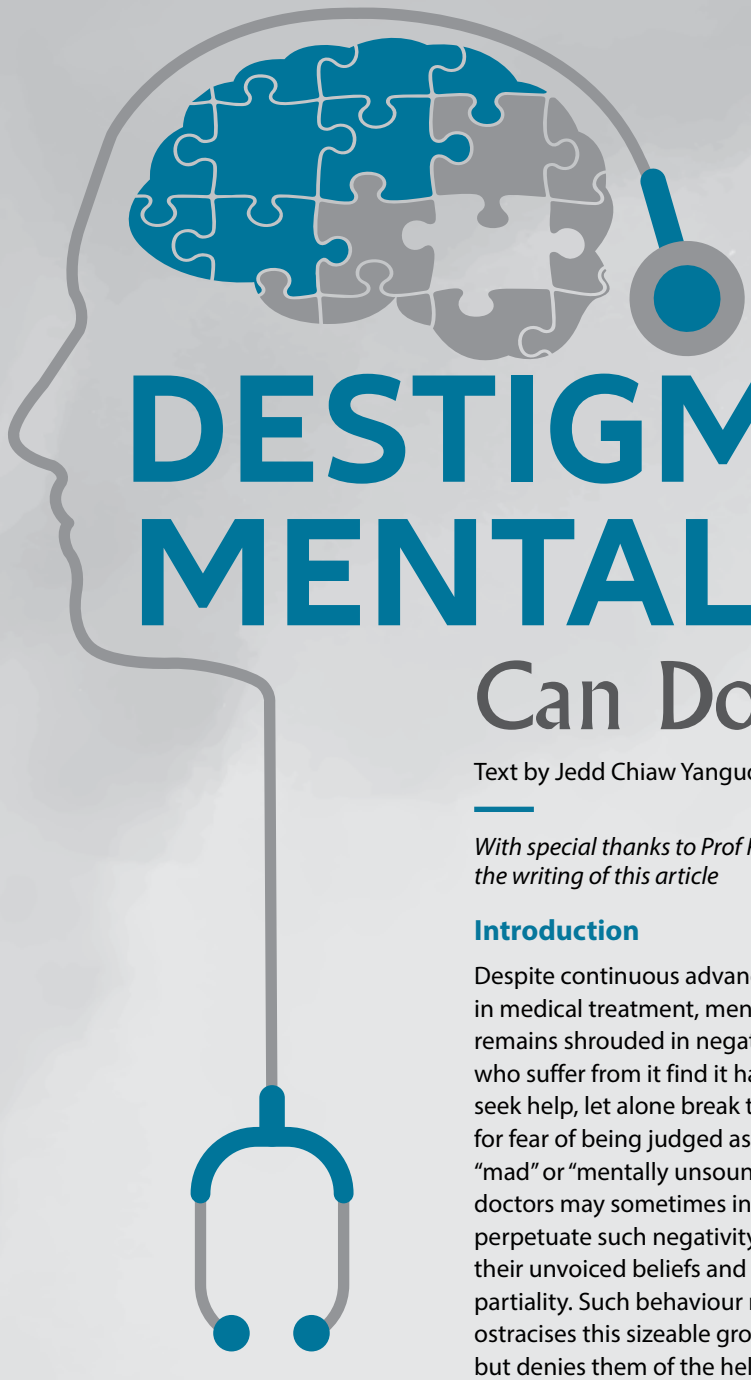

DESTIGMATISING MENTAL ILLNESS

Can Doctors Do Better?

Text by Jedd Chiaw Yanguo and Caitlin Choo Min Ci

With special thanks to Prof Kua Ee Heok for his continual guidance in the writing of this article

Introduction

Despite continuous advancements in medical treatment, mental illness remains shrouded in negativity. Many who suffer from it find it hard to even seek help, let alone break the silence, for fear of being judged as "weak", "mad" or "mentally unsound". However, doctors may sometimes inadvertently perpetuate such negativity through their unvoiced beliefs and unintentional partiality. Such behaviour not only ostracises this sizeable group of patients, but denies them of the help they require, compromising our role as physicians – "to cure sometimes, to treat often, to comfort always".

Compared to diabetes mellitus, mental illness contributes to almost the same amount of disease burden in terms of disability adjusted life years in Singapore.[1] Recent health statistics have shown its prevalence to be on the rise.[2] Mental disorders are a known comorbidity of chronic medical conditions[3] like hypertension, diabetes mellitus and ischemic heart disease, and it is inevitable that doctors from most disciplines will have to manage mental illness at some point in their careers.

There is, in fact, a growing global recognition of the importance of mental health. Mental well-being now forms part of the World Health Organization's definition of health.[4] For the first time ever, achieving mental wellness was listed in 2015 as one of the United Nations' sustainable development goals to be achieved by 2030.[5]

So, why does talking to a patient with mental illness still incite a feeling of unease and apprehension among some doctors in Singapore? In order to shed light on this matter, we conducted interviews with doctors of different ranks, specialties and healthcare institutions.

Understanding the stigma of mental illness

Regrettably, stigma of mental illness does exist in the medical community. To understand how said stigma develops, American psychologist Prof Patrick Corrigan identified that mental illness has the tendency to create certain discriminative stimuli, mainly in the form of labels, psychiatric symptoms, skill deficits and physical appearance. In response to these stimuli, stereotypes and prejudice against mental health

Caitlin and Jedd are medical students who are advocates of mental health awareness.

patients develop among members of the public, whose behaviour toward them changes accordingly, resulting in their discrimination.[6]

Labels play a part in rousing prejudice among doctors. Prof Low Cheng Hock from Tan Tock Seng Hospital felt that "*labelling is the main cause of the stigma*". He added, "*labelling patients with psychiatric conditions as mad is completely wrong. It isolates them and puts them in a different class. It makes some doctors not really want to manage them*".

The nature of certain psychiatric conditions may also generate stereotypes. Dr Low May Fong, a psychiatry resident in the National University Hospital (NUH), recognised that "*consultations with this group take a longer time – sometimes [patients] are circumstantial or have many issues to tackle. It is also not easy for a suicidal patient to reach out to a stranger. So they will naturally take time to open up as compared to an abdominal pain, which can be [expressed] very directly. So, some feel it is [more] tiring to speak to a psychiatric patient.*"

These factors, as identified by Prof Low and Dr Low, perpetuate stigma as a previous negative experience with a patient with mental illness which may lead doctors to generalise this group to be more difficult.

The impact of stigma on mental illness

Holding preconceived notions leads doctors to behave in certain ways. However, knowledge of a patient's psychiatric background sometimes results in greater understanding. Dr Nurul, a medical officer in NUH, has observed that "*some doctors spend more time with these patients and are more cautious with their words*". Dr Low, too, has seen doctors conscientiously explaining symptoms to the patients, offering them the much needed reassurance. Indeed, as doctors, we play a powerful role as an antidote to our patients' anxiety; we must reassure them and be aware that any negativity on our part might exacerbate their situation.

In fact, when a negative attitude is adopted toward mental illness, patient care is inevitably affected. At times, it can result in minor changes in the treatment of these patients. Prof Low noted that "*sometimes, not always, doctors may be a little impatient with patients with mental illness*". Other times, stigma can prove detrimental. A large study conducted in the US, involving 113,653 individuals suffering from an acute myocardial infarction, showed that patients with a comorbid mental illness were significantly less likely to undergo percutaneous coronary angioplasty, possibly due to an element of physician bias.[7] Several other studies support this finding: that a physician's stigma against mental illness does create a significant barrier to full access to medical treatments.[8,9,10,11,12] Therefore, it is crucial that we choose to adopt the right attitude.

Destigmatising mental illness

It is heartening to know that sentiments toward mental illness have much improved compared to the past when "*not many realised that these patients can be treated and can function very well*", as noted by Dr Ong Seh Hong, a senior consultant at Khoo Teck Puat Hospital, Department of Psychological Medicine. This could be attributed to the commendable efforts made to normalise mental illness in recent years.

An example of such a move would be the 2017 Community Mental Health Masterplan,[13] which aims to decentralise the management of stable mental illness and shift it to a primary care setting. Dr Ong said that the presence of satellite clinics will allow doctors and the public to "*see that these patients look just like you and me*". The adoption of consultation-liaison psychiatry in hospitals also plays a role in this aspect. Dr Ong believes that "*by working closely with us (psychiatrists), colleagues in other disciplines become more psychiatrically-minded*" and would have a "*lesser tendency to miss psychiatric conditions*".

Toward the future

Nevertheless, there is always room for improvement, with doctors in a prime position to spark a change in the perception of mental illness. British psychiatrist Prof Sir Graham Thornicroft referred to stigma as an "*overarching term that contains three elements: problems of knowledge (ignorance), problems of attitudes (prejudice) and problems of behaviour (discrimination)*".[14] As a medical community, there is a multitude of resources at our disposal to tackle **problems of knowledge**. "*Education is the beginning*", Prof Low declared, "*and understanding and respect follows. Hospitals have a big part to play as they are the first place to educate, but it all depends on the drivers and how determined they are to make a change*". Dr Ong concurred, urging psychiatrists to "*project our profession better, get the right image out and also advocate for our patients*".

Prof Low also expressed hopes for "*continual education and integration of mental health into various specialties*", especially on the basics of "*how to manage depression, grief and stress*". Dr Nurul reflected that "*a lack of confidence in communicating with psychiatric patients*" also plays a role. It causes not so much the overt stigmatisation of mental health patients, but rather, wariness towards them. Building confidence in dealing with psychiatric patients is hence another key aspect to tackle, "*especially for junior doctors and primary care physicians*". She added that complete risk assessment and mental capacity assessment should be learnt as fundamental skills so that referrals made to psychiatry are appropriate and aversion towards managing psychiatric patients can be minimised.

Dr Ong offered that stigma can be tackled even earlier in our careers, "*by first educating our medical students better*". A recent 2016 cross-sectional study done

in Singapore showed that, surprisingly, medical students who attended clinical attachments had more stigmatising attitudes compared to students who had not yet attended such attachments. The study attributed such attitudes to students coming into contact mainly with patients with severe chronic symptoms during their attachments.[15] Hence, the type of exposure garnered during such attachments potentially plays a key role in stigma reduction, as a negative experience can "*further etch prejudiced images in [the students'] minds*", added Prof Ong. This is further supported by yet another study done in Australia that found students attending non-traditional, non-clinical postings having a significantly more positive change in attitudes towards mental illness, compared to students who had attended a clinical posting.[16] Hence, it may prove useful to allocate time for students to have interactions in an outpatient or social setting with stable patients. This will paint a more optimistic picture of mental healthcare – one in which patients can function as everyday members of society.

Dr Low expressed that receptiveness to such programmes boils down to "*interest and the incentives provided*". She agreed that doctors would be open to joining education programmes, especially with incentives such as continuing medical education points. However, many junior doctors "*haven't had the time to join*", citing a lack of manpower and time as the main reasons, which is unavoidable given their packed schedules. Receptiveness to such programmes is hence not as big a barrier as feasibility. With limited time, many "*would think it (these programmes) isn't as important*" and find it too great an opportunity cost to forgo other alternatives.

As for **problems with attitudes**, the solution lies with the individual. Prof Low urges doctors to "*always treat the patient as a whole, never in isolation, never in compartments. Only by addressing their mental attitudes, stressors and approach will we appreciate the patient better and create a conducive environment for interaction*".

Conclusion

Although mental illness is pervasive in our society, its debilitating nature often isolates those who suffer from it. We must embrace the fact that anyone can fall prey to mental illness; with the stresses of overworking and sleep deprivation, doctors, too, are susceptible to anxiety and depression.[17] It is only through sheer circumstance that the rest of us manage to escape.

Given our role as physicians whose actions can leave an indelible impact on patients, it is our job to give patients reassurance – the therapeutic value of which we must never underestimate. As Dr Ong rightly puts, "*if doctors themselves are unconvinced that mental illness is not something to be shunned, I think we have failed our patients. These patients, your patients, they suffer and they seek help. We as doctors are trained, if not to cure, to reduce such suffering.*"

Further improvements can be made in both undergraduate and postgraduate education to temper negative perceptions of mental illness, should there be any. Individuals must also constantly remind themselves to apply soft skills – compassion, empathy and active listening – such that they become second nature. These offer as much comfort as the drugs we administer. In the words of John Forbes Nash Jr, world-renowned mathematician and chronic schizophrenic: "*the only thing greater than the power of the mind is the courage of the heart*". Removing stigma against mental illness is undeniably a daunting task. However, if we muster a collective effort, there is truly real potential for a positive change. ◆

References

1. *Data.gov.sg. Distribution of Disability-Adjusted Life Years by Broad Cause Group. Available at: http://bit.ly/2QT4Mz8.*

2. *Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2016 (GBD 2016) Disability-Adjusted Life Years and Healthy Life Expectancy 1990-2016. Seattle: Institute for Health Metrics and Evaluation (IHME), 2017.*

3. *Sartorious N. Comorbidity of mental and physical diseases: a main challenge for medicine of the 21st century. Shanghai Arch Psychiatry 2013; 25(2):68-9.*

4. *World Health Organization. Frequently Asked Questions. Available at: http://www.who.int/suggestions/faq/en/.*

5. *United Nations Development Programme. Goal 3: Good Health and Well-Being. Available at: http://bit.ly/2pttpWl.*

6. *Corrigan PW. Mental Health Stigma as Social Attribution: Implications for Research Methods and Attitude Change. Clin Psychology: Sci and Pract 2000; 7:48-67.*

7. *Druss BG, Bradford DW, Rosenheck RA, Radford MJ, Krumholz HM. Mental disorders and use of cardiovascular procedures after myocardial infarction. JAMA 2000; 283(4):506-11.*

8. *Druss BG, Rosenheck RA. Use of medical services by veterans with mental disorders. Psychosomatics 1997; 38(5):451-8.*

9. *Digiusto E, Treloar C. Equity of access to treatment, and barriers to treatment for illicit drug use in Australia. Addiction 2007; 102(6):958-69.*

10. *Copeland J. A qualitative study of barriers to formal treatment among women who self-managed change in addictive behaviours. J Subst Abuse Treat 1997;14(2):183-90.*

11. *Keyes KM, Hatzenbuehler ML, McLaughlin KA, et al. Stigma and treatment for alcohol disorders in the United States. Am J Epidemiol 2010; 172(12):1364-72.*

12. *Semple SJ, Grant I, Patterson TL. Utilization of drug treatment programs by methamphetamine users: the role of social stigma. Am J Addict 2005; 14(4):367-80.*

13. *Ministry of Health. COS Media Factsheet: Beyond Hospital to Community. In: Strengthening Mental Health Services: Community Mental Health Masterplan. 24 August 2017.*

14. *Thornicroft G, Rose D, Kassam A, Sartorius N. Stigma: ignorance, prejudice or discrimination? Br J Psychiatry 2007; 190:192-3.*

15. *Chang S, Ong HL, Seow E, et al. Stigma towards mental illness among medical and nursing students in Singapore: a cross-sectional study. BMJ Open 2017; 7(12):e018099.*

16. *Moxham L, Taylor E, Patterson C, et al. Can a clinical placement influence stigma? An analysis of measures of social distance. Nurse Educ Today 2016; 44:170-4.*

17. *Kua EH. Doctor under stress. Singapore Med J 1998; 39(11):478.*