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Stigma and what we can do about it

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Editorial

Psychiatrists and their patients deal with the social stigma of mental illness every day. Who among us has not heard a request from a patient or a loved one for referral to "a real doctor". Who of our patients has not lost contact with friends or even loved ones and family over the fact of their mental illness? Some diagnoses are associated with more stigmas, especially the psychoses, and substance addictions. Antibiotics have made psychosis due to neurosyphilis much less common, but before the discovery of antibiotics, it was the most common indication for psychiatric hospitalization with diagnosis of general paresis [1]. It was also the most associated with stigma, as it always implied sexual misconduct in the eyes of the public, including patients. Historically, physicians have always been identified in common parlance by the organ system their training and studies and their professional activities most covered. Even today cardiologists are commonly called "heart doctors", and nephrologists are called "kidney doctors". Psychiatrists are not often addressed that way today, but at the time of the American Revolution, members of our profession were commonly called "Mad Doctors". That father of our nation and professional organization, Benjamin Rush would have commonly been addressed this way, as a commonplace term [2]. The story of how that changed is fascinating. It involves the development of psychosurgery and its popularization, the development of convulsive therapies near the same time, as well as other important cultural currents. Egas Moniz reported his prefrontal leucotomy in 1937 [3,4], a procedure that is much more similar to the cingulotomy still performed by neurosurgeons, than to the prefrontal leucotomy as it was popularized by Freeman [4,5]. Freeman's procedure involved driving a sterile ice pick through the roof of the orbits, to a depth of several inches, and then waving it once from side-to side, cutting the white matter tracts, and usually, no major blood vessels [6]. After undergoing the procedures, patients were likely to be much less aggressive, but also to have much less motivation, memory, and the executive functions of the frontal lobes. This procedure is not performed anywhere today.

The convulsive therapies were developed in Italy and Germany in the 30's. Meduna was the first, developing Metrazol shock therapy, using a drug that lowers the seizure threshold, and so, causes the patient to have a grand-mal seizure. Sakel [7] was next, administering an overdose of insulin to the patient, so that hypoglycemia would precipitate a seizure. The release of stress hormones, adrenaline, noradrenaline, and cortisol during the seizure would (usually) cause enough glycogenolysis and gluconeogenesis to raise glucose to a normal level in time to save the patient's life. Electroconvulsive therapy was by far the safest of the convulsive therapies. Professor Bini wrote the first paper reporting it in 1938, [8], and following up with studies the next year [9]. ECT has been both safe, and in many ways the most effective therapy for catatonia, for severe major depression, and it sometimes has a place in the treatment of refractory schizophrenia. Today, mad doctors and mad scientists are staples in horror films, including the Frankenstein movies. In Mary Shelley's classic novel [10], Frankenstein was neither a doctor nor a medical student; he was a first-year college student beginning studies in biology when he thought of his grandiose plan to revive dead flesh, building an outsize monster so that he could do the surgery of connecting blood vessels of various parts from various dead people. He has been the very model of today's idea of mad scientists and mad doctors, who, in the grip of intellectual pride, and in search of glory, violate the laws of nature and moral decency, and bring evil to others and grief to themselves. There was no mention of electrical equipment in the novel, but in the movies. "Dr Frankenstein's" laboratory is full of electrical equipment whose purpose is never explained except as a way to animate the monster. I originally thought the use of electroconvulsive therapy might have something to do with the presence of these machines generating frightening sparks [11]. However, Bini's first report was published in 1938. The Original Frankenstein movie was brought out in 1935, too early for the screenwriters and director to know about electroshock. Where does the idea of a lab filled with elaborate electrical equipment come from?I believe that the "Mad Scientist" mystique was appropriated by the Serb-American inventor of the late 19th and early 20th century, Nicola Tesla. While he is most famous for his Tesla

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coil, he invented alternators, the step-up and step-down transformer, the first radio, and the first remote control, and several kinds of electric motors. The coils he invented were able to achieve very high voltage and frequency, and were able to generate what were essentially lightning bolts. He was as great a showman as he was an inventor, and loved to frighten the townsfolk with his electrical displays. He loved to think of frightening names for his inventions: a "Death Ray" did not kill any kind of animal, but generated an electromagnetic pulse that would melt and fuse cars' ignition systems [12,13]. I think that we in psychiatry owe a debt of gratitude to Tesla both for bringing us into the electrical age, and for taking the mantle of "mad scientist" that might have remained ours.

Still, there are many sources of stigma, which include the long experiment with Prefrontal Leucotomy [4,5], electroconvulsive therapy, which is still in use because it is helpful for severe depression, but came into use about the same time as Freeman's Leucotomy. Some of the old asylums and hospitals were truly havens for the mentally ill, but some, whether due to poor planning and funding, or due to prejudice, were not. A stereotype was created and amplified by movies such as The Three Faces of Eve (1957), The Snake Pit (1948), and One Flew over the Cuckoo's Nest (1975). More recently psychiatrists figured prominently in Halloween (1978) and their sequel, in which for example Donald Pleasance portrayed Dr. Samuel Loomis, the psychiatrist who attempts to treat Michael Myers, but then decides to kill him and pulls a handgun from his desk drawer. I am sure none of our patients like the thought of us doing the same. We have been treated much more sympathetically in films like Good Will Hunting (1998), and TV shows such as M. A. S. H. (1972-1983, still in syndication). In that show, Alan Arbus's portrayal of Dr. Sidney Friedman showed him to be a kind, humorous, and skilled medical professional, just the psychiatrist many of us aspired to become when we entered training, and the one our patients hope to meet.

So, stigma remains a problem for us and our patients after all the progress that has been achieved. What can we do about it? Several papers literature observes its sources and the profound impact it has on our patients and the progress they make, and their quality of life [14-17]. There have been a number of attempts to measure stigma with a rating scale [18], and to improve it by educating psychiatrists in training [19,20], patients' families and those who know them [21], and schoolchildren [22]. Corrigan and Penn [23] took a shrewd approach to stigma in their attempt to apply the findings of social psychology of prejudice against immigrants or those of other races and nations. They observe that three different approaches have been used in both problems. Attempts to deal with stigma in the Press by protest have sometimes backfired. Attempts to educate the public, the patients and those who treat the mentally ill help, but are limited by the resilience and persistence of prejudice. Exposure by contact between the mentally ill and other people are useful, and the effect is influenced by both persons' social status (Closer is better), by cooperative interaction, and by institutional support. I can attest to the impact of one of my teachers' encouragement in my choice of psychiatry by confiding to me how much help his psychiatrist has been, and how much he valued their relationship. Another similar and touching moment of insight came some years ago, the last time the APA met in New York when the cab driver who picked me up from the train station remarked, "You must be a shrink. Let me tell you about my shrink…"

Perhaps the very best thing we can do about it is emulate the fictional Dr. Friedman in kindness and good humor-have a relationship with each patient. We should really try to help, keeping up with the evidence in our field, and to practice evidence-based psychiatry. We must avoid Frankenstein's mistake, eschewing intellectual pride, and never, ever violate the laws of nature and moral decency.

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