Mental Health Stigma in Society, Medical Education, and Medicine

4th Friday Preceptor Development Series

January 24, 2025

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- I have no conflicts of interest with regards to this presentation.

Objectives.

- Define stigma, elements of stigmatization, and stigma promoting causes of mental illness.
- Discuss self, public, and structural stigma.
- Address barriers, facilitators, consequences and impacts of stigma.
- Define and review examples of structural stigma in medical education along with a framework for destigmatizing.
- Discuss various causes of medical professional self-stigma and intraprofessional stigma (specialty bashing) and what it means for the landscape of healthcare in the US.

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Mental Health Stigma in Society

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Why mental health stigma matters…

- 1:5 people in US suffer from a mental illness
- Half of the US population lives in mental health workforce shortage areas.
- 60% of outpatients receiving mental healthcare do so from their Primary Care Provider.
- 11.3 adult psychiatrists per 100,000 adults; estimated shortage of adult psychiatrists between 14,000 and 31,000
- 14 CAP:100,000 children – the need is for 47:100,000
  - Average wait time for appt: 7.5 weeks
- Aging psychiatry workforce (average age of practicing psychiatrist is 55 years old)
- Higher rates of burnout, low job satisfaction due to administrative burden, limited time with pts, etc.

What is stigma? [2]

- Stigma: in Greek, a tattoo used to visibly mark slaves or criminals as members of society with diminished value
- Goffman (1963) defined stigma as a “deeply discrediting” attribute that reduces a person “from a whole and usual person to a tainted, discounted one.”

Elements of mental health stigmatization[7]

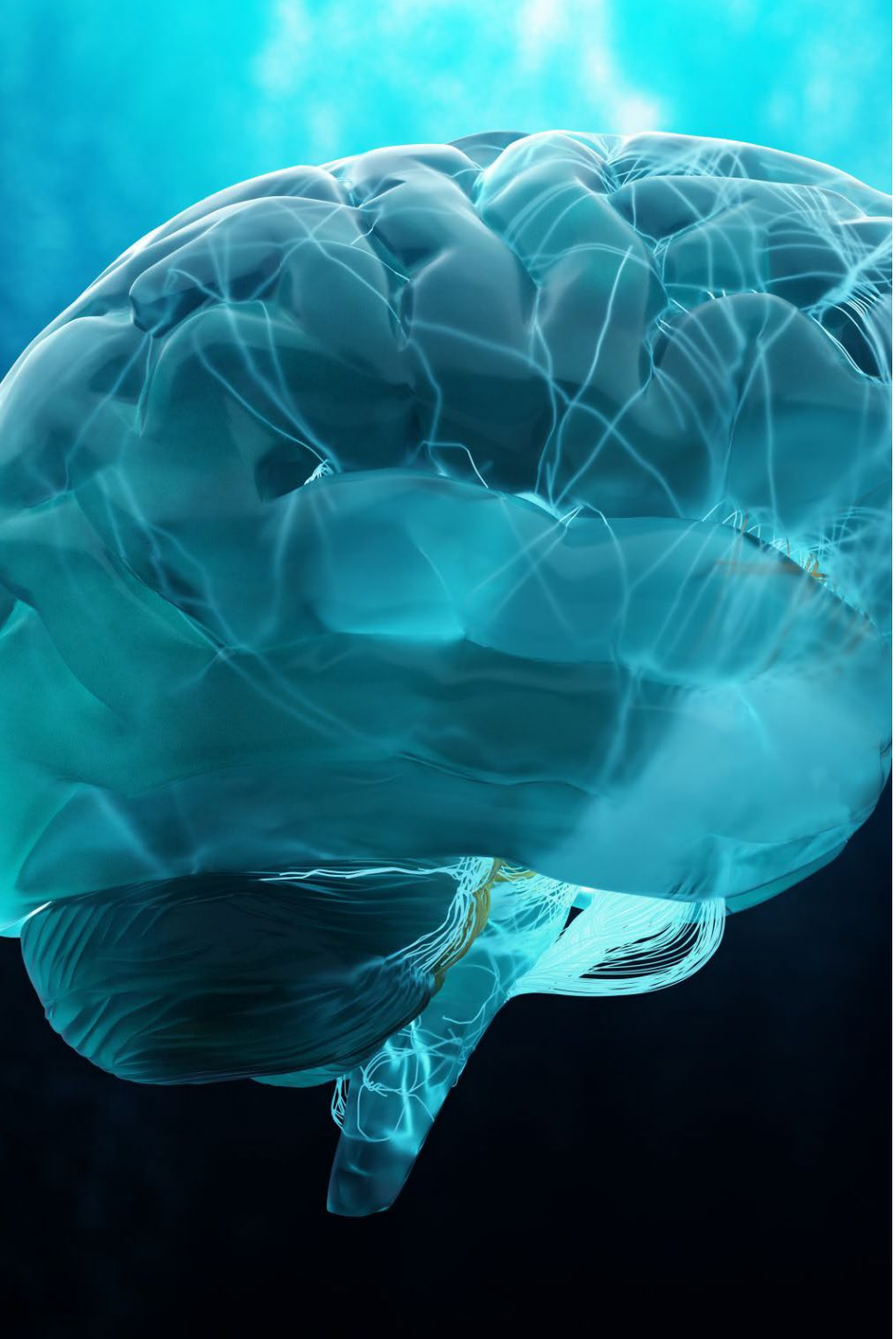
- Labelling: identifying and highlighting human differences that matter socially
- Stereotyping: set of undesirable characteristics assigned to a group based on dominant cultural beliefs
- Separation: “us” vs. “them” or “othering”
- Status loss: social, economic, personal
- Discrimination: justice, social equity, human rights

People with Lived Experience (PWLE) say…

- Survey of 500 adults with chronic, severe MI
  - 74% felt no improvement in stigmatization in last decade
  - 86% fear of stigma or discrimination prevented them from
    - Seeking help for MI
    - Disclosing to others
    - Applying for job or promotion
  - 88% said discrimination towards those with MI is widespread

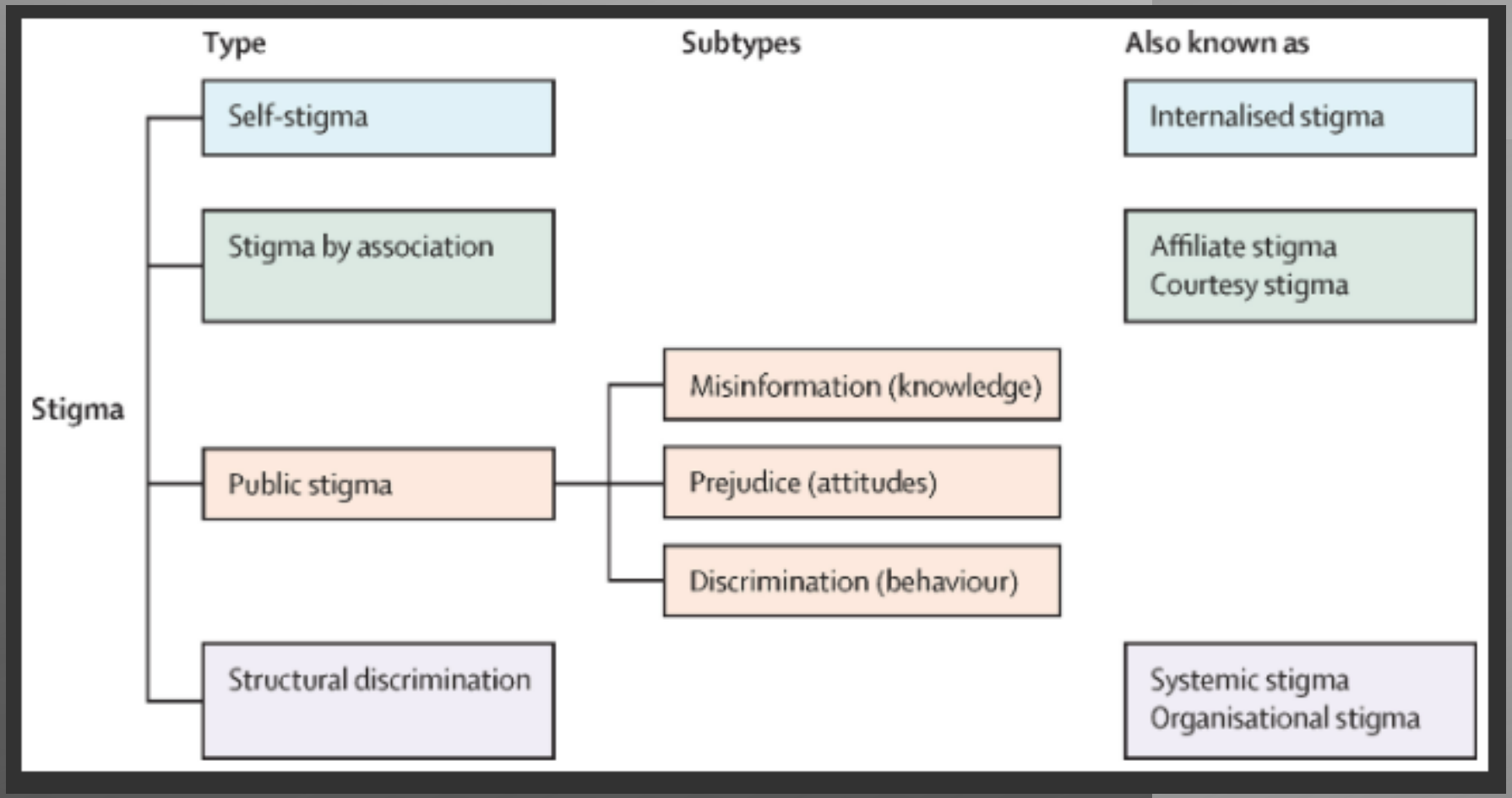
Employees with Lived Experience say…

- 2022 National Poll from American Psychiatric Association
  - ↓ 48% of workers can discuss mental health with supervisor (56% in 2021, 62% in 2020)
  - ↓52% uncomfortable using MH services from employer (64% in ‘21, 67% in ‘20)
  - ↓Fewer worry about retaliation if time is taken off to seek MH care (36% in ‘22, 48% in ‘21,52% in ‘20)
  - ↓Less than one third worry about retaliation for seeking care (31% in ‘22, 42% in’21, 43% in ‘20)



Stigmatized causes of mental health conditions[8]

- Self-responsibility
  - Volitional: within person's control
  - Weakness, character flaw
  - Amoral
- Rooted in genetics or neurobiology
  - Beyond conscious awareness
  - Unpredictable
  - Dangerous
  - Chronic, unrecoverable


Type
Subtypes
Also known as
Stigma
Self-stigma
Internalised stigma
Stigma by association
Affiliate stigma
Courtesy stigma
Misinformation (knowledge)
Public stigma
Prejudice (attitudes)
Discrimination (behaviour)
Structural discrimination
Systemic stigma
Organisational stigma

Types of Stigma

	Public	Self	Structural
Stereotypes & Prejudices	People with mental illness are dangerous, incompetent, to blame for their disorder, unpredictable	I am dangerous, incompetent, to blame	Stereotypes are embodied in laws and other institutions
Discrimination	Therefore, employers may not hire them, landlords may not rent to them, the health care system may offer a lower standard of care	These thoughts may lead to lowered self-esteem and self-efficacy: "Why try? Someone like me is not worthy, or unable to work, live independently, or have good health."	Leads to intended and unintended loss of opportunity

Source: Adapted from Corrigan, et al., 2014.

Impact of mental health stigma [10,7]

- Reduced hope
- Lower self-esteem
- Increased psychiatric symptoms
- Difficulties with social relationships
- Reduced likelihood of staying with treatment
- More difficulties at work
- Lack of understanding by family, friends, coworkers, or others.
- Fewer opportunities for work, school or social activities or trouble finding housing.
- Bullying, physical violence or harassment.
- Health insurance that doesn't adequately cover your mental illness treatment.
- The belief that you'll never succeed at certain challenges or that you can't improve your situation.

Impact of mental health stigma[2]

- Delayed treatment seeking behavior***
- Social isolation and discrimination
- Reduced treatment adherence
- Perpetuation of misconceptions

- "In Western societies, stigma often stems from misconceptions about mental illness, including the belief that individuals…are dangerous or unpredictable. While mental illness is recognized more as a health issue, stigma still exists, often resulting in social exclusion and discrimination."

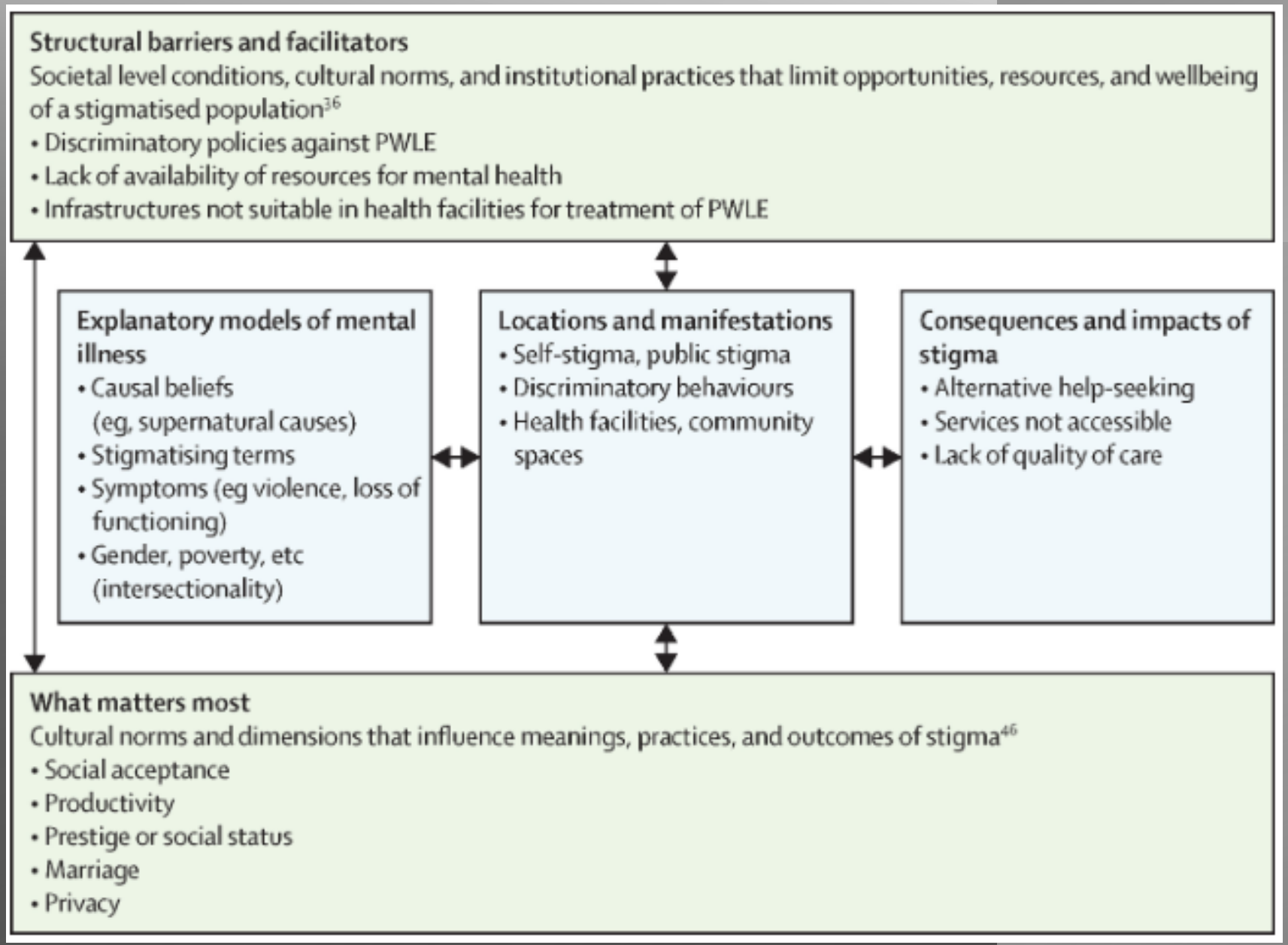
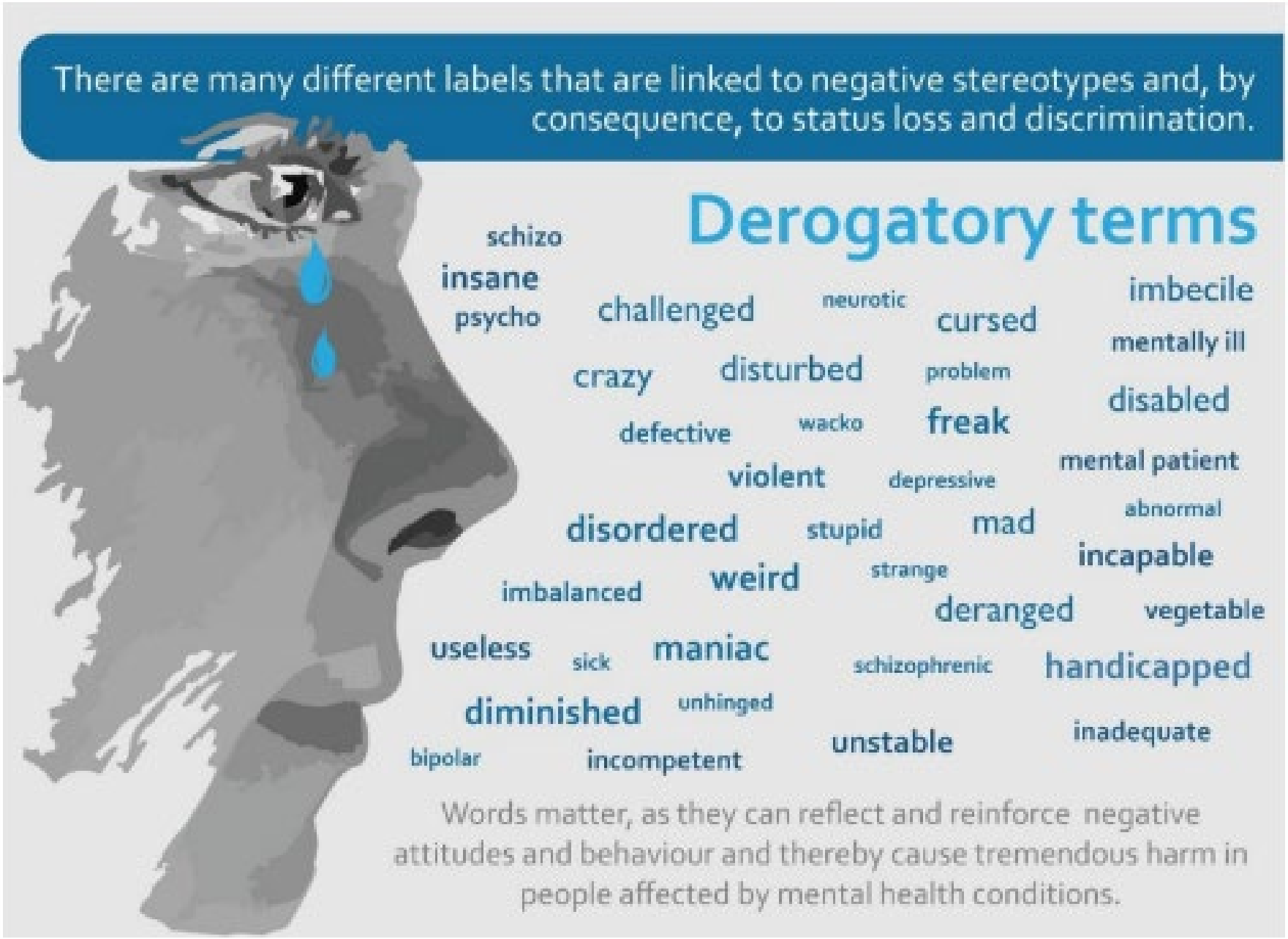

Structural barriers and facilitators
Societal level conditions, cultural norms, and institutional practices that limit opportunities, resources, and wellbeing of a stigmatised population[36]
• Discriminatory policies against PWLE
• Lack of availability of resources for mental health
• Infrastructures not suitable in health facilities for treatment of PWLE
Explanatory models of mental illness
• Causal beliefs (eg, supernatural causes)
• Stigmatising terms
• Symptoms (eg violence, loss of functioning)
• Gender, poverty, etc (intersectionality)
Locations and manifestations
• Self-stigma, public stigma
• Discriminatory behaviours
• Health facilities, community spaces
Consequences and impacts of stigma
• Alternative help-seeking
• Services not accessible
• Lack of quality of care
What matters most
Cultural norms and dimensions that influence meanings, practices, and outcomes of stigma[46]
• Social acceptance
• Productivity
• Prestige or social status
• Marriage
• Privacy

Figure A11.1 Derogatory terms used to refer to people with mental health condition



Public health approaches that work[11]

- Include contact (in person, but video can also be a feature if done right).
- Focus on a range of disorders, not just depression or mental illness broadly.
- Involve participation of people with “lived experience.”
- Target groups that have the most interaction or where lack of help-seeking is most problematic (e.g., young people, undocumented communities, military communities).
- Tailored to be credible to specific language and cultural signifiers of the target group.
- Last several years to be effective.

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Mental Health Stigma in Medical Education

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Structural stigma in medical education[6]

- Structural stigma refers to inequity manifested in rules, policies, procedures embedded in organizations and society at large.
- In clinical learning environment, structural stigma can be transmitted through role modeling resulting in inequitable care for those with mental illness – aka “the hidden curriculum”. How?
  - Students see pt admitted for physical treatment who also needs MH/SU treatment but it is unavailable. Student sees physical illness is priority, mental illness is not as important so can be left untreated.
  - Students learn about mental, physical, and substance use disorders separately without considering integration in patient presentation.
  - Students work with doctors who convey people with MHSU issues as less treatable and less deserving of care, who force treatment, and/or who criminalize mental illness.
  - Cyclical shame, blame, and mistrust of mentally ill or substance using patients - student learns and internalizes beliefs of attendings then in turn teaches to their students in future.
- Patients who are marginalized by mental illness are less likely to receive general medical care

Clinical Scenario #1

- Mr. S, age 37, presents to the ED with fever, chills, and an open skin ulcer. He is admitted for IV antibiotics to treat what is presumed to be an IVDU related ulcer.
- During rounds, the intern introduces Mr. S as a “known drug user” and “frequent flyer” in the ED prompting several members of the team to comment how he may be “difficult” or “drug seeking”.
- Requests for pain medication are denied for Mr. S.

Meanwhile, next door…

- Mrs. J, age 37, presents to the ED with fever, chills, and cellulitis secondary to a spider bite on her LLE. She is admitted for IV antibiotics.
- During rounds, Mrs. J is described as “pleasant”.
- The team prioritizes attention to and relief of pain for Mrs. J. All pain med requests are granted.

Component	Focus	Examples
Recognize	Recognizing how structural stigma manifests during care processes	• During rounds, when one patient is described as "drug seeking" while another is described as "pleasant," the clinical teacher draws attention to the differences both in language use and in the perceived need to attend to the 2 patients' pain, despite similar complaints.
Reflect	Reflecting critically on how assumptions, values, and biases underpin systems of care	• A clinical teacher assigns students to critically reflect on language use in a patient's health record, challenging learners to consider the following: – How certain words transmit assumptions, values, and biases. – How their assumptions and judgments might be different if they knew the patient's full life story. – How structural factors may have influenced the patient's presentation and course. • These are examples of critical reflections: – How would the patient's presentation differ if they had timely or equitable access? – Did the patient perhaps avoid care because of unsatisfying or unhelpful past clinical experiences, such as being treated poorly in previous encounters with the health care system or because they felt they would not be listened to or understood?
Reframe	Reframing situations to highlight structural components and enhance connection	• The clinical teacher shifts from using diagnosis- to person-centered language. Reframing should incorporate how various structural determinants have influenced the patient's status and symptomatic presentation, their orientation toward care and treatment, their relationship with care providers and institutions, and other experiences and realities. • These are examples of reframing: – Reframing an individual from being a "schizophrenic" to someone with a "brain illness." – Recharacterizing a patient from "drug seeking" to "seeking relief from pain." – Shifting from asking "What's wrong with you?" to "What happened to you?" • The clinical teacher debriefs conflict between the team and a patient by recognizing power asymmetries and differences in roles and responsibilities to promote shared decision making.
Respond	Responding by role modeling structural humility and by advocating for structural change	• The clinical teacher role models awareness of a patient's individual behavior as symptoms of an underlying illness or traumatic experience. • Teams should encourage quality improvement initiatives to address structural vulnerabilities. For example, institute a standard clinical algorithm for medical clearance. • Teams should support patients' housing, economic, or social needs as part of their medical care. For example, write a letter to a landlord to address housing issues. • Teams should advocate for structural change or for access to evidence-based care, such as harm reduction (safe consumption sites) within hospital settings.

Proposed Framework for Addressing Structural Mental Health and Substance Use Stigma in Education for Health Professionals

Level of stigma	Educational strategies
Structural	• Increasing awareness of the social, historical, cultural, and moral influences on the design and delivery of services • Fostering critical consciousness regarding structural forms of stigma within educational and health systems • Learning skills to recognize structural stigma and redesigning policies, rules, practices, and systems to improve equitable outcomes
Interpersonal/public	• Learning skills to challenge negative attitudes and misperceptions • Increasing awareness of how labeling and stereotypes lead to discrimination and inequitable outcomes • Fostering empathy and shifting attitudes through education based on social contact • Recognizing and managing biases
Personal (self-stigma)	• Increasing awareness of how stigma can be internalized and contribute to learned helplessness, self-blame, and shame • Learning skills to practice self-validation, self-forgiveness, and self-compassion

The Knowledge-Attitude-Behavior Practice Paradigm[8]

Knowledge: Do we lack professional knowledge when it comes to caring for patients with mental health issues?

Attitude: Do we “other” those with mental illness? Do we ascribe to the negative societal attributes assigned to those with mental illness?

Behavior: Do we socially distance ourselves from people perceived as mentally ill or with lived experience of mental illness?

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Mental Health Stigma within Medicine: "Specialty bashing"

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Choosing psychiatry as a specialty…

- Aliana is a third-year medical student. As the psychiatry clerkship director, you meet with many students interested in the field. Aliana is a second-generation Southeast Asian student. She states, "I came to medical school to go into internal medicine and specialize in cardiology, but I just completed my psychiatry rotation and loved it so much! I really want to be a psychiatrist, but my parents will never go for it."
- Aliana is one of three children. Her brother is an engineer and her sister is in surgery residency. She says, "My parents gave me three options – I could be a doctor, an engineer, or a lawyer. I chose medicine – never thinking I would love psychiatry. My family doesn't really believe in mental illness. It is felt to be a moral or spiritual matter, not medical. My parents will freak out if I choose psychiatry as my specialty. They will say I have wasted all this time and won't even be a 'real' doctor."
- Aliana sought psychotherapy and medication management for depression as a first-year medical student without her parents' knowledge. She felt seeking help for depression would "shame" her parents.

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Intra-professional stigma[3]

- Medical faculty rarely self disclose mental health issues
- Fear of mental health issues impact on residency application, licensing and privileging
- A culture of shame and silence

- Licensing question endorsed by FSMB and AMA/APA:
- "Are you currently suffering from any condition for which you are being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?"

Intra-professional stigma[1]

- 27% medical students suffer from depressive symptoms
- 11% suffer from suicidal ideation
- Small fraction seek help and if they do, they hide it from others
- 50% of medical students surveyed felt a residency training director would pass over their application if they admitted to mental or emotional health problems.
- 75% of trainee psychiatrists reported hearing denigrating or humiliating remarks about their profession[6]

Intra-professional stigma[4]

- Psychiatry and psychiatrists indirectly stigmatized due to discrimination towards mentally ill patients.
- Negative comments about psychiatry by other specialties experienced by over half medical students in one survey.
- More negative comments as one moves further along in training
  - “Psychiatry is more art than science.”
  - “Psychiatry is a pseudoscience.”
  - “No one ever gets better in psychiatry.”

Proposed Solutions	Current culture	Suggested actions
Transform the narrative	Media reinforces fears of mental illness as moral weakness, violence related, loss of control, etc.	Use PWLE to share personal stories of help seeking, recovery, healing, courage, hope as with any other medical concerns
Address regulatory screening questions	Inappropriate questions about history of mental disorders on licensing and privileging applications	Advocacy with state governing bodies, medical boards, and hospital credentialing committees
Expand perspective of mental health disorders	One dimensional models (weakness, moral failing, brain disorder)	Conceptualize with students how mental disorders are complex (bio-psycho-social-cultural)

Implement EBM	Campaigns focused on gen pop or target populations	Address cognitions, attitudes/prejudices, behaviors of stigma among colleagues and leaders; have respected colleagues share experiences of mental illness/burnout;train leaders to recognize depression and use supportive skills
Use nonjudgmental language	Commonly use disease first language	Maintain awareness of of stigmatizing terms, replace “commit suicide” with “died by suicide”, replace addict, alcoholic, schizophrenic, autistic.

Create a culture of caring for each other (professional courtesy)	Free or discounted medical care by physician colleagues (psychiatrists)	Respect each other as members of health professions, peer support in sickness and in health, discuss prof/personal challenges and stressors without judgment
Learn to be a patient	Self dx and trx outside of physician-pt relationship	Establish routine medical care with trusted PCP prior to urgent need. Develop acceptance as a patient who is a physician.
Address training curriculum	Hidden curriculum for medical students and residents about values, norms, attitudes in learning environment that stigmatize mental disorders and discourage help seeking	Create visible structures and processes for normalizing help seeking and encouraging easy access to care (opt-out health checks and affordable, schedule friendly services.)

Why does this matter?

- 1:5 people in US suffer from a mental illness
- Half of the US population lives in mental health workforce shortage areas.
- 60% of outpatients receiving mental healthcare do so from their PCP.
- 11.3 adult psychiatrists per 100,000 adults; estimated shortage of adult psychiatrists between 14,000 and 31,000
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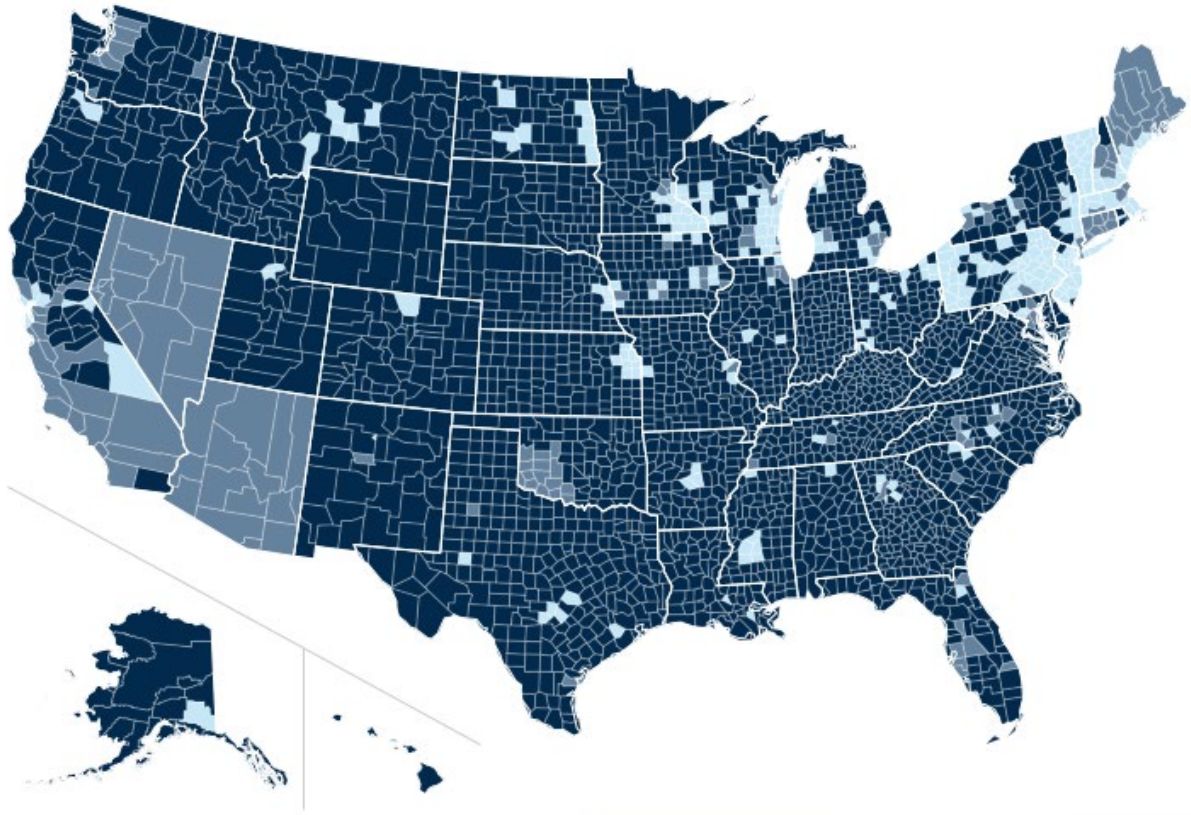
  - Average wait time for appt: 7.5 weeks
- Aging psychiatry workforce (average age of practicing psychiatrist is 55 years old)
- Higher rates of burnout, low job satisfaction due to administrative burden, limited time with pts, etc.

Health Professional Shortage Areas: Mental Health, by County, July 2024

Nonmetro | Metro | All



None of county is shortage area | Part of county is shortage area | Whole county is shortage area

Source: data.HRSA.gov, July 2024.

Practicing Child and Adolescent Psychiatrists

Use the filter menu to the right to interact with this dashboard

State: All

** Hover for Data Source*

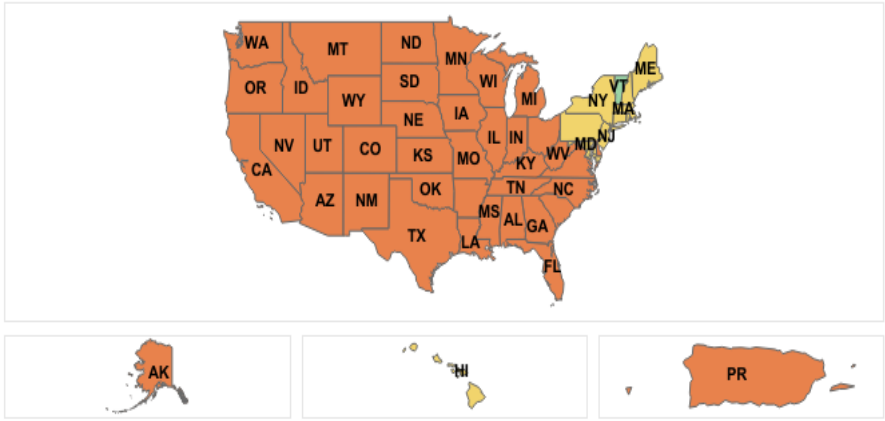
** Hover for Tips & Definitions*

American Academy of Child & Adolescent Psychiatry
www.aacap.org

Number of Children < 18	Total CAPs	Number of CAPs/100k Children	Average CAP Age	% of No CAP Counties
73,918,230	11,422	15	52	72%

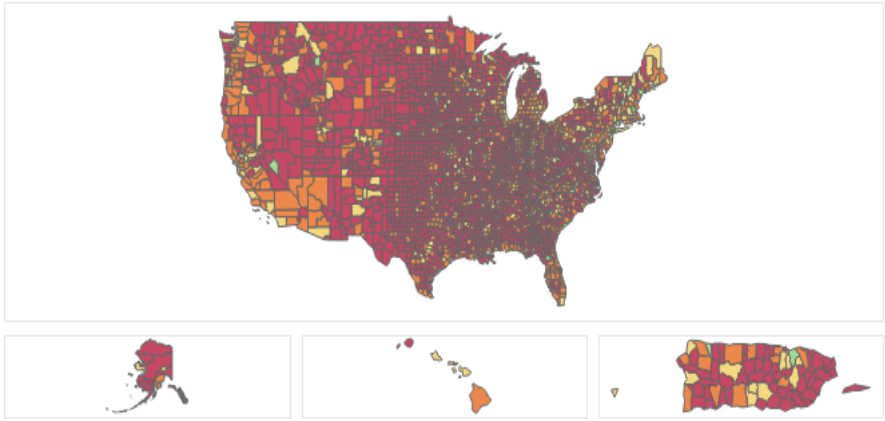
State Map

Mostly Sufficient Supply (>=47) | High Shortage (18-46)* | Severe Shortage (1-17)* | No CAPs

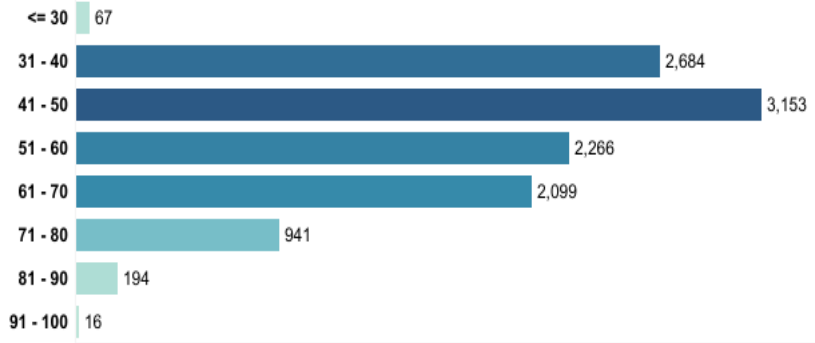


County Map

Mostly Sufficient Supply (>=47) | High Shortage (18-46)* | Severe Shortage (1-17)* | No CAPs



Number of CAPs by Age Group



Breakdown by County

	CAPs	Number of CAPs/100k Children	Pop. < 18
Abbeville County, SC	0	0	4,833
Acadia Parish, LA	0	0	14,909
Accomack County, VA	0	0	6,835
Ada County, ID	12	11	112,655
Adair County, IA	0	0	1,653
Adair County, KY	0	0	3,829
Adair County, MO	1	22	4,599
Adair County, OK	0	0	5,221
Adams County, CO	33	25	133,106

Practicing Child and Adolescent Psychiatrists

Use the filter menu to the right to interact with this dashboard

State: Tennessee

** Hover for Data Source*

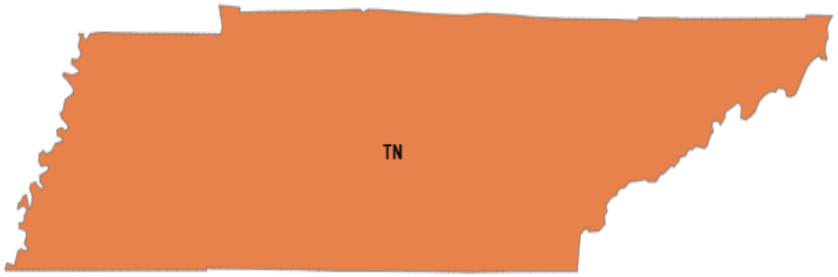
** Hover for Tips & Definitions*

American Academy of Child & Adolescent Psychiatry
www.aacap.org

Number of Children < 18	Total CAPs	Number of CAPs/100k Children	Average CAP Age	% of No CAP Counties
1,526,480	137	9	50	79%

State Map

Mostly Sufficient Supply (>=47) | High Shortage (18-46)* | Severe Shortage (1-17)* | No CAPs



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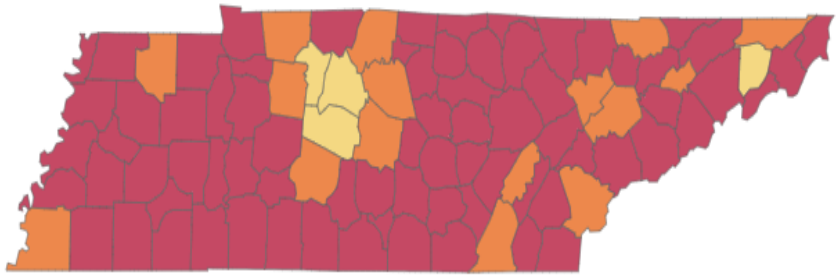

Summary

- Self, public, and structural stigmatization and discrimination leads to negative outcomes for people with lived experience of mental illness.
- Structural stigma towards mental health (of provider) and mental illness (of patient) is rampant in medical education and beyond (in residency and practice).
- Changing the culture of medicine to encourage students who want to go into psychiatry, support students, residents, and colleagues with mental health issues, and provide structurally competent care for patients with mental health issues is the answer to ending medical stigmatization of mental illness.

Questions?

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Resources

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