Commentary

Attitudes to Psychiatry Can Change But What About Stigma?

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For many doctors, the only exposure to psychiatry is during a rotation in medical school. The knowledge, interest, and attitudes formed in those few weeks will hopefully last throughout their medical careers. Unless they choose to specialise in psychiatry or other related disciplines that include aspects of psychological care, this exposure is very much dependent on the individual doctor's subsequent conscious acquisition of knowledge in this area to support patient care. This is important, as psychological care is a crucial component of holistic care, viz. the World Health Organization (WHO) dictum, "there is no health without mental health".[1] Attitudes to psychiatry affect personal and professional behaviours, even amongst psychiatrists and mental health nurses who have been found to hold the same prejudices as primary care teams about schizophrenic patients.[2,3]

Fifteen years ago, Feifel et al, in studying the declining interest in choosing psychiatry as a career amongst US medical graduates, found that students entering medical school already viewed psychiatry as "distinctly and consistently less attractive than other specialties".[4] They recommended that underlying false beliefs be actively targeted for remediation in the medical school curriculum. Studies have also shown that mentally ill patients provoke less favourable responses that were unaltered by furthering education in medical students.[5] The findings of Fischel et al that attitudes amongst medical students in different cities did not significantly change following a psychiatry rotation led Richard Balon, editor of Academic Psychiatry, to decry, "no matter what we do, what we teach and how we do it, we are basically doomed and students do not like us!".[6,7]

Yet, some studies still reveal positive attitudinal changes following a psychiatry rotation. Kuhgnik and Taryan, for example, found that the educational and personal experience from direct patient contact and observing psychiatrists interacting with patients not only enhanced students' clinical skills, but also contributed to positive attitudinal change.[8,9] Our study in 2008 using the same Attitudes to Psychiatry (ATP) scale revealed similar findings amongst medical students at the National University of Singapore (NUS) ($n = 146$, $P = 0.002$); students recognised and appreciated the efficacy of psychiatric treatment and they could transfer the knowledge and attitudes to other disciplines.[10] However, we found no changes in some areas, in particular, the perception that psychiatrists and psychiatry make little use of medical training, raising concerns about collegiality and professional conduct in care delivery.

Five years on, the psychiatry curriculum at the National University of Singapore (NUS) has undergone significant revisions. The psychiatry rotation is now a complete 6-week programme in Year 4, with opportunities for electives for clinical and research work. Psychiatry pedagogy is now focused on developing competencies in clinical skills through the introduction of observed clinical interviews and standardised patients for skills training, improving the breadth and depth of experience. Didactics are centralised with large group lectures and small group teaching, and skills are developed through team-embedding. ATP, reviewed in 2013, using a new version of ATP, the modified Attitudes to Psychiatry Scale (mAPS),[11] again revealed significant attitudinal improvements at the end of the rotation ($t [99] = -2.89$, $P = .006$). These improvements were specifically in the following 2 domains: recognising the merits of psychiatry as scientific medicine ($Z = -3.09$, $P = .022$) and the effectiveness of psychiatric treatment ($Z = -4.74$, $P < .001$); however there were no improvements in a new domain specific to the mAPS: stigma of psychiatry ($Z = -0.52$, $P = .60$). Additionally, longer-term follow-up assessments were not conducted for both studies, so the sustainability of the positive changes has not been established.

This is possibly the underlying problem: we have focused on attitudes, not stigma. Attitudes are only one component of stigma; the others of the tripartite model

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being knowledge and behaviours.[12] While the revised curriculum has enhanced attitudes, it has not, like many medical education programmes, addressed stigma, which is more deeply rooted and related to societal, cultural, and religious beliefs. Stigma is much more pervasive, associated with discrimination, and is described as a "primary barrier to treatment and recovery", with far reaching negative consequences and quality of life impairments for patients.[13]

Although programmes have been established to reduce the stigma associated with psychiatry and mental illnesses, progress has been slow unfortunately, amongst mental health professionals themselves.[14] In fact, psychiatrists, often from clinical experiences with difficult, challenging, and treatment-resistant patients, may hold more "pessimistic views" of psychiatric illnesses.[15] Patients with medical problems and psychiatric comorbidity and those with dual psychiatric conditions face greater challenges and may be doubly burdened.

The WHO calls for greater mental health advocacy at the general public health level and with other healthcare professionals and particularly medical students—a challenge psychiatrists need to undertake. The National Mental Health Policy and Blueprint drawn in 2007 led to an extensive build-up of services across the age spectrum, but we need to ensure our patients avail themselves to these and that there is greater awareness of the services and programmes amongst our medical colleagues.[16] A pilot project involving secondary school students in the UK found that mental health education sessions with adolescents were useful in challenging the development of stereotypical attitudes towards mental health problems.[17] This bodes well for greater attention to the issue in medical schools.

Secondly, it appears that conventional psychiatric education alone will not reduce stigmatising attitudes;[18] knowledge to correct misinformation needs to particularly focus on actively shaping medical students' perspectives on mental illnesses and addressing stereotypes. Papish et al have suggested that focusing on students' "internal experiences" in caring for people with mental illness might be "an integral factor in modulating perceptions".[19] Pinfold has suggested that contact-based educational strategies are especially effective in facilitating this.[16]

Students should have the opportunity to interact with and hear patients' stories about their mental illness experience and then the opportunity to discuss these experiences with tutors. As NUS develops community health programmes for medical students, interactions with those who are mentally ill could be included for greater opportunities to understand mental illnesses. In so doing, the necessary steps taken to address the gaps in misinformation will hopefully erode the discrimination and stigma.

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