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Title: The old and mentally ill in Australia: Doubly stigmatised

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Abstract

This review proposes that the stigma attached to being old and having a mental illness has a disproportionate impact on those who are categorised as both. A brief historical account is given of what it means to have a mental illness and, separately, what it means to be old. Next, the stigmatising attitudes and their implications for the two separate groups will be reviewed, with discussion of the Australian media's portrayal of mental illness and old age. It is further argued that the implications of double stigma may be multiplicative, having even more of an impact on elderly mentally ill people than a separate consideration of these categories might suggest. Finally, some suggestions are made for beginning to address the double stigma attached to being both old and having a mental illness in Australia.

The marks of shame attached to both mental illness and to old age create a double stigma for increasing numbers of individuals (de Mendonça Lima, Levav, Jacobsson & Rutz, 2003). While the stigma attached to mental illness has been widely documented (for example, Arboleda-Florez, 2003; Gaebel, Baumann, Witte, & Zaeske, 2002; Hocking, 2003; Johnstone, 2001; Walter, 1998), and the problems faced with growing old in a given society attract some research attention (Davis, 1996; Edgar, 1991; Hugman, 2001; Pinkerton James, 1992), review of the literature suggests that there is a lack of knowledge, understanding, and even awareness of the double stigma attached to those who are categorised as both. The current review, therefore, explores the problems faced by elderly persons who have a mental illness. First, the review presents a brief historical account of what it means to have a mental illness and, separately, what it means to be old. The stigmatising attitudes and their implications for the two separate groups will also be reviewed, with discussion of the Australian media's portrayal of mental illness and old age. Next, it is argued that the implications of double stigma may be multiplicative, having even more of an impact on the old and mentally ill than a separate consideration of these categories might suggest. Finally, some preliminary steps towards solving the problem of the double stigma attached to being old and having a mental illness are suggested.

An historical account

The term stigma comes from the Greek language, referring to signs that indicate something out of the ordinary about the person, and was adopted by the eminent twentieth-century sociologist Goffman to refer to various attributes of a person that lead to that person being regarded as less than human (Goffman, 1963, reprinted in

Lemert & Branaman, 1997). Stigmatisation is thus a process whereby a negative social meaning is attached to certain behaviours or individuals (Joachim & Acorn, 2000).

Stigmatising attitudes existed in Greek society towards those with mental illness, with associated concepts of shame, loss of face, and humiliation (Arboleda-Florez, 2003). Walker (2003) discusses the "dark ages" of the English speaking people, describing society's approach toward people with a mental illness as cruel and violent: such people were considered as under the influence of Satan and demons and burned at the stake as witches. Later, among Christians, "madness" was regarded as a form of punishment that God inflicted upon sinners (Arboleda-Florez, 2003).

Eventually, during the 19th century, such notions largely gave way to the concept of mental illness as a medical condition, though how far it is biologically determined and how much a social construction remains at issue (McNamara, 1996). For the purpose of the current review, it is important to recognise that the notion of mental illness involves the connotations, whether positive or negative, that society attaches to it.

The meaning of what it is to be old, of course, has also developed through particular historical and social processes (Berger & Luckmann, 1972, cited in Hugman, 2001). Generally, though, old age is defined as those who are 65 years and older (De Mendonça Lima et al., 2003). Stigma against the elderly depends on the status of elderly people in a given society, and when we look at the stigma attached to being old, we must consider the discourse of "old age" (Hugman, 2001). Evidence of the separation of the elderly from other members of society is apparent throughout history among tribal communities, where the elder was seen to

be of high status, but it has been suggested that, in more recent times, the consideration of old age as a separate category within the lifespan must be understood in relation to the withdrawal of older persons from the employment market (Minois, 1989, cited in Hugman, 2001).

Hugman (2001) argues that the high status that Western society used to ascribe to older people has not been lost in recent generations, despite popular opinion to the contrary. Hugman also disagrees with the notion that, compared to earlier times, families by the late twentieth century were ceasing to provide needed care for their older relatives. Whether or not one agrees with such claims, what is clear and indisputable, even to Hugman, is that recent years have seen a rapid growth of the creation of a separate space for older people, both physical and social, the creation of which can be seen to result from stigmatising attitudes towards elderly people.

Prevalence of mental illness among the elderly

There are inconsistencies within the literature in reporting the prevalence of mental disorders among the elderly. Australia's Commonwealth Department of Health and Aged Care (2000) states that the prevalence of most mental disorders reaches a maximum in late adolescence/early adulthood, and falls off thereafter. Henderson et al. (1998) report more specifically that symptoms of depression show a decline with age in both men and women. What does not make sense to Snowdon (1997), however, is why an increased loss of funds, relatives, status, income, accommodation, and health does not lead to increased depression. Snowdon goes on to argue that claims that depressive disorders become less frequent in later life are not supported with evidence; critiquing a paper by

Henderson and Jorm (1997), Snowdon points out that major depressive episode and dysthymia were the only DSM-III-R depressive disorder categories included, with no discussion of the rates of depressive disorder not otherwise specified, dementias with co-morbid depression, organic mood syndrome or adjustment disorder with depressed mood (Snowdon, 1997).

There are other, more recent claims that depression in older adults is largely under-diagnosed and under-treated (Kanapaux, 2004; The Lancet, 2000). Furthermore, incidence of chronic physical conditions increases with age, with some conditions, such as heart disease, shown to predict depressive symptoms (Broe et al., 1998). Overall, therefore, while there is evidence that some mental disorders may be less frequent in older people (ABS, 1997) there is also reason to believe that mental disorders go underreported in this population. This is of particular concern given that some three-quarters of elderly suicide completers have been found at psychological autopsy to have had a mental health disorder (Preville, Hebert, Boyer, Bravo & Seguin, (2005).

Old age and mental illness today

Inconsistencies in the literature also arise when we consider the stigma attached to mental illness today. Walker's (2003) extreme view is that not only did the First Fleet carry prejudices to Australia, but that many of these beliefs still lie beneath the surface of modern society. It is argued that while the attitude of most of our community leaders and members of the medical profession towards those with mental illness has shifted over the years from one of rejection towards guarded acceptance, this is not true for all Australian society (Walker, 2003). In sharp contrast, Walter (1998) reports the overwhelming belief that consumers

experience more stigma and discrimination from mental health professionals than from any other sector of society. While few would argue that these prejudices do exist, there is a need to identify characteristics of those who hold stigmatising beliefs so that intervention strategies can be directed accordingly (Corrigan & Miller, 2004).

When we consider what it means to be old, Keigher (1999) expresses what may be considered a rare and valuable view: that older people of today possess a vitality of spirit made possible by healthier lifestyles, diversity-creating lifetime experiences and positive reciprocity between the generations (Keigher, 1999). While Keigher's view, optimistic as it is, would erase much of the stigma associated with old age if shared by more members of society, the disappointing fact is that it is far from reality. Existing social, economic, and demographic changes create a series of challenges for elderly people, jeopardizing their role in society. The "International Year of Older Persons" in 1999 aimed to work towards a society based on acceptance of all ages, but, as Keigher (1999) acknowledged, this would take more than on International Year. Now, in 2006, further changes of the kind identified by Keigher are required, including reforming the nation's policies and health practices and professions (Keigher, 1999).

Stigma and the mass media

The media play an important part in shaping public attitudes, and public attitudes towards people with a mental illness and those who are old are no exception (Blood, 2002; Edgar, 19991). Blood found the most stigmatising forms of Australian media, with regard to mental illness in particular, to be news coverage of courts, coronial inquiries, and information from the police. Such reports do not necessarily contain inaccuracies but, rather, the communication

technique of "framing" commonly employed in these instances promotes fear of those with mentally illness (Blood, 2002). Cases of violence are often reported as though they were typical of people with a mental illness despite the fact that, statistically, such people are no more violent that the general population (Blood, 2002).

Williams and Taylor (1995) performed an analysis of 83 newspaper articles from February 1991 to January 1993 to determine the role of Australian newspapers in the portrayal of the mentally ill. In total, 145 negative themes about the mentally ill were recorded, 107 of which referred to the mentally ill as being aggressive, violent (or potentially violent), dangerous and destructive. They went on to list other sub-categories that descriptions of the mentally ill were placed into, including their portrayals as wanderers, homeless or impossible to place into the community, irresponsible, vague, and ignorant. Perhaps even more alarming is the fact that only five statements within the 83 articles analysed in the study contained positive themes about the mentally ill. Of these, four stated that they were courageous, while one article referred to a person as "very pleasant once he was back on his medication" (Williams & Taylor, 1995). Williams and Taylor observed that the power of the ubiquitous print media has indeed helped to maintain the stigma associated with mental illness.

Writing in 1991, Edgar noted the negative image of ageing, with its associated stereotypes, compounded by fear-engendering discussions about what an ageing populace means for the future. Edgar suggested that our sense of self, as we age, is dependent upon our health and sense of control. The latter, he proposes, is subject to external influences in the form of feedback from others, so that the existential aspect of ageing is open to strong influence from stereotypes in the mass media.

The mass media can thus be seen as a major source of the stigmatising attitudes towards mental illness and old age inherent in modern society. Edgar (1991) suggested that the Australia of the early 1990s was facing a media archaic in its social understanding, stuck in the cult of youth and promoting an image of aged people that denies their status as elders with useful resources to offer society. Fifteen years on from Edgar's article, the stigma of ageing, particularly for women, may be even greater, given the current vogue in Australia for US-inspired TV shows depicting cosmetic surgery to disguise the visible signs of ageing (Feldman, 2004).

Implications of stigma

Sartorius (2003) recognises that the stigmatisation – because of mental illness and because of being old – makes life difficult to endure for this growing population. Today, mental illness is generally considered one of the most stigmatised human conditions worldwide (Johnstone, 2001). Johnstone holds that the mentally ill have been subject to major breaches of their human rights, while those with additional disabilities are even more vulnerable. Equally, it can be argued that those who are both mentally ill and considered old in age may be among the most disadvantaged groups.

Not surprisingly, these stigmatising attitudes lead to overt acts of discrimination. Stigmatisation creates difficulties in accommodation, decreases access to health care, isolates the individual from family and other members of the community and, in many cases, leads to a loss of self respect (Hocking, 2003; Sartorious, 2003).

McNamara (1996) argues that the policy of deinstitutionalisation and community care for those with mental illness is dependent upon their being successful in finding accommodation, yet fitting into the community is, in practice, no easy matter (Hugman, 2001). Contributing factors include constraints on public funding, poverty and discrimination (McNamara, 1996), with stigma leading people to not wish to live near, or socialise with, those who have a mental illness (Graham et al., 2003).

Gaining access to appropriate mental health care is a further difficulty for those who are also elderly. Financial difficulties, poor health and the deaths of loved ones can leave elderly people socially isolated and at risk of depression (Davis, 1996), yet appropriate treatment may not be forthcoming. Katona and Livingston (2000) suggest that the stigma of mental illness is perhaps the most fundamental reason why elderly people are not treated for depression. While those in need of help for depression may not receive it, it should also be recognised that at least 85% of elderly people do not have depression, yet ageist assumptions that depression is an inevitable consequence of old age continue to exist (Katona & Livingston, 2000). This ageist assumption can lead to depressive symptoms being ignored and wrongly accepted as part of the normal ageing process (Davis, 1996). Moreover, the recognition of depression late in life may be difficult because of the likelihood of its presenting in the form of somatic and anxiety symptoms rather than with overt sadness; also, in the face of concurrent physical illness, the importance of depressive symptoms may be minimised (Katona & Livingston, 2000), especially as older individuals tend to complain less about their depressed mood and focus on physical symptoms (Davis, 1996). In this way stigmatising

attitudes, whether directly or indirectly, decrease the older person's access to health care and form a real barrier to optimal recovery.

Graham et al. (2003) recognise that stigma erodes the confidence that mental disorders are valid, treatable conditions. A popular belief among young people that depression is an emotional state and not a health risk (Martin, 2003) highlights the stigma attached to even "minor" mental illness. Furthermore, it has been found that community care and mental health workers in Western Australia agree that stigma is a significant barrier to the use of mental health services (Sweeny & Kisely, 2003); that study found the stigma of mental illness to be especially pronounced in elderly people themselves, leading to barriers to the management of mental health problems.

The provision of health care in general to elderly people is not seen as an attractive career by medical students, despite the obvious demand for doctors specialising in this age group (Edwards & Grant, 2000). It is important to note, however, that students do not seem to be concerned with the age of the patient, but with the characteristics of the patient's illness. Work of a geriatrician is seen as a career in which treatment of chronic disease is the norm, and chronic disease itself carries notions of marginality, dependence and burden (Walker, Peterson, Millen & Martin, 2003). Edwards and Grant (2000) suggest that, rather than attempting to improve medical students' attitudes towards elderly people, the focus should be upon trying to improve their attitudes towards chronic disease. Results of their study are in one respect promising: at least stigma attached to old age itself is not preventing doctors wanting to care for these patients.

Family relationships are another important area affected by the problems associated with being old and having a mental illness. With the ageing population,

there is concern about whether the taxation of younger workers will suffice to provide welfare services for the elderly, who will also have fewer children of their own to provide support (The Australian Institute of Family Studies, 1998). With the concomitant problem of mental illness, care by one's immediate family may become even less of a reality.

Retirement from the workplace brings a reduction in external relationships so that older persons may depend more on their family for company and support (Australian Institute for Family Studies, 1998). Theoretically, the older generation, having succoured the next, will expect that younger generation to support them in their old age. However, Walker (2003) argues that, in contrast to the 19th and early 20th centuries, when extended families were available to care for those with mental illness, this is not feasible with the modern nuclear family. Davis (1996) maintains that we live in a youth-oriented culture which strips people of their social status as they enter later life. These views are in contrast to those of Hugman (2001), discussed earlier.

What is rarely emphasised are the figures that show how centrally involved our elders in fact are in supporting family life. Older people are more likely to be providers than recipients of many kinds of support: for example, they are twice as likely to give money to their families as the reverse (Kendig, 1983, cited in Edgar, 1991). Further, more recent research suggests that when grandparents' children need help due to financial, physical, or emotional problems, some grandparents provide extensive babysitting or financial support (Reynolds, Wright, & Beale, 2003). This is in contrast to the common portrayal of elderly people as a burden on families.

Implications of double stigma

When we look at old age and mental illness the effects of stigma and discrimination appear cumulative: it is hard to deny that old people with a mental illness are worse off than those who fit into only one of these categories. However, it is possible to argue that the effects may not simply be additive, but multiplicative. Such effects become evident when we compare access to care for older and younger persons with a mental illness.

As established above, it is more difficult to identify mental illness when there is a concurrent physical illness (Katona and Livingston, 2000). As physical illnesses are more common among the elderly population, it is reasonable to suggest that mental illnesses such as depression are more likely to go unnoticed among the elderly than depressive symptoms presenting in those who are young. In this way, the discrimination experienced by a depressed older person is enhanced.

Another way to demonstrate the disproportionate impact of stigma against old age and mental illness is to consider the notion of social support. Social support has been shown to influence people in many positive ways, acting as a buffer against depression and suicidal ideation for older adults (Straub, 2002; Vanderhorst and McLaren, 2005). It is also true that young people are more likely to have a higher level of social support than older adults, i.e., family and friends who show emotional concern and provide tangible assistance (Straub, 2002). In this way, an older person with a mental illness may experience enhanced negative effects from double stigma, not just because they are experiencing two types of stigma, but because they are less likely to have the social support to help deal with it.

Moreover, access to mental health care for the older population may be further hindered by Australian society's view that older people have already lived most of their life. It seems reasonable to suggest that when younger people are recognised as having a mental illness there is a greater focus on increasing the quality of life, as there may be a lot more of that life to be lived. As discussed earlier, Australians make a separate space for older people, and this is perhaps driven by the view that their days are indeed numbered.

There is also evidence to suggest that there are fewer services and less funding for the psychogeriatric than the younger population with mental health needs. Draper (2006) reports that younger adults in Australia receive three times more private psychiatric services and four times more office consults per capita than those aged sixty-five and older. Moreover, per capita Medicare expenditure on younger adults is reported to be four times that of people aged sixty-five and over (Draper, 2006).

Evidence presented in this paper clearly highlights the double burden of being old and having a mental illness in Australia, at both the individual and community level. One can further add that, given the increase in chronic physical conditions in older age, yet another stigma may come into play, from doctors and policy-makers who blame chronically ill patients for their own conditions (Walker & Millen, 2003).

De Mendonça Lima et al. (2003) suggest that there is limited public and professional awareness of stigma and discrimination-related issues with regard to the elderly with a mental disorder. While, as argued here, there is good reason to believe that elderly people with mental illness are doubly stigmatised, with at least additive, and perhaps multiplicative, effects, we have found it difficult to obtain

direct information about the consequences for this marginalised group. De Mendonça Lima's study of discrimination against European older people with a mental disorder had a single informant - the WHO representative on mental health - and this person still did not have access to all the sources of information. It seems there is a need for multiple informants and further research in this area (De Mendonça Lima, 2003).

A look to the future

Stigma against older people with mental illness is reinforced by many factors. Two such factors summarised by Graham et al. (2003) include specific beliefs regarding the value of older members of society and the lack of information systems to educate both professionals and the general public. McNamara (1996) argues that discrimination against people with mental illness is entrenched in Australian society and that our anti-discrimination laws, while not perfect, play an important role in a project aimed at eliminating that discrimination. The policy to treat people with mental illness in the community rather than institutions will only work if the community accepts such individuals as equal members of society (Blood, 2000). While Edgar (1991) notes that older people can be drawn into new social roles, this may also be true for those with a mental illness. Edgar agrees that a change in community attitudes and good support structures are needed to help ensure that this process is effective, and calls for a balance between having older people available as a source of wisdom and experience, and enjoying a well-deserved retiring stage of life.

Elderly people with a mental illness have to deal with double the generalisations and double the labelling. As established above, it appears that the media have

much to answer for when it comes to the perpetration of such stigma. Shute (2004) recognises that there is a moral imperative for the media to give due weight to stories about achievements and successes, as opposed to setting the criteria for news stories around negative events such as violence, conflict and disaster. This is in accord with Seligman's (1998) call for a "positive psychology" which focuses not just on problems and psychopathology but on strengths and resilience.

In Australia at least, care of the very young, those with disabilities, or elderly people is seen as the responsibility of the community. Instead of gaining the respect and care that older individuals with a mental illness deserve, society attaches shame, guilt, and stigma to this less fortunate minority group. As argued by Davies (2003), we need education about how to recognise, manage, and overcome difficulties associated with old age and mental illness to reduce ignorance, pejorative labels, and stigma generated by outmoded stereotypes. As the population ages, better funding is needed for research on how to care for the elderly. As those with a mental illness are brought back into mainstream society, steps need to be taken to create awareness and education for members who discriminate against those that they fear; encouragement of more positive media news stories could be one aspect of this.

Further research should aim to better understand the mechanisms leading to stigmatisation and the extent of the double stigmatisation we are suggesting to exist, and how far such effects might interact to magnify the resulting discrimination. Ultimately, this should lead to the development of interventions to prevent and reduce the effects of stigma and discrimination for the elderly with mental illness. Research is also needed into the effectiveness of anti-stigma programs. For example, Corrigan and Miller (2004) maintain that programs based

on public service announcements are only weakly effective, and they have proposed a model based on education, protest and contact with the stigmatised group as offering a way forward.

Conclusion

In conclusion, research confirms the existence of negative public attitudes towards mental illness and towards old age (Arboleda-Florez, 2003; Edgar, 1991; Hocking, 2003; Pinkerton James, 1992; Reinke, Corrigan, Leonhard, Lundin, & Kubaik, 2004; Walter, 1998). There are inconsistencies, however, in reporting the specific characteristics of those who hold such beliefs, be it the general public, professionals working in the health care system, or both.

What is known and should be taken from the current review is that the stigma attached to being old and to having a mental illness has an even more profound impact on those who are categorised as both. The stigma evident in Australian society manifests itself in acts of discrimination, jeopardising access to accommodation, health care, positive family relations, and basic human rights. Let us become aware of and understand the problem of double stigma so that those who suffer it can be treated in a way that those of us who are younger and mentally well would hope to be treated.

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