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Medical Education

Stigma, Society, and Specialty Choice: What's Going On?

There are many misconceptions about psychiatry as a science that contribute to the continued social stigmatization of mental illnesses.

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If psychiatry offers the flexible and reasonable hours, compensation, and autonomy that students cite as important to their lifestyle as a physician, why do applicants to psychiatry residency programs remain steady? If mental health has such an impact on disability adjusted life years (DALY) and lost productivity, why won't health insurers cover proper treatment, and why do we cloak records of mental illness in secrecy [1]? The answer, some say, is the continued social stigmatization of mental illness [6]. Stigma is present among medical students as well as the general public, and a poor opinion of psychiatric patients has spread to include the professionals who care for these patients [7,8].

Much has been written about student and general public attitudes about both the mentally ill and psychiatric treatment, but little effort has been made to examine whence these attitudes might come. Attitudes include a public perception of danger from the mentally ill, imprecision in diagnosis and diagnosis by phenomenology, ineffectiveness of treatments, and difficulty with chronic disease in general as well as an opposing general accusation that mental illness does not exist at all except as an instrument of social control [9-11]. In addition, the public's fear of violence is greater now than in past decades despite analysis to the contrary [1, 11].

Rather than address individual claims about the veracity of mental illness or the efficacy of current diagnosis and treatment, this discussion will address ideas about the sources of stigmatizing attitudes. Beyond historical misunderstandings of psychiatry's checkered past and individual experiences of mental illness, little consideration has been given to why we are thinking this way. With the intention of provoking critical thought and discussion, I propose 3 interrelated constructs that contribute to our popular (mis-) understanding of the mind and mental illness.

Underlying our opinions are Descartes' mind-body dichotomy, popular mistakes about Freud, and trouble with the concept of the nature-nurture relationship inherited from Sir Francis Galton. Together, these 3 features (1) form a popular understanding of the mind that only vaguely resembles what contemporary psychiatry has to offer; (2) create a disjuncture between reality and public opinion; and (3) fuel negative attitudes about contemporary psychiatry. Understanding this model will help in efforts to reduce both the stigma of mental illness and the undesirability of psychiatry.

Generally, when we think about the mind, we comfortably make the distinction between things "out there" and the thoughts we have about them inside our heads. Even when thinking about our own bodies, we can distinguish between ourselves (a thing out there) and the thoughts that play out inside our heads. This idea is derived mainly from a Cartesian conception of the body and the world with input from Kant [12]. Descartes envisioned a mechanistic body with strings and pulleys and a separate soul that pulled the levers [13]. In fact, he worked for some time with William Harvey of blood-circulation fame. The operational dichotomy that develops is called mind-body dualism, a result of intricate church-science social relationships and a mainstay of Cartesian thought [14].

The Cartesian mind-body paradigm, leaves a legacy of reductionism. It neglects psychosocial and multifactorial

etiologies of mental illnesses in favor of linear and biologic mechanisms. Furthermore, it makes personal thoughts inaccessible to anyone other than the individual who is having them, thus making it difficult to generalize any insight gained on the "mental" side of the mind-body gap [15]. Most importantly, it separates treatment loci to either physical *or* mental domains. With a Cartesian model, either psychiatry should look a lot like neurology, or it should not resemble "physical" medicine at all. This understanding limits our imagination when it comes to disease states or methods of addressing them.

A second facet of our popular understanding of the mind is evident in the Freudian terms that are littered throughout our vernacular. They are found in mainstays of popular culture from sitcoms to coffeehouses and fashion magazines, though much of their original meaning has been lost. The weaknesses and criticism of Freud's models have been misinterpreted and also become entrenched in contemporary popular thought. We talk about egos, Oedipus complexes, Freudian slips, anal retention, and the subconscious or unconscious without much regard to their source or original definitions. Freud has also been interpreted as being pessimistic about the ability of anyone to be happy or free from mental illness [16]. It doesn't matter in this instance if he is right or wrong, merely that we fail to think clearly about his theories. The result is a caricature: psychiatry is about obsession with sex and childhood, mental disorders are unavoidable since there is unconscious determination of many actions, and the best we can hope to be is only a little neurotic. Popular Freudianism also leads to a skewed view of what treatment in psychiatry looks like, and skepticism about both the diagnosis and treatment of mental disorders.

A third source of a stigma-prone model of the mind is the nature-nurture relationship first characterized by Sir Francis Galton in 1869 [17]. The nature-nurture dichotomy asks whether certain traits, diseases, personality, and other factors arise in individuals because "they were born that way," or because of their upbringing and environment. To answer the question requires either a dogmatic choice of nature or nurture or what has been called the "commonsense" answer that both play a role in any situation [12]. Choosing nature, nurture or both tends to be a dynamic decision, with variable answers for different situations. So, the question becomes "what is the source of *this* particular trait?" Applying the nature-nurture paradigm to the mind generates a tension between the contemporary fascination with both genetic determinism (nature) and the primacy of autonomy and free will (nurture). Neither nature- nor nurture-based theories leave the individual mind a sophisticated role, and suggest that psychiatry is unable to make a useful contribution to health. Either the mind is at the mercy of fate and genetics, or it is a *tabula rasa*, continually being written upon and shaped by the environment, without active participation of its "owner" other than conditioned (learned) responses. Regardless of its merits, choosing to think within Galton's structure discourages us from considering other models of the mind and mental illness; models that move beyond or coordinate mechanistic genetic explanations and environmental factors. An example of such innovative thinking is the biopsychosocial model of health and illness first proposed by George Engel, and other articulations of the holistic health movement in contemporary medicine [18].

From these tacit (even "unconscious") philosophical underpinnings comes an understanding of the mind and psychiatry that is neither flattering nor prima facie true. Using the above constructs, it is easy to think that the mind and body (brain) are completely separate, that parts of the mind control behavior without our knowing it, and that any attempt to explain how the mind works is tangled up in a web of conjuring, projection, and the problem of brain chemistry versus upbringing and free-will behavior [12,15]. This model leads us to think that mental illness is either ubiquitous (ie, we can't help it) or nonexistent (a lack of self-discipline disguised as illness) and that those with mental illness are fundamentally different from the rest of us. Seeing others as foundationally different rather than just functionally different is a key point in the development of stigma because it allows for a complete separation between the sick and the well [19]. Sociologically speaking, it is easier to stigmatize and denigrate someone who is in a different category than we. Keeping illness and health separate fosters stigma in this way.

Thinking "outside the box" of Cartesian dualism is just the beginning for combating stigma and changing attitudes, but recognizing where some of our current thoughts come from is an important step toward awareness. Our collective attitudes toward patients and the professionals who treat mental illness have an impact on research, reimbursement, and physician supply, not to mention the quality of life for patients and communities.

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