# The Stigma of Seeing a Psychiatrist

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*Mental and physical illnesses are compared and contrasted and reasons for the stigma attached to seeing a psychiatrist are discussed. Psychiatrists appear to share in the responsibility for perpetuating such a stigma. VIP's and others are sometimes prevented from seeking competent help because of such attitudes, which fit into the systems theory model of mental illness. The validity of the medical model is re-emphasized.*

Not so long ago, on the first slow day of a Senate Committee hearing on the nomination of Representative Gerald R. Ford to be Vice-President of the United States, an event occurred which was of prime significance to our profession. The nominee, undergoing careful scrutiny, emphatically denied that he had ever needed or received psychiatric treatment, adding that he was "disgustingly sane" and not in need of such help now or at any time in the past. On that day it again became clear that the possibility that Mr. Ford had ever needed or received psychiatric treatment was not a neutral question but an accusation which threatened the very confirmation of his nomination. The stigma of seeing a psychiatrist seems, indeed, not to have diminished in strength, and in fact constituted a direct and immediate threat to his political career.

Consulting a psychiatrist or a psychotherapist is, accordingly, an unforgivable sin for an American politician. The popular myth holds that a mere consultation with a psychiatrist casts serious doubt on the sanity of a person and may disqualify him from holding public office. Mental illness is regarded as being basically incurable, and any contact with a psychotherapist indicates the presence of some lifelong, hidden emotional malformation.

The Group for the Advancement of Psychiatry recently issued a report entitled "The VIP with Psychiatric Impairment" (1). This report, which was approximately ten years in the making, addresses itself, among other things, to the issue of consulting a psychiatrist. On page 48 it says as follows:

> The VIP fears, with good reason, that medical records may be used against him. The agency involved may wish to know the chance of recurrence, espe-

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cially if the patient is paranoid, depressed or alcoholic. In theory, no need exists to release detailed confidential information. Unfortunately, however, confidentiality is frequently breached, as the VIP knows. His bias against psychiatric consultation, evaluation and treatment, therefore, has a realistic as well as an emotional basis.

The same bias that makes an individual reluctant to place himself in the hands of a psychiatrist causes his associates to distrust him if he continues in office after it becomes known that he is or has been a psychiatric patient. Mental illness is viewed by the populace in general with fear and hostility. Psychological difficulties are regarded by some people as indicating moral weakness or defects in character. Many believe that treatment is vague and uncertain, that patients invariably deteriorate and that the ultimate outlook is hopeless. Since mental illness is stigmatizing, it must be concealed. The mentally impaired VIP recognizes this and realizes that he is vulnerable.

An intelligent observer of the psychiatric scene these days will sadly recognize this statement as true. When such an observer happens to be a psychiatrist, he owes it to himself and to his patients to ask whether and to what extent he has himself helped to either change or perpetuate this state of affairs. How much do we as a profession contribute, actively and passively, to this stigmatization of patients seeing a psychiatrist? What might be some of the conscious and unconscious reasons for such an apparently senseless course of action on the part of our profession? There seems no doubt that some common practices in psychiatry are unique within medicine and contribute to the distorted view of psychiatry:

It is not uncommon to find, even today, private consultation rooms of psychiatrists with two doors, one leading from the waiting room and the other directly to the outside, all designed to prevent patients from ever meeting each other.

Regardless of objective indications of its usefulness, group psychotherapy has not made many inroads in the specialty, in part because it necessitates exposing patients to each other.

It is still common to find psychiatric units in general hospitals not only refusing to give information about a patient, which is understandable and proper, but denying the fact that a patient is in the hospital altogether.

Psychiatrists who enter therapy as patients often hide this fact or otherwise explain that their therapy stems from a professional, rather than from a personal, need. They find it apparently hard to accept that they, too, being human, may need some help for unresolved emotional conflicts.

The rate of suicide among psychiatrists is reportedly the highest among medical specialists, perhaps because some fail altogether to come for any help before their demise. Some of these despairing and hopeless psychiatrists find it more difficult to accept their own mental illness before this point of no return and, unconsciously at least, prefer the possibility of death itself. In doing so they deny, in fact, that a cure is possible.

The rationalizations given for these practices are many, and on the surface they appear quite reasonable. Concern for the patient's privacy and rights is often cited. In fact, the practice of having two doors to the consultation room had its roots in Freud's Vienna, at a time and place when suppression and repression were much more prominent and the stigma of seeing a psychiatrist was strongest. The specialty of psychiatry was young and suspect and the clandestine method of seeing patients was perhaps understandable under those circumstances. Many psychoanalytic practices have acquired Freud's halo and have simply been handed down as a tradition without re-examination. Yet, the implication to others of our perpetuating such clandestine practices at the present time is that good reason must still exist for such unusual procedures. Patients see other patients in physicians' waiting rooms routinely, why not in psychiatry? The fact that a patient is hospitalized is not denied in any other section of the hospital, why only on the psychiatric unit? Since physicians generally have no need to hide the existence of their physical illnesses or the fact that they consult another physician nor his identity, why do psychiatrists hide their own emotional illnesses so laboriously, so often, and for so long, and why do they often hide even the fact that they are in therapy?

Regardless of all other explanations, is it possible that many of us are afraid of mental illness, like so many others out of the profession? Are some of these practices not really a result of our own apprehensions? Are perhaps many of us psychiatrists as afraid of emotional exposure and involvement as are most of our patients?

The perpetuation of the myth that the one-to-one relationship is the only necessary setting for true self-revelation long after it has been proven untrue, may well be a result of our own discomfort in other settings. If we are uncomfortable with some of our own feelings, how likely are we to be at ease in the presence of strong feelings in our patients? If we are actually ashamed of our own unresolved emotional conflicts, are we not likely to transmit such an attitude also into our role as therapists? No therapist can help his patients beyond the point where he, himself, had the courage to go. Other developments in the field of psychotherapy have also come into the picture in the last few years and further complicated it.

Medicine is practiced generally in the tradition of the medical model in which a sick and suffering patient is diagnosed by a competent physician and treated with the aid of specific curative agents which he is qualified to administer. The disease process takes place within the patient, who is the focus of the physician's attention. Some psychiatrists, on the other hand, have become enamored with a newer, more glittering, and allegedly more attractive model that did not exist before the age of the computer, the Systems Theory model. While the medical model is based on the fact that

the patient has a set of symptoms that constitute a syndrome which is treated with the aim of restoring homeostatic balance, the systems theory model considers the individual and his symptoms as part of a communication within the social system, with "feedback" between himself and the group of which he is part. In other words, what is considered normal behavior on the part of an individual may not be so considered on the part of the group of which he is part. Normality, thus, is a relative concept, which is defined to a large extent not by an objective deviation from a standard of health but by a complex system of evaluations by which the individual is seen against the background of his social environment. Normality is defined, therefore, differently from time to time and from location to location. Both diagnosis and treatment of abnormal behavior have to be modified with changes in time or space, when the systems theory model is followed. It does not allow for any objective definition of either mental health or mental illness.

The medical model considers man as a self-contained entity who is essentially "inner directed." The systems theory model, on the other hand, regards the person as a part of a larger whole, not complete in itself, "outer directed." The differences have deep philosophic implications about the nature of Man and society, the meaning of human progress, and the goals of an educational system. One of the implications of the systems theory model is that the individual as such does not really exist and, instead, the success of his capacity to function is measured in terms of his adaptation to the more complex organization of which he is part.

While all this may sound somewhat academic and of no direct relevance to this discussion, it really is not so. According to the systems theory model, the mere fact of going to see a phychiatrist in consultation or the fact that a person is diagnosed as having some emotional difficulty would *necessarily* effect some changes in his relationships with others. Depending on the attitudes of such others and on their prejudices and fears regarding mental illness, an appointment with a psychiatrist may further alienate the person designated as patient, and such a visit may therefore constitute a self-fulfilling prophecy. It introduces a variable into a previously constant situation. According to the systems theory model, it is not possible to go to a psychiatrist for a mere evaluation, for any known need for an evaluation constitutes a change in the preconditions of the patient. A person seeing a psychiatrist, even outside of a regular therapeutic setting, affects the "feedback" between himself and those around him and, depending on their value systems and their prejudices, it may affect his employability or his insurability. According to this model, it is therefore the responsibility of the psychiatrist to do all he can to keep such potentially change-producing information secret. Hence the justification for the two separate doors and

similar practices which may have had a reality basis in the distant past but not now.

The attraction of the systems theory model is that it seems to be based on greater respect for the integrity of the patient and for his right to decide consciously what information about himself he wishes to reveal and what information he wishes to hide. Ignoring the fact that a wish to hide may well be a manifestation of resistance rather than of reality, some claim that the systems theory model shows a greater degree of sensitivity to individuals in a difficult situation.

This line of reasoning would, unfortunately, not stand the test of closer scrutiny. It is based on mental acrobatics involving moral and value systems that equate health with good and sickness with bad. It knocks the props out from under the claim that psychiatry is a medical specialty and that patients come to us, as they come to physicians generally, not out of any interest in our moral judgments about them but for diagnosis and for treatment of painful conditions from which they suffer. If psychiatrists were to adjust their behavior to fit the systems theory model, then they would have to live their lives and practice their profession according to the prejudices, value systems, and insanities of those who are most afraid of mental illness. Since "they" see mental illness as bad and would hold it against the patient, we as psychiatrists would adjust our behavior accordingly. Acceptance of this model requires no less than the sacrifice of our autonomy, our sanity, and the reality principle.

Not so long ago, when a patient died of cancer, he was often eulogized as having died of "a long and serious illness." Cancer was an unmentionable diagnostic entity in public, too frightening to be mentioned by name, and the euphemism was used instead. To the extent that physicians participated in such a system, they became part in perpetuating such a fear of cancer as a contagious or as an otherwise demeaning way of dying. Not only were such physicians participating in a superstition but, more frighteningly, they made it more difficult for future patients with such possible diagnoses to avail themselves of help early enough and in an appropriate fashion. Similarly, such euphemisms as "being in a family way," or "being indisposed" during the monthly period were the result of moralistic Victorian mores and have been a source of unnecessary pain and shame for generations of women.

The minimum that we can ask of ourselves as a profession is that *we* examine our own true reasons for continuing to behave in such irrational ways. Is it possible that some of us became psychiatrists as a desperate counterphobic move? Since the etiology and pathogenesis of mental illness are not as clearly established as those of bacterial or viral diseases, its existence may well be very frightening even to some in the profession. When

we treat our patients year after year in a fashion so radically different than is customary in other branches of medicine, we must not shirk the responsibility for examining the true causes for such strange practices.

It is up to the VIP as it is up to "ordinary" patients to decide how much or how little they want to reveal of the fact that they are in therapy. They may or may not wish to tell their associates, friends, and others about the fact that they go to a psychiatrist and what happens to them there. They may similarly decide to hide or reveal the fact that they are under treatment for diabetes, heart trouble, or any other condition. But if psychologic illness is as real and at least as debilitating as most physical illnesses, then it is grossly unfair that *we* treat our patients as if there is something about their condition that *we* need to hide, as if it were truly shameful. We, at least, must act according to the reality principle and not distort facts to fit the distortions of those who are unreasonably and irrationally afraid of emotional illness. The point is not that psychiatrists take upon themselves the mission of becoming agents of social change in relation to the public's attitude about mental illness. The point is that we not become part and parcel to distortions based on unreality for by doing so we endorse, in effect, such distortions and perpetuate them.

It would have been important and in the interest of destigmatizing mental illness and the seeing of a psychiatrist for our profession to have made clear public statements after the confrontation between Gerald Ford and the Senate Committee. It needs to be said clearly, emphatically, and repeatedly that not only does a visit to a psychiatrist not in itself disqualify a person from holding a job or public office but, on the contrary, the aim of psychotherapy is to expand conflict-free areas of the patient, to widen the range of his rational choices, and to make him more independent of internal pressures that might otherwise hamper his objective judgment.

Such statements are specifically true for psychotherapy and are obviously not related to drug or shock therapy or to any other mode of therapy which aims at suppressing conflict rather than reconstructing the patient's ego. Senator Eagleton's shock therapy experience is a case in point. It probably decreased rather than increased his fitness for holding positions of responsibility. The public that is asked to entrust elected officials with the power to make life and death decisions of frightening proportions is entitled to know the psychiatric histories of such candidates, the type of help they received, and the chances of recurrence of previous mental illness. In the same way the public may also demand that a person seeking high public office reveal other facts about his health and illnesses, very much as it may demand the revelation of other personal data such as finances, which normally are confidential. Such information belongs to the individual and only he has the right to divulge it, which is what he may have to do to get elected.

As physicians, we must keep all details of our relationships with patients in a completely confidential manner. This does not mean, however, that we can agree to see them in a clandestine fashion. To act in any other way is to join in an irrational act, which obviously is untenable. We are not "shrinks," we are expanders. We may sometimes not come as close to this ideal as we wish, and as we ideally should, but surely we cannot act as if our work with patients cannot bear the light of day and must be hidden. When we engage in such practices, as many of us continue to do, patients are likely to believe that perhaps there is something truly shameful connected with their relationship with a psychiatrist and will attempt to avoid it, to postpone it, or to deny it, and in any event to be ashamed of it and to be afraid to be found out.

Unless and until we as an organized group and each one of us individually acts openly, consistently and repeatedly within the framework of the medical model, we fail to meet our responsibility as physicians and as sane individuals. We also perpetuate the stigma attached to having contact with a psychiatrist which is based on irrational fears of a frightened public that does not understand what mental illness is all about. We may, indirectly, also make it more difficult for public officials or for those aspiring to high public office to seek psychiatric help when needed. Such need may be very immediate and strong among those holding high office at times of personal or national peril. The events of Watergate provide ample examples. To deny such officials the opportunity to obtain competent psychiatric help because of this irrational stigma is grossly unfair to them individually. Such denial of the need for help may also have the gravest national consequences. Decisions by central decision-makers based on impaired judgment resulting from emotional stress may well have serious consequences for us all.

## SUMMARY

Mental illness and consultations with a psychiatrist carry with them a stigma that has not disappeared with the years. This is in sharp contrast with attitudes toward physical illnesses. As a result, VIP's and others are frequently unwilling to seek psychiatric help in time, or even at all. Psychiatrists follow practices that perpetuate this stigma, possibly because of unresolved fears they themselves have in regard to mental illness.

The medical model of health and illness allows patients to seek help without embarrassment or shame, since no moral values are attached to being sick. The popularity of the newer systems theory model may well be a result of discomfort with emotions and with emotional difficulties within the profession. In this model reactions of those who are afraid of mental illness and prejudiced against psychotherapy are considered legitimate and require psychiatrists to modify their relationship with patients accordingly.

The continued use of the systems theory model increases the difficulties potential patients have in seeking therapy, with possible serious consequences for the individual and for society.

REFERENCE

1. Group for the Advancement of Psychiatry. The VIP with Psychiatric Impairment. Scribner's, New York, 1973, p. 48.

**Joseph Wilder, M.D.: Comment on Bar-Levav's article, "The Stigma of Seeing a Psychiatrist"**

Dr. Bar-Levav starts with quoting President Ford testifying before a Senate Committee that he has never needed or received psychiatric treatment and that he was "disgustingly sane." There follows a long polemic to the effect that it is wrong to be ashamed of seeing a psychiatrist and that psychiatrists regrettably condone such an attitude.

As I have stated on various occasions, I do not agree with President Ford's (and possibly the Senate's) attitude. Nobody is the judge of his own sanity. Only when you have seen a psychiatrist and have been certified as sane can you say of yourself "I am disgustingly sane." All insane people consider themselves as sane. In addition, many neurotics and addicts consider themselves as normal. Every psychiatrist wonders occasionally how many years mentally and emotionally sick people can get away with it before they or others decide that they must see a psychiatrist. In addition, we are also dealing with the propensity to periodic mental disturbances (manic-depressive, psycho-epilepsy) where people are normal but may become mentally sick any minute.

One still often encounters the opinion that if an individual has achieved fame or a high position it makes it very improbable that that individual has a sick mind. And yet history if full of examples to the contrary. We do not have sufficient information to write "pathographies" of a Caligula, Nero, Ivan the Terrible, and others. However, as we approach modern history the task becomes easier. We know of King Ludwig of Bavaria who was officially declared insane and even killed his psychiatrist. Who can doubt that Hitler was a schizophrenic; Hess was officially diagnosed as such, Goering was a morphinist; Stalin was described as paranoic by his former associates; Mussolini suffered from a hypochondriacal anxiety according to his former collaborator Angelica Balabanoff.

To get closer to home Lincoln is described as manic-depressive in the three-volume biography by Edward J. Kempf (New York Academy of Sciences, 1965) and so was a recent candidate for the Vice-Presidency. Our former Secretary of the Navy, Forrestal, committed suicide while in office. Our Secretary of State for many years, Cordell Hull, certainly could not have used Kissinger's method of visiting foreign countries since he had a

phobia of trains. I am informed that two important Russian diplomats, Molotov and Vishinsky, had a fear of flying and could do it only with the help of large doses of barbiturates and that they were always accompanied by a physician. Few doubt that Franklin Roosevelt in his last term (which included the important conference at Yalta) suffered and died from cerebral arteriosclerosis. I know from a witness that the brain of Crown Prince Rudolf, the heir to the mighty Habsburg empire, showed all the signs of progressive syphilitic general paresis.

The important question is not whether one should be ashamed of consulting a psychiatrist, but how and when one should consult a psychiatrist without creating an embarrassing situation. This question has already been solved by some of our most efficient organizations. At induction the Army and Navy give a psychiatric examination either to all candidates or to those singled out by general practitioners. Big business corporations do the same for their valuable executives. Could we not demand the same from all candidates for public office, new or long serving, who carry such a heavy burden of responsibility? And should this not be extended to teachers, judges, and others? I shall not discuss here separately the abuse of drugs and alcohol since this is a routine part of psychiatric examinations.

A breach of secrecy is not involved here since it is up to the candidate for any of these offices to submit a certificate of health which would always include mental and emotional health.

**Reuven Bar-Levav, M.D.: A Comment on a Comment**

Dr. Wilder's interesting contribution raises enough important issues for an entire separate article. The very definition of sanity, with psychiatry in as primitive a phase of development as it is, is unfortunately still disputed. As Wilder suggests, the single-minded devotion of many sick but talented individuals throughout history to the attainment of power has resulted in many tragedies. It seems unrealistic, however, to expect that therefore we already have the means to prevent such situations from developing. Enthusiasm whipped up by sick demagogues has always brought the masses to their camps as followers, probably because mental illness was common in every generation, and followers may have unconsciously recognized that a disturbed leader legitimizes their own disturbed existence. To hope that things are better now in our own society seems rather unsupportable by the facts. If reality testing and rationality were truly the yardsticks of our political and personal behaviors, we would have to scrap the majority of our institutions. It is, in fact, easier to exist in this society if one is a little crazy, and our leadership on all levels seems to cater to and reflect this sad fact.

Psychiatrists are hardly exempt. As my article can only suggest, both the private and the public behavior of many psychiatrists and other professionals are often determined by unresolved, internal needs rather than by

reality factors. If certification as sane were at all possible, surely psychiatrists would themselves have to submit to scrutiny first. By whom? By which objective standards?

The greatest contribution that psychiatrists can make to the political process and to our society at the present time consists of they themselves becoming more rational in their own personal and professional relationships. Psychiatrists must work harder to eliminate the stigma that they themselves attach to their own profession, thus making it easier for the public and for public officials to accept emotional difficulties without shame and to treat them without delay and before harm is done to the population at large.