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EDITORIAL

Stigma and Mental Health: A Proposal for Next Steps

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It might be difficult for yet another commentary exploring the effects of stigma on mental illness to sound fresh and exciting. For this reason, we want to begin by accentuating and actively guarding against the phenomena of intellectual and emotional fatigue that accompanies stringent calls to action that seem nevertheless continually ignored. In this way, we can both recognize the laudable advances that we have made in the fight against stigma, such as in the case where insurance policies in the USA have been challenged and amended in favor of mental health parity [1] and also keep in mind that much remains to be done. In this editorial, we intend to identify some areas for further attention and to argue that the practice of psychiatry will be advanced and enriched by an intermingling of coherent and consistent policy initiatives with grass-root actionable endeavors.

Current Advances

Over the last three decades, medical advances in the treatment of psychiatric illness and often corresponding policy changes have made slow but still measurable progress toward decreasing stigma. In the USA, insurance policies have been challenged and amended in favor of mental health parity [1]. There are signs that the general US public has become substantially more accepting of mental health struggles [2]. Mental health topics are discussed on news programs and in popular dramas with increasingly favorable compassion and realistic portrayals [3–8]. The climate has slowly improved. Still, the work is far from finished.

The Mental Health Parity Act of 2008 and the Patient Protection and Affordable Care Act of 2010 [9], though far from perfect, have indeed made it easier for patients with psychiatric illness to receive care. It is of course frustrating that the USA needs to invoke special legislation to provide adequate care for a group of diseases that strike approximately 20 % of the population [10]. Nevertheless, inequalities with long cultural histories frequently require binding laws to remedy the existing disparities. These legislative initiatives in the USA and abroad have also stimulated a series of anti-stigma and pro-mental health public service initiatives. Endeavors such as the "Time for Change" campaign in the UK [11], "Like Minds, Like Mine" in New Zealand [12], and "Open the Doors" in Germany [13] and foundations such as "Bring Change 2 Mind" [14], Active Minds [15], and "In Our Voice" [16] from the National Alliance on Mental Illness in the USA are all working to diminish stigma and lessen barriers to early identification and treatment of mental disorders.

In education, there has been increased attention to curricular planning to strengthen psychiatric context instead of diminishing its importance across medical training. At least historically, psychiatric education has been relatively neglected. The attention given to mental health concerns in the typical medical school curriculum falls far short of what many would see as proportionally appropriate given the impressive prevalence, morbidity and mortality, and overall cost

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of mental disorders [17]. Additionally, the clerkship experience, at some institutions as short as 4 weeks, continues at many schools mostly on an inpatient unit. This setting has disadvantages in that medical students cannot readily determine what it is like to be a psychiatrist from an inpatient experience alone.

These practices and concerns implicitly influence students to believe that psychiatry is less valued given its apparent underrepresentation and odd course times in many curricula. Additionally, students may be explicitly told by their mentors that psychiatry is a less worthy career choice [18]. These effects have taken their toll, and indeed the new frontier in the battle against mental health stigma has shifted substantially to the issue of access. Due to a significant paucity in their education and training, primary care physicians feel underprepared to diagnose and treat much of the mental health problems for which they are asked to take responsibility [19]. Moreover, there is a national shortage of psychiatrists, especially in subspecialties such as geriatric, child, and addiction psychiatry. On virtually every front, current advocacy efforts will have to include shifts in our educational approach, both within and outside of medical school, if we are to continue to effect change.

Interconnected Challenges

We know that stigma against mental health exists. We know that stigma against psychiatric patients exists. And, perhaps most important to the medical educator, we know that stigma against the medical discipline of psychiatry exists. We know as well that all of these biases are the product of complex and incorrect cultural beliefs. Perhaps most damagingly, we continue to suffer from the unfounded public view that psychiatric suffering is intractable and poorly responsive to treatment. We also must account for the ongoing gap between the basic science that strives to explicate the etiology of psychiatric disease and the clinical parameters that constitute standard of care practice. It is not, however, within the scope of this editorial to summarize the mismatch between basic research and clinical practices. Nor do we wish to give the impression that basic science efforts have been ineffective. We need only to look at the growing understanding of epigenetics to appreciate the extent to which practice patterns have changed as more sophisticated assessments are increasingly integrated into diagnosis and treatment strategies. Still, surveys continue to show that some medical students view psychiatry as the least scientific field of medicine and many worry that by becoming a psychiatrist they will be abandoning the foundations of science on which the "rest of medicine" more firmly sits [18].

Doctors and student doctors in training thus may get the impression that psychiatric suffering is neither real nor the purview of the physician. These student doctors subsequently may have their suspicions confirmed by ongoing explicit biases stated by their teachers. As physicians in general are in the powerful position of becoming de facto as well as deliberate advocates and spokespersons for their patients, psychiatric sufferers receive perhaps less advocacy from the institutions where doctors are trained. This translates into diminished appetite among policymakers toward furthering change and a sense of at first ennui and later frustration among patients and their families who are attempting to receive care.

To the extent that public acceptance of psychiatric illness has been arguably more robust than the overall response of medical education, patients find themselves willing and encouraged to seek care but quickly encounter an immensely frustrating, byzantine, underpopulated and poorly integrated workforce of qualified providers. In other words, medical education, culture, economic barriers, and prevailing lack of incentives all come together to fuel stigma and mental health despite our best efforts. Attempts to solve only one or two of these many issues related to mental health and stigmas will fall short of what is needed. All of these issues are intimately interconnected. *So what to do?*

As suggested earlier, we urgently need a series of reforms that are coherent and consistent in their goals and that take into consideration the multifaceted ways that stigma persists despite our efforts. In the following sections, we will outline in broad strokes what we feel is necessary to effect these changes.

Medical Education

Medical education must allow psychiatry and psychiatric principles to play a greater role in the education of future doctors. Clerkships must be longer than 4 weeks and/or more longitudinally designed. One can convincingly make the case that given the lack of emphasis on psychiatry that characterizes preclinical and clinical curricula, the psychiatry clerkship ought to include inpatient, outpatient, and substance abuse treatment experiences.

Additionally, non-psychiatric courses and clinical curricula must be more inclusive of psychiatric content. Psychiatry is part of all fields of medicine, whereas one might be hard pressed to make the same claim for other clinical medical disciplines. There is psychiatry in nephrology (e.g., delirium in the elderly following a urinary tract infection), psychiatry in dermatology (e.g., worsening psoriasis during increased stress), psychiatry in primary care throughout the entire lifespan (e.g., visits to a primary care clinician that require mental health treatment are not recognized as involving mental health concerns), psychiatry in obstetrics and gynecology (e.g., with perinatal depression being the most common complication of childbirth), and psychiatry in surgery (e.g., chronic pain and poor oxygenation can mimic depression). And this is by no means an exhaustive list. Ample opportunities exist to weave psychiatric content throughout the curricula, and the

more this is done, the greater headway we will make as medical educators in dispensing with the biases that insist that psychiatry has little role in the rest of medicine. Moreover, we as a field have had difficulty fostering comparable integration of psychiatric education in graduate medical education (GME). This has been loudly called for by many specialty organizations, and any medical education initiative must also include better training in mental health concerns for the primary care physicians who remain the most common providers of mental health care.

In concert with these changes, psychiatrists are increasingly focused on the primary and secondary prevention of psychiatric illness. We can accomplish this goal through attention to environmental changes that result from mindfulness training and increased awareness of the principles of wellness and resilience and through research that informs the early diagnosis and treatment of mental disorders. These skills are essential for tomorrow's physicians, as a means of not only staving off their own stress, distress, and mental health conditions when possible but also avoiding the pernicious and destructive emotional exhaustion to which physicians are more and more at risk. Psychiatrists should aim to work with other medical professionals and health care disciplines to teach these skills together, ideally in clinical settings that meaningfully integrate psychiatry into other specialty services.

Finally, neuroscience, genetics, epigenetics, and the science of the relationship between patient and doctor are perhaps the greatest frontiers in modern medicine and these basic science endeavors are uniquely and excitingly linked to psychiatry [20]. Whenever possible, students should be exposed to the ways that these scientific pursuits currently advance or can potentially advance psychiatric treatment in the coming years. Medical students should be as energized about translational science in psychiatry as they are about subjects such as solid organ transplants.

Incentivizing the Practice of Psychiatry

In the USA in the mid-1980s, the government enacted a series of very public initiatives toward recruiting more graduating physicians into primary care. There were loan forgiveness programs in concert with active and well-managed public information campaigns about the satisfaction that accompanies the work of primary care. Although many would argue that today's primary care physicians are harried and overwhelmed, this may in part be due to a relatively rapid growth in the numbers of primary care patients coupled with an increasingly burdensome administrative and bureaucratic system that has little to do with practicing medicine. It could also be argued that at least some of this discontent is correlated with a corresponding increase in the number of psychiatric problems that primary care providers must treat despite their overall lack of training in how best to assess and manage these patients.

To this end, we recommend a campaign similar to the public mandate for primary care recruitment, this time focused directly and without ambiguity on choosing psychiatry as a discipline. It is not uncommon to see posters in medical school hallways advertising loan forgiveness for primary care. These posters should also explicitly mention psychiatry. In fact, already loan forgiveness programs are in place for psychiatry [21], but these programs are poorly advertised and difficult to understand. A high-level, professionally driven campaign that links the frequently pro-psychiatry desires of medical students as expressed in their personal statements with the ways we are lucky enough to practice psychiatry could go a long way toward helping students to overcome their reluctance to choose psychiatry as a profession. Admittedly, more students are matriculating into psychiatry than a decade ago, but the numbers still fall far short of what we need. It is important to note that because the overall number of medical student graduates has increased, the percentage of students choosing psychiatry has stayed roughly the same. Our medical and public health infrastructure must therefore take a more active role in recruitment.

We as educators must also increase our recruiting efforts. We have some of the highest job satisfaction rates in all of medicine [22]. We should take pride in what we do. And we should help our students learn about the wide range of exciting and professionally fulfilling career opportunities available in the practice of psychiatry.

Finally, as members of the academic community, faculty members need to be far more proactive. We should participate on medical school and GME committees to promote the inclusion of psychiatric education across specialties. We should submit proposals for grand rounds, poster sessions, and talks within hospital communities that demonstrate the integration of our scientific foundations with evidence-based clinical practice. We should round more often and participate more readily in clinical conferences with other disciplines to demonstrate the wealth of expertise and contributions that we can make in general medical education and clinical care. Additionally, we should be active participants early in medical school, especially in courses that emphasize interpersonal communication skills, history taking, the neurosciences, evidence-based medicine, ethics, and doctoring curricula. Finally, we should engage student interest groups in a wide range of areas including psychiatry, community and global health, public policy, and physician wellbeing. In short, psychiatry needs to become more engaged and present on our medical school and GME communities. None of this will be possible without adequate funding. These initiatives must also involve stringent efforts toward securing financial support for these important endeavors.

Advocacy

The fact that we need to have laws protecting parity with regard to mental health treatment is somewhat astounding,

given current epidemiologic burdens. As is often argued, can anyone imagine having to call a separate number on the back of an insurance card in order to obtain cardiac or renal care? Psychiatry should not be singled out in this way. The marginalization of psychiatry leads students, patients, and the general public to believe that psychiatry is somehow less important. Patients then quite rightfully complain to their non-psychiatric providers that they cannot find a psychiatrist, or they simply give up. Absenteeism at work, as well as presentism—being at work but functioning at a much-diminished capacity—is just part of the economic costs of the ongoing lack of parity. Worse, patients continue to suffer in virtually every arena of their lives [23]. There are no upsides to the ongoing lack of access to psychiatric care that third party payers create in the USA.

Psychiatrists are of course physicians. As such, psychiatrists have potent voices in local and federal politics. We also have potent voices in public education spheres. We must remain organized and active to combat this lack of parity. We need to engage in public outreach through editorials, speaking at community forums, and participating in political action. We are not suggesting that psychiatrists need run for office, though retired US representative and child psychiatrist Jim McDermott's tenure in Congress was enormously helpful in keeping mental health concerns on our nation's legislative dockets. We do recommend, however, that psychiatrists never hesitate to contact state and local political figures. Important laws and initiatives are considered by local and national legislatures virtually every legislative session. It behooves us to be aware of these movements and to have our voices heard. In particular, we must fight the economic stigma that hinders psychiatry and other so-called non-procedural medical disciplines. It is difficult to justify the disparity in average salaries among different kinds of physicians given the enormous debts that student doctors accrue. We will need revolutionary legislative changes to remedy these disparities. We should especially stress the important role that psychiatrists have in addressing behavioral issues such as addiction, nonadherence, and unhealthy lifestyles. These behavioral challenges account for no less than one third of the estimated 1.2 trillion dollars that scholars have argued is annually wasted in the US health care system [24].

We should also advocate for programs that counter the perpetuation of generally negative and stigmatizing portrayals of mental illness in the mass media. As noted earlier, media depictions of mental illness are increasingly less biased, although much remains to be done on this important front. Stigma threatens funding, encourages fear, and potentially undercuts the recovery of those with mental disorders. Psychiatrists should seek to understand the cultural processes that contribute to and sustain stigma and should actively work to diminish these processes [6–8, 25]. Understanding these mechanisms is essential to working effectively with media personnel and to developing effective programs for countering stigma. We can accomplish some of these goals by making ourselves available as instructors for undergraduate courses or even high school seminars.

Finally, we need to be more inclusive within our own ranks. There are many acceptable and effective ways to practice psychiatry. It is actually difficult to create a comprehensive list of the various ways we define ourselves. At the most basic level, we are therapists, pharmacologists, generalists. But we know well that we define ourselves by all of these distinctions and more. We should actively and without hesitation celebrate with our students the choices and freedom we enjoy when we practice psychiatry. This is one of our greatest strengths.

To paraphrase a popular bumper sticker, "stigma happens." That stigma, however, should never be taken for granted. We have the power to change these issues, but we must be united and consistent in our goals. By addressing stigma at curricular, social, cultural, and political levels, and by coordinating these approaches, we will continue to make progress. Our patients depend on us to fight for these important changes.

Compliance with Ethical Standards

Disclosures On behalf of all authors, the corresponding author states that there are no conflicts of interest.

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