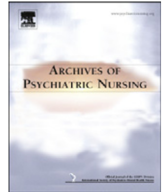
Archives of Psychiatric Nursing xxx (2016) xxx–xxx

Contents lists available at ScienceDirect

Archives of Psychiatric Nursing

journal homepage: www.elsevier.com/locate/apnu



Stigma as a Structural Power in Mental Health Care Reform: An Ethnographic Study Among Mental Health Care Professionals in Belgium☆

Charlotte Sercu *, Piet Bracke

Department of Sociology, Ghent University, Belgium

A B S T R A C T

The growing interest among scholars and professionals in mental health stigma is closely related to different mental health care reforms. This article explores professionals' perceptions of the dehospitalization movement in the Belgian context, paying particular attention to the meaning of stigma. Combined participant observation and semi-structured interviews were used to both assess and contextualize the perceptions of 43 professionals. The findings suggest that stigma may function as a structural barrier to professionals' positive evaluation of de-hospitalization, depending on the framework they are working in. It is important to move beyond a unilateral understanding of the relationship between stigma and de-hospitalization in order to attain constructive health care reform.

© 2016 Elsevier Inc. All rights reserved.

Care for people with mental health problems has undergone major changes since the construction of the first mental asylums in the 19th century (Fakhoury & Priebe, 2007). In particular, the second half of the 20th century was characterized by a landscape of institutional change in mental health treatment, with alterations to the definition of mental illness, treatment modalities and the structures of institutions providing care, together with transformation of the entire organization of the treatment system (Pavolka, Harding & Pescosolido, 2007). Many countries have followed the trend of psychiatric hospital run-down, often referred to as deinstitutionalization (Pilgrim & Rogers, 1993, p126). Although it is certain that numerous developments are related to this evolution – such as advances in the medical treatment of mental illness and the identification of stress as a cause of disease – the shift toward de-hospitalization has been equally informed by the critical gaze of the anti-psychiatry movement (Cooper, 1967). This movement has expressed concern about the social control function psychiatry performs in society, and has challenged the medicalization of mental illness (Crossley, 1998).

The criticism of psychiatry has been adopted as the central premise of the sociological approach to stigma by seminal authors, such as Ervin Goffman for example in his works on institutional life (1961) and stigma (1963). Moreover, the rise of mental health stigma research has to an important extent been informed by the identification of both institutional policies and professionals as stigmatizing (e.g. Cohen & Struening, 1962). Hospital treatment has been identified as a damaging enterprise, which ultimately results in a 'spoiled identity' (Goffman, 1961, 1963).

The previously dominant inpatient stays have nowadays been lessened and community mental health care facilities established, because community-based care is assumed to be intrinsically more humane, more therapeutic and more cost effective than hospital-based care (Thornicroft & Bebbington, 1989). In relation to stigma – conceptualized by Link and Phelan (2001) as the co-occurrence of labels, negative stereotypes, separation of us from them, discrimination and status loss in a context of power that allows these components to unfold - the guiding idea is that increased contact between the public and people with mental illness, due to the de-hospitalization of care, will provide an opportunity to diminish stigma and facilitate the social reintegration of people with mental illness into the community (Novella, 2010).

However, the unilateral approach of community care as a positive alternative to hospital care has also been criticized. The whole movement toward de-hospitalization, together with the described transformations in both the professional organization and the scope of mental health problems, has been interpreted as a further colonization of the social space by the psychiatric discipline. Although these changes at first glance appear in line with the anti-psychiatrist appeal for de-institutionalization, theorists such as Szasz (1970) identify the developments as a further medicalization of the abnormal. The shift in focus onto social relationships and other stressful conditions has been interpreted by critics as a means to classify anyone as having the possibility to be in need of psychiatric care. Further, although every individual should now be attentive to signs that may alert them to mental health problems, the concern exists that community care only serves

☆ Funding: The Research Foundation Flanders (FWO).

* Corresponding Author: Charlotte Sercu, PhD Student, Herlegemstraat 17, 9040 Sint-Amandsberg, B-9000, Ghent, Belgium.

E-mail address: charlotte_sercu@msn.com (C. Sercu).

http://dx.doi.org/10.1016/j.apnu.2016.06.001

0883-9417/© 2016 Elsevier Inc. All rights reserved.

Please cite this article as: Sercu, C., & Bracke, P., Stigma as a Structural Power in Mental Health Care Reform: An Ethnographic Study Among Mental Health Care Professionals in Belgium, *Archives of Psychiatric Nursing* (2016), http://dx.doi.org/10.1016/j.apnu.2016.06.001

ARTICLE IN PRESS

the newly diagnosed and less severely ill individuals, instead of those with serious problems (Fakhoury & Priebe, 2002; Van Hecke, Joos, Daems, Matthysen, & De Bruyne, 2011). Moreover, community care is believed to prolong the differential treatment of individuals who occupy different social positions; in the great majority of cases, middle-class patients with acute or mild disorders are those who benefit the most from the new community system (Novella, 2010).

PROFESSIONALS AND COMMUNITY CARE

The critics of the de-hospitalization movement from within the profession first illustrate a certain reluctance to believe in the movement. Research into professionals' attitudes and beliefs confirms that professionals do not differ notably from other people in their evaluation of community care (e.g. Lauber, Anthony, Ajdacic-Gross, & Rossler, 2004).

Second, it is found that psychiatrists rate it more positively than nurses do (Prior, 1993, p.83), which indicates the need to contextualize professionals' beliefs. This concerns, for example, the relevance of their relationship to the medical psychiatric framework and how this framework is questioned or reinforced through the current movement. Work on mental health nursing showed for instance how nurses' intricate relationship with the medical, psychiatric model of care is at the core of their identity construct (e.g. Handsley & Stocks, 2009; Mior & Abraham, 1996). Nurses' efforts not to define mental health nursing in medical scientific terms were then identified as a means to construct a distinctive professional identity, rather than to be the result of fundamental changes in mental health work (e.g. Cutcliffe & Happell, 2009). In relation to stigma, recent work (XX, 2015) suggested that nurses' particular relationship with the medical model of care has an impact on their perception of stigma, which in turn seemed to influence the understanding of their professional role. When nurses did not depend on a therapeutic, goal-oriented framework in the construction of their relationships with service users, the stigma they observed in society informed their internalized role expectations. Contrarily, when nurses worked in a setting with a clear diagnostic and therapeutic framework they distilled less meaning from possible external frameworks like mental health stigma. This may firstly suggest that nurses' perception of the current community movement and the role stigma plays in it, may equally be informed by the professional framework they are working in. Furthermore, the differences in evaluation of community care between professions may equally be brought back to the meaning of the professional framework people are working in. As such, it may also be too simple to just state the similarity between professionals' perceptions and those of the general population, as these may be shaped by different dynamics.

Community Ideology and Stigma

Somehow in line with the previously mentioned work on nurses' perceptions, it appears that the proponents and opponents of the community ideology differ considerably in their approach to mental health stigma. Although the reform toward community care intuitively implies change at the organizational level, the conceptualization of stigma in the ideology concerns an individual-level approach, with a prime focus on changing stereotypes and negative beliefs through the increase of interpersonal contact, in line with the contact hypothesis (Couture & Penn, 2003). This lack of attention to the broader picture, in terms of the position and role of both mental health care and stigma, forms the main issue for the critics of the community ideology. They severely criticize the ignorance of the power context in which both care and stigma processes take place (see Link & Phelan, 2001), and ignorance of the structural component in the debate on community care and stigma. This structural dimension of stigma has recently gained increased attention by sociological stigma theorists, who denounce the unilateral individual focus, stressing the essentially social nature of stigma, rooted in social structure, and the need to go beyond one-to-one stigmatizing interactions (e.g. Parker & Aggleton, 2003). Hatzenbuehler and Link (2014, p.2) define this focus as one on the "*societal-level conditions, cultural norms and institutional policies that constrain the opportunities, resources and wellbeing of the stigmatized*".

This article focuses on professionals' perception of the de-hospitalization movement and more particularly studies the dynamics which influence these perceptions and how these are informed by mental health stigma (see Fig. 1). This involves the perceptions of professionals working in different inpatient care settings in the Belgian context, who are these days exposed to the idea of de-hospitalization.

In Belgium, innovation in the mental health care sector is still on the agenda. Within this, the most comprehensive development concerns the regulation that allows psychiatric hospitals to test the organization of care circuits (programs and services) and networks of services, which should lead to a more integrated and individualized approach to service users' problems. This is based on Article 107 of the Hospital Act of 2008 (Gerkens & Merkur, 2010), aiming at both the establishment of community care and enhancement of the integration of care (Nicaise, Dubois, & Lorant, 2014). However, efforts in terms of community-based care remain minor compared with the residential centers linked to psychiatry (Report of the Economist Intelligence Unit, 2014). In 2010, there were 38 psychiatric hospitals in Flanders, 10 in Brussels and 20 in Wallonia, with almost 177 beds per 100,000 inhabitants, whereas the European average is 61 beds. Furthermore, between 2005 and 2011, the number of beds in psychiatric hospitals actually increased (Samele, Frew, & Urquía, 2012).

Accordingly, we analyze how professionals perceive the turn toward community care and how stigma informs these perceptions, drawing on qualitative data from two psychiatric hospitals in the region of Ghent (Flanders). The key question is: How do professionals perceive the community turn in mental health care and how does stigma influence these perceptions? In an effort to contribute to the discussion on the role of stigma as a contextual feature in the situation of de-hospitalization their accounts are framed within the broader functioning of mental health care in society. The focus on the dynamics between context and personal experience makes it further possible to view professionals as social agents who employ different levels of resources, rather than categorizing them as good or bad actors.

METHODOLOGY

Case Selection

This article is based on case-study research into stigma in mental health care, conducted between 2011 and 2012 in two psychiatric hospitals in the region of Ghent, Belgium. For this study, qualitative data were gathered through semi-structured interviews with service providers (n = 43), combined with participant observations (750 hours in total). Based on the specific intent to study stigma in the context of mental health care as a contextual issue, theoretical sampling was chosen as the main sampling strategy; a type of purposive sampling proposed by Glaser and Strauss (1967, p.45) in their grounded theory. We chose two hospitals with different notions of care for people with mental health problems. Hospital A adhered to a more social explanatory model in the definition of its service users, and identified the less healthy as socially marginalized and misfortunate. In hospital B, service users were primary perceived from a diagnostic point of view and the care approach was based on the dichotomized categorization of healthy versus ill. This background was crucial to orient the hospital sample, because it is recognized that dominant processes of dichotomized categorizations are at the core of stigma processes (Link & Phelan, 2001).

At the time we designed our methodology, a significant proportion of the users in hospital A had multiple psychiatric problems, were homeless or faced juridical procedures. This setting had a high prevalence of long-term inpatient care. Hospital B focused on the treatment of people with acute mental health problems, and served as an

Please cite this article as: Sercu, C., & Bracke, P., Stigma as a Structural Power in Mental Health Care Reform: An Ethnographic Study Among Mental Health Care Professionals in Belgium, *Archives of Psychiatric Nursing* (2016), http://dx.doi.org/10.1016/j.apnu.2016.06.001

Download English Version:

https://daneshyari.com/en/article/6786910

Download Persian Version:

https://daneshyari.com/article/6786910

Daneshyari.com