# Stigma: Its Pernicious Effects on Health Professionals

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# Disclosure Slide

- Medical education speakers network – two grand rounds in 2017
- Book royalties

# Learning Objectives

1. Define the various types of stigma and summarize how stigma affects recognition of mental illness in health professionals, their families and colleagues
2. Explain the ways in which stigma affects timely diagnoses, treatment adherence and success
3. Cite the changes that must occur at a macro level (systemic, institutional, organizational and training) in order to eradicate shame and stigma

# Clinical anecdotes

- Stigma can kill!
  - 32 year old IM resident
  - 44 year old surgeon

# What is stigma?

- Greek origin
- Refers to bodily signs designed to expose something unusual and bad about the moral status of the sufferer
- The signs were cut or burnt into the body and advertised that the bearer was a slave, a criminal or a traitor

# What is stigma?

- The term stigma conventionally refers to any attribute, trait or disorder that marks an individual as being unacceptably different from the ‘normal’ people with whom he (she) interacts and elicits some form of community sanction
    - Goffman E. Stigma: Notes on the Management of Spoiled Identity. New York, Simon & Schuster, 1963.

# What is stigma?

- A mark of disgrace or infamy
- A stain or reproach, as on someone's reputation (eg Philip Roth's *"The Human Stain"* and Bliss Broyard's *"One Drop: My Father's Hidden Life — A Story of Race and Family Secrets."*)
- A characteristic mark or sign of defect, degeneration or disease
    - American College Dictionary 1969

# A salute to Dr Paul Fink

- “Today, stigma against those with psychiatric illness and those who treat them is the single most destructive element impeding progress in the care of the mentally ill. The effects of stigma begin with the hesitation of a person with mental illness to seek early psychiatric intervention”
    - Presidential address Annual Meeting American Psychiatric Association 1989

# Enacted vs Felt Stigma
## (aka public stigma vs self-stigma)

# Enacted Stigma

- Enacted stigma is exterior and refers to discrimination against people with a psychiatric illness because of their perceived unacceptability or inferiority.

    - Myers MF. Stigma and the Ailing Physician. Part 3 http://www.psychcongress.com/blogs/michael-myers-md/stigma-and-ailing-physician-part-3

# Felt Stigma

- Felt stigma is interior and refers to both the fear of enacted stigma and a feeling of shame associated with having a mental illness.

    - Myers MF. Stigma and the Ailing Physician. Part 3 http://www.psychcongress.com/blogs/michael-myers-md/stigma-and-ailing-physician-part-3

# Enacted and Felt Stigma

- Both types of stigma can be at play when a symptomatic health professional decides to seek treatment
- Both types of stigma threaten self-esteem, security, identity and life chances

# Clinical stories flood my mind….

- Five clinical vignettes that illustrate the profound effects of stigma

# Example of enacted stigma in MDs (real and perceived)

- Intrusive questions asked about one's health history on medical license application and renewal – and on hospital credentialing applications
- Drives MDs away from seeking help:
  - Gold et al 2016, 2017
  - Myers MF 2017
  - Jones JTR et al 2018

# Stigma in mental health professionals

- This is a form of internalized stigma
- Despite medical knowledge about mental illness, there is a residue from growing up in a culture that historically has viewed the mentally ill as crazy, inadequate, morally weak, strange, frightening or violent
- Overcoming stigma in ourselves is a lifelong challenge

# Stigma in mental health professionals

- Many MHPs think that because they have trained in the field and toil daily caring for patients, that they have purged themselves of stereotypic, false and mean-spirited notions of mental illness and its sufferers
- Some disguised examples from my practice or friendships with psychiatrists:

# Stigma in mental health professionals

- The downside of this is how much internalized stigma affects how the MHP approaches patients with a negative counter transference that leads to major errors in clinical judgment
- The patient does not get a proper diagnosis and effective helpful treatment which can lead to increased morbidity and mortality ie. death by suicide

# How stigma hampers illness recognition

- Who wants to recognize the signs and symptoms of an anxiety disorder or mood disorder or a substance use problem in oneself if its acceptance is terrifying and shameful?
- Who wouldn’t want to just bury their head in the sand? Throw themselves into their work?
- Who wouldn’t use magical thinking? (“if I help others who are sick I’ll be ok myself”)

# How stigma hampers illness recognition

- And if it doesn't go away, who wouldn't want to wait just a little bit (or a lot) longer?
- Or who wouldn't think that he/she just needs to just, in today's vernacular, "suck it up"?
- Is it any wonder then that when ill HPs finally do seek professional help, they feel defeated and diminished?
- How sad that so many do not feel good about reaching out for professional help

# How stigma hampers illness recognition

- In some situations, the HP accepts that he/she has a mental illness but its recognition, acceptance and loyalty to diagnosis and treatment is undermined by the spouse, children or parent(s)
- Clinical vignettes with sad and frightening consequences

# Stigma and many variables

- Cultural studies have confirmed that the stigma associated with psychiatric illness varies enormously with one's race, ethnicity, country of origin, religious beliefs, age, gender, sexual orientation, gender identity and upbringing
- Also, stigma may be on a continuum so that it increases and decreases during the course of illness and its treatment

# Stigma, procrastination and worsening

- The process of delaying and avoiding treatment can have untoward consequences
- Increasing the magnitude of symptoms or developing additional symptoms leads to more suffering
- This can result in an obsessive state of rumination and morbid egocentricity, including isolation and withdrawal from supportive others

# Adverse Consequence #1

- The original illness becomes more entrenched, tough to treat or refractory to treatment altogether = poorer prognosis
- The individual becomes more resistant to spontaneous recovery, single drug pharmacotherapy and simpler forms of psychotherapy
- Treatment protocols become more complex, more costly and multidisciplinary

# Adverse Consequence #2

- Work performance is at risk
- Errors of commission or omission
- Cognitive slowing and/or distorted thinking
- Multitasking, an essential skill, becomes impossible
- Memory impairment occurs
- Self doubts encroach and accurate decision making is harder

# Adverse Consequence #3

- Comorbidity risk accelerates
- Other DSM-5 disorders
- Medical disorders – coronary artery disease, hypertension, diabetes, flu, etc
- Substance use disorders – increase use of alcohol, self-prescribing, diversion of drugs in the workplace, use of street drugs, etc
- Non chemical addictions – porn, gambling

# Adverse Consequence #4

- Self-medicating of tranquilizers, antidepressants, sleeping medication, stimulants in those HPs who can prescribe
- Others who can't prescribe, convince their primary care physicians to write prescriptions for them that may not be treating the original problem so they become dependent on these meds and the PCP becomes an enabler

# How does stigma affect treatment adherence?

- Just because a HP has now ‘sort of’ accepted that he/she has a psychiatric illness and has consented to go to see someone does not mean that he/she will accept becoming a patient (‘the patient role’) and cooperate with the prescribed treatment
- Becoming a patient is a process – cardiologist example

# How does stigma affect treatment adherence?

- If you feel ashamed of your symptoms you may be less forthcoming with your doctor
- You may be embarrassed to disclose key pieces of your situation that will help your doctor make the correct diagnosis
- You are well intentioned but yet are late for appointments (so you don't need to endure the full 50 minutes) or 'forget' or 'miss' or 'cancel'

## How does stigma affect treatment adherence?

- You ‘forget’ to take your medication as prescribed
- Or stop it because of side-effects without calling your doctor
- Or you stop it the minute you begin to feel better
- Or forget to refill it

## How does stigma affect treatment adherence?

- You assume a passive role in treatment – as opposed to a collaborative one
- You resist any/all forms of important psychotherapy except supportive psychoRx
- You demean or challenge your treating professionals
- You associate being a patient with dependency and loss of power

# How does stigma affect treatment adherence?

- Pills and appointments are symbolic of illness and you don’t want to be reminded of that
- You may seduce (or try to seduce) your treating professional into believing that you are much more improved than you really are
- If you leave and then relapse or develop a recurrence later, you delay or avoid calling because you feel you’ve failed or you’re ashamed for ‘acting out’ earlier

## How does stigma affect treatment adherence?

- Types of treatment may carry less/more stigma for some HPs
- Medication – use of mood stabilizers and neuroleptics frighten many patients, higher doses equate with “I must be really screwed up”
- Psychotherapy – psychodynamic psychotherapy may be resisted more than CBT or motivational interviewing

# The bottom line….

- Never underestimate how much stigma might be affecting the HP sitting opposite you
- Be informed about the many ways that stigma causes resistance to accepting and embracing treatment in HPs
- Always approach your patients/clients with an open mind, active listening, kindness, suspended inquiry and acceptance with where they are at (example of OBGYN)

# Stigma: A Call to Arms

# Educating Health Professionals

- Basic education in training programs about depression, bipolar illness, substance use disorders, anxiety disorders, trauma, personality disorders, suicide IS NOT ENOUGH
- Continuing education via annual scientific meetings, periodic updates, newsletters, websites and other forms of social media have become essential to enhance the working knowledge of today's very busy HPs (book research)

# Educating Health Professionals

- What about first person accounts?
- HP specific have more meaning and personal relevance
- The goal is more than making HPs better at recognizing and diagnosing psychiatric problems in their patients/clients but also more equipped to look inward and be mindful of one's own personal health and functioning

# Examples of individuals who have ‘gone public’ (see references)

- “Take a Look at Me Now” – Quinn Leslie, MD
- “The Gift of Self-Disclosure” https://www.psychcongress.com/blog/gift-self-disclosure
- “Mercy” – Elizabeth Fortescue, MD, MPH
- “Stigma: ‘I need to tell you something I’ve never spoken to you about’” – Renee Binder, MD
- “Fighting stigma begins at home” – Miller KL

# Self-disclosure

- Public disclosure may promote empowerment and reduce self-stigma
- Selective self-disclosure weighs the costs and benefits: use of different strategies, obtaining peer support, being selective vs public revelation
  - Corrigan PW, Kosyluk KA, Rusch N. Reducing self-stigma by coming out proud. Am J Public Health 2013;103(5):794-800

# Educating Health Professionals

- Continuing education enables us to be up to date on the latest research on risks that are specific to our particular branch of health professionals
- Examples are burnout, depression, substance use disorders, PTSD, vicarious traumatization and so forth

# What about our families?

- Education is key here as well (book research)
- Some of this can occur via general media
- Can some education occur as an offshoot of how we are kept informed?
- Having more knowledge about target illnesses in us enables our loved ones to reach out to us, be firm and insistent with us when necessary and to know what options exist

# What about advocacy?

- Advocacy is an imperative for all health professionals
- It goes beyond rendering safe and compassionate clinical care
- It means speaking up for your patients/clients, reaching out to their families, volunteering, writing letters on their behalf, speaking out against ignorance and discrimination

# What about advocacy?

- It works!
- It loops back into the clinical setting and informs your patient/client who in turn experiences some relief of their suffering
- It also promotes healing
- But most important it diminishes isolation, loneliness and forges connection and intimacy in the therapeutic milieu

# What about the culture?

- Addressing the culture of medicine and ways in which it has changed – and must continue to change – is foundational
- Burnout studies have taught us that health professionals cannot survive in assembly line settings, in corporate models, in impersonal institutional structures where they do not have a voice in decision-making and personal agency

# What about the culture?

- All health care professionals must feel valued as human beings and not simply ‘workers’
- They need leaders and bosses who don’t just ‘talk the talk’ but ‘walk the walk’
- There also must be an institutional ethos of caring that goes way beyond the mission statement
- Are we are brothers’ and sisters’ keepers?

# What about the culture?

- Our leaders need to know that stigma has a corrosive influence in many sectors of care – into many healthcare policy decisions, how people access health care, decisions about research and allocations of money, sexual harassment, employment discrimination, health care insurance, disability insurance and more
- Stigma silences all of us

# The wise words of Kay Jamison, PhD

(The many stigmas of mental illness. Lancet 2006;367:533-534)

- We have to accept that mental illness can have a powerful effect on those close to it
- Research is the greatest destigmatizer so it is important to attract brain researchers
- There needs to be more open discussion about impaired doctors, psychologists and nurses – this will offset so much bad teaching and inadequate treatment

# The wise words of Kay Jamison, PhD

(The many stigmas of mental illness. Lancet 2006;367:533-534)

- Referring to letters she has received from physicians and other health professionals about their own illnesses she writes: “All made the irrefutable point that it was disingenuous for hospitals and medical schools to expect health care professionals to be straightforward about mental illness when their hospital privileges, referral sources and licenses to practice were on the line”

# A mandate for those who treat us

- All mental health professionals who treat us have a responsibility to be informed and practice ‘state of the art’ mental health care
- This includes the latest evidence-based care whether it is psychopharmacology, substance use models, psychotherapy approaches, suicidal ideation interventions and more

# Other stakeholders

- Association of American Medical Colleges – examining burnout in medical students and steps for prevention, healthy living initiatives, well-being articles in *Academic Medicine*
- Accreditation Council for Graduate Medical Education – MD wellness symposia annually since 2015
- American Medical Association – next International Conference on Physician Health October 11-13, 2018

# Other stakeholders

- National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience (next NAM meeting is May 2, 2018 in Washington, DC with a live webcast
  - https://nam.edu/event/establishing-clinician-well-national-priority-meeting-3)
- Federation of State Physician Health Programs – education, setting standards, research and advocacy for ailing health professionals
- American College of Health Care Executives
- Federation of State Medical Boards – input via affiliates and courtesy members

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# In appreciation

- To all my colleagues, mentors, friends and students in the health professions who inspire me
- To the many courageous health professionals quoted here who have shared their personal stories to educate all of us about stigma
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