ills, with numerous prejudices about their behaviour and treatment. To make the change possible, first there is a need for the patients and health professionals to understand the *stigmatization process*, the *stereotype development* and *maintenance* in the general population. The stigmatization itself probably arises from fear of the otherness. When perceiving some group according to the differences only, it appears to be stranger and thus more threatening. The stereotype of psychiatric patient presented by the media is very effective in the stigma maintenance. Once any accident, suicide, aggression or crime is committed by the mentally ill, it is always mentioned. This stereotype does not differentiate between psychosis, depression, neurosis etc. – simply the indi-

vidual was psychiatrically treated and that is clear to everyone! Interestingly the psychiatrists are treated in the same fashion by the media (Nawková et al 2008). Should Radovan Karadzic had been an ophthalmologist or radiologist most likely his specialization would not have ever been mentioned. The fact he was a psychiatrist was a sensation! That's why many of the popularizations of psychiatry may miss their aims and even augment the stigmatization when stressing the otherness. Psychiatrists priding on the genetic and biologic findings in patients just highlight their feeling of being different. Once husband of one of my agoraphobic patients, convinced he understood everything well, told me: *"Those nuts just have got a diverse brain, I've heard it on TV!"* I comprehend psychiatry among other medical fields feels to be stigmatized and therefore is trying to let everyone know it does not have anything to do with things like magic, that we are able to scientifically measure all our findings. But the impact on the patients may be catastrophic thanks to other arguments for stigmatization. The demands for information selection for general public are obvious. Some informations are almost unacceptable, because of arousing anxiety in public and can increase the stigmatization of the patients (Winkler *et al* 2006). For example some biologic and hereditary aspects of psychiatric disorders are inspiring for the professionals, but threatening for the general public. The facts are not as threatening as is their interpretation and extrapolation. That's why it is so crucial to think well about what we present in media and state in popular papers. I do not thing we should withhold the reality, but there is a need not to present it one-sidedly. The constantly deepening understanding of processes in patients mind, their experiences, reactions to the stress and many others are parts of this reality as well. We can especially integrate a person we understand well. The more people understand why someone is depressed, anxious or having other psychic symptoms, the more they tend to integrate him/her.

The "*neurotic*" *stereotype destigmatization* by the health professionals should be one of the goals of the pregraduate as well as postgraduate education. The professional's attitude to the individual with psychiatric disorder also largely depends on the lay image of the mentally ill, that he/she learned in their early childhood. This attitude was modified during the medical studies, later by the medical praxis itself and is still been formed by the postdoctoral studies, discussions with the colleagues, psychotherapeutic trainings etc. But the professional attitude may represent a *"professional prejudice"* as well. Unfortunately not even the accessibility of complete informations about psychiatric disorders can sufficiently change those prejudices. Moreover the psychiatric staff in many countries hold extremely negative attitudes towards mental illnesses. Even the professionals read mainly those informations supporting their beliefs and disqualify easily the opposing ones. This may lead to the reinforcement of the original stereotype. I am confident about uselessness of moralizing and clichés about therapeutic relationship. Similarly the diagnostics and treatment understanding enables only a tenuous insight in things patient is experiencing. More practicable is to enable deeper understanding of the internal processes of the patient in their context by the perceptive professional conveyed discussions, video records etc. There is a need also to focus on the patient's *"positive diagnosis"*, which means to stress all their skills and competences, what is sympathetic about them, what they are good at and what they may in their lives rely on. This helps to regard a person not only through diagnostic criteria focused mainly on the maladaptive features.

Working with particular patient it is essential to monitor our own thought processes (cognitions) related to this patient. The work with countertransference is a continuous process throughout the therapy. Labeling always signifies a negative countertransference, which we use as a defence mechanism in patients not improving rapidly enough to satisfy our need for success, or are not grateful enough (or even criticizing us), want more care than we want to provide or we envy them (if they are more successful in their lives). Labeling renders us a false feeling of being more valuable than to one we are labelling.

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