Residents

A Stigma Named by an Antistigma?

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Abstract: Psychiatrists may often be guilty of raising and dashing the hopes of patients by prescribing medications under different categories such as antidepressants or antipsychotics. By using antidepressants to alleviate the symptoms of depression, patients become labelled as "depressed," inducing a stereotype that may lead to stigma. If the standard medication does not work, the psychiatrist will change medications because the usual drug failed the patient. This may have inadvertent semantic implications that may exacerbate the problem. This short essay further explores the issue of stigmatization of patients by psychiatrists and suggests a solution at the residency level.

Résumé : Un stigmate nommé par un antistigmate?
Les psychiatres peuvent souvent être coupables de nourrir et de décevoir les espoirs des patients en prescrivant des médicaments de différentes catégories, comme les antidépresseurs et les antipsychotiques. En ayant recours aux antidépresseurs pour soulager les symptômes de la dépression, les patients sont alors étiquetés « déprimés », produisant ainsi un stéréotype qui peut mener au stigmate. Si le médicament régulier ne fonctionne pas, le psychiatre le changera parce que le médicament habituel n’a pas réussi au patient. Cela peut avoir des implications sémantiques involontaires qui peuvent exacerber le problème. Ce bref article examine plus à fond la question de la stigmatisation des patients par les psychiatres et suggère une solution au niveau de la résidence.

Key Words: stigma, mental health, stereotyping, post-graduate education, pharmacy, psychopharmacology training

Throughout my psychiatric residency, I noticed that we were introduced to the major Axis I disorders, taught the signs and symptoms and then taught the management of specific symptoms. Medications were classified, not by their actual function, but rather, by the major Axis they treated. For example, depression was treated with antidepressants such as selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs) or serotonin norepinephrine reuptake inhibitors (SNRIs). There were various regimes and courses of treatment for these drugs; if one failed, another would be tried, according to evidence-based, standardized guidelines (1). The drug nomenclature was interesting. For example, in bipolar illness, and in particular for mania, “antimanic agents” or “mood stabilizers” were used. In schizophrenia, “antipsychotics” were used; these were subdivided into “typical”—meaning older or first generation—and “atypical”—meaning newer or second generation, with potentially fewer extrapyramidal side-effects. This psychotropic nomenclature seemed nonscientific, and it was interesting to me that we did not begin by discussing function; that is, how each of these medications actually worked. Instead, what was taught was dosage, half-life, duration, augmentation strategies and when to switch medications.

From Kraepelin to Freud, from Klein to Winnicott, from Kohut to Yalom and now, with the DSM-IV, the way we think about mental illness has evolved. With the introduction of the DSM in North America (now at DSM-IV-TR [2]) and the ICD-10 in Europe, the philosophy of psychiatry changed. Psychiatry seems to have become focused less on the person and more on the phenomenology of the illness.

When this occurred, psychoanalysis was in retreat, cognitive therapy had passed its infancy and was entering an adolescent vigour and psychotropic medications were on the market (3). The pharmaceutical industry boomed. Major and minor tranquilizers were renamed as antipsychotics and anti-anxiety agents. With the discovery of TCAs for the treatment of depression, the word “anti-depressant” was coined. To those with new onset of depression or to those with remitting–relapsing depression, the fear of permanent medication became a reality, as our society regarded depression as a deficit in character rather than in biology (4). This context was significant in that psychiatry inadvertently became a guilty party to the production of stigma.

The process of stigmatization through pharmacotherapy is as follows. A person is diagnosed as having schizophrenia, for example. The “antipsychotic agent” is prescribed because the person is “thought-disordered,” which leads to an idea in society that this sick person may be hearing voices and could be violent. This idea, or stereotype, in turn creates a certain stigma (5–8), resulting in the production of fear within society. Therefore, society becomes fearful of psychosis, the “schizophrenic” and the mentally ill who may be treated with such medications. While this is an old argument, the reality still persists. The irony is that schizophrenia affects roughly 1% of the population and almost 25% of our health-care budget, whereas major depression has quickly moved into the top five most prevalent disorders in the world, with three other disorders in the top 10 (9).

Within the individual, and within society in general, a reverse stigmatization of psychiatry itself occurs (10,11). For example, if one sees a psychiatrist, then one must be
crazy. This is obviously not the reputation a profession seeks for itself. Even those mentally ill persons who are aware of their illness may not want to seek psychiatric help or will stop seeing a psychiatrist because the changes in combinations of medication wear them down. These common effects of medication may lead affected persons to experience paranoia, believing that they are subjects of an experiment. This “guinea pig syndrome” may be reinforced through repeated changes as physicians prescribe the “new drug on the block” (4).

When patients do not respond, for example, to a first trial of an antidepressant, they may perceive that they have failed the medication and a new one must be tried. This “failure” only further decreases their self-esteem, as they may perceive that we are blaming them. In actuality, it is the drug that has failed for that patient, but even when this is discussed, patients may be left with the impression that they are somehow defective (2). Is psychiatry, and are psychiatrists, failing patients by employing easy-to-use, yet ambiguous, terms (such as “antidepressant”) as an antistigma device, thereby inadvertently labelling patients for life?

While this may be a matter of semiotics, it is a relevant and significant difference in terms of the objective truth of the medication’s failure for an individual patient and the subjective experience of the patient’s mental illness. Knowing something about a medication is different from understanding how it may work and why a patient should try it. Psychiatry has been described, according to the cliché, as an art and a science. Art is more than an initial interview, if one follows a patient: it is active concern, listening and, sometimes, advice giving. The science is our expertise (2). Nevertheless, despite depression’s reconception as a chemical imbalance, the stigma of the shadowy world of mental illness remains for society (4).

Within our culture, there are various domains of stigma regarding mental health. The hierarchy is structured by age, race, sex, family, culture, societal expectation, profession and, of course, by each unique individual (8). Because of people’s imagination and ability to catastrophize, some never seek help. In other instances, witnesses to a colleague’s or a family member’s illness do not have the courage to intervene. The worst outcome would occur if the stigma created by a biological model of psychiatry were to turn away those in need of psychiatric help. As professionals, we must be vigilant in our advocacy, steadfast in the scholarly pursuit of knowledge, and open to our critics (3,4).

To its credit, psychiatry has generally been responsive to its critics; for example, credentialing authorities for the most part now demand annual Continuing Medical Education (CME) credits (for example, see the RCPSC Web site: http://rcpsc.medical.org). The focus of interviewing techniques has returned to a formulation-based, person-centred style. Ongoing limitations are the scarcity of professionals in the field and slowness to recapture the belief that psychotherapy can still cure people as well as medication, in many cases. Psychiatrists must not fall victim—as they may have in the past—to a belief in antidepressants being the “quick fix.” Learning about what we prescribe, independent of pharmaceutical industry influence, is a skill that needs to be fostered at the postgraduate level and beyond.

How should this problem be addressed? I believe that the problem starts at the medical school level but that it may be easier to rectify in residency. For example, in addition to teaching a list of antidepressants when introducing the Axis I disorders, educators should indicate which medications are used to treat specific depression symptoms, together with their mechanisms of action. It may be useful for pharmacists or psychopharmacologists to teach courses about the nature of these medications in the context of the medical management of these disorders. With that model in place, it will be easier for psychiatric residents to understand the basic biology of the brain—its neurochemistry, neuroanatomy, and each medication’s mechanisms of action. Basic science should not be considered boring if one is to be given the privilege of prescribing these drugs in a rational manner. Further, this model would also much more efficiently and usefully teach residents about drug interactions. Residents would be taught by experts in the field and would learn to respect the pharmacist’s role in the multidisciplinary team involved within psychiatry. Writing a patient’s prescription is a meaningful act, and more care should be taken in this act before, and especially after, graduating from training.

Certainly, this topic has many layers of issues that need to be addressed, both at the levels of postgraduate and continuing education and on a larger scale, when reflecting together about our identity as a profession. Psychiatry grew out of neurology, with Freud as its pioneer. It would be a shame if we forgot the positive aspects of our history and became so engaged in genetics and biology that we created stigma by our own search for treatment. To lose the ability to learn and teach about the human condition by observing the subtle nuances of nonverbal communication or transference exchanges would be sad. It would also be psychiatry’s undoing.

Recognition that a diagnosis may carry implied stigma is important. When we make a diagnosis or when a certain treatment does not work, we stigmatize a person in the eyes of society because mental health work is not a priority in public policy. As previously stated, the different domains of stigma may always be present, but our methods of postgraduate education can change. In its training and tutoring of the neophyte resident, psychiatry must foster these skills and attitudes.
The issue of access to team members’ schedules was more problematic. Through the Palm Desktop program, the team secretary had everyone’s schedule on her PC, but each team member only had access to his or her own schedule. Appointments still had to be coordinated through the secretary, who could place tentative arrangements on each PDA. These would then be confirmed between team members. Some programs do allow for all team members’ schedules to be viewed on each PDA; however, this was found cumbersome to use, and not everyone felt comfortable sharing such information. After two years, only one-half of the team use the PDA for scheduling; the rest use a regular day planner.

**Team Satisfaction with the PDA**

The satisfaction of the individual team members varied according to their level of comfort in using computers. The initial Pocket PC trial was short-lived because the operating system was thought to be complicated and unstable. After frequent software crashes, most stopped using the Pocket PCs. The Palm devices were found to be more stable and seemed to be more intuitive for the less experienced users. Initially, we chose an inexpensive model that did not have a backlit screen or rechargeable batteries (Palm M100). This was a mistake, because the screens were difficult to read and batteries had to be changed frequently. A change to a higher-end, rechargeable model with a backlit screen (Palm M130) resulted in higher user satisfaction, because the PDA could be seen more easily in the dark and did not require battery changes.

Satisfaction was highest with the PDA’s data-management function. All team members found this to be a valuable application and a significant improvement over the previously used printouts. Specifically, the medication notes that were now available helped in medication management and administration. This was not surprising: PDA use has been found to decrease medication errors in discharged psychiatric patients (6). The two psychiatrists and three of the four nurses found the pharmacopoeia application very useful, especially because of its included drug–drug interaction software. It was not used to any significant degree by the occupational therapist or the social worker.

Only one-half of the team continued to use the PDA’s datebook function. Those who did not found it difficult to enter data on the PDA and easier to use a regular daily planner. The purchase of a portable keyboard did not change this, although two team members began to use the keyboard to write patient notes on the PDA.

Other functions that were found to be useful included a street-finder application (Mapopolis) and downloaded city maps that helped team members navigate through different neighbourhoods on home visits. The Note Pad application was frequently used to jot down medication changes or changes in patient contact information. With this application, the user writes in longhand directly on the PDA screen, and the note is automatically transferred to the secretary’s PC for transcription and entry.

**Summary**

Increasing sophistication and availability of handheld computers will allow for wider use of these devices in various clinical applications. Psychiatric outreach programs are an ideal clinical setting for PDAs. Although laptop computers may offer more functions, they are heavy, difficult to use in non-office situations and can intimidate patients and some staff. The PDA provides a wide range of clinical applications in a package that is convenient and easily adopted by most clinicians. Many impressive higher-end devices are now available for more sophisticated users. However, it is more likely that front-line clinicians will adopt a simpler device that is easier to use and provides the basic functions necessary for clinical work in outreach psychiatry.

**References**

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