

Bulletin comment: Openness, transparency and candour[†]

Health professionals are well known for being the worst patients. They refuse to seek help for difficulties that, if addressed earlier, might not have resulted in catastrophic complications for themselves and those around them including friends, family and indeed patients. With particularly high rates of psychiatric illness in those working in mental health, it is vital the reasons why those affected delay getting treatment are identified and eliminated.

Research exploring stigmatising beliefs and attitudes among colleagues in mental health services may help. In addition, the general public's understanding of psychological issues will not change unless everyone – especially mental health professionals – has the courage to stand up and be counted when they are affected in the same way. Policy makers, agenda setters and strategy shapers should be aware of high levels of psychiatric illness among practitioners and any research confirming such facts ought to be used as a burning torch highlighting ways to combat it.

Personal difficulty, with or without diagnosable episodes of mental illness, is part of the human experience and needs to be acknowledged by all, but particularly by mental health professionals and organisations involved in the care of patients. Recognition of one's own shortcomings paradoxically might lead to greater respect from both patients and society in general.

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Profile: Stigma and the psychiatrist – Julia Bland talks to Dinesh Bhugra

Julia Bland

Professor Dinesh Bhugra made bold attempts to move psychiatry forward when President of the Royal College of Psychiatrists. In May 2012, **Julia Bland** went to pick his brains as he prepares to take up the post as head of the World Psychiatric Association (WPA).

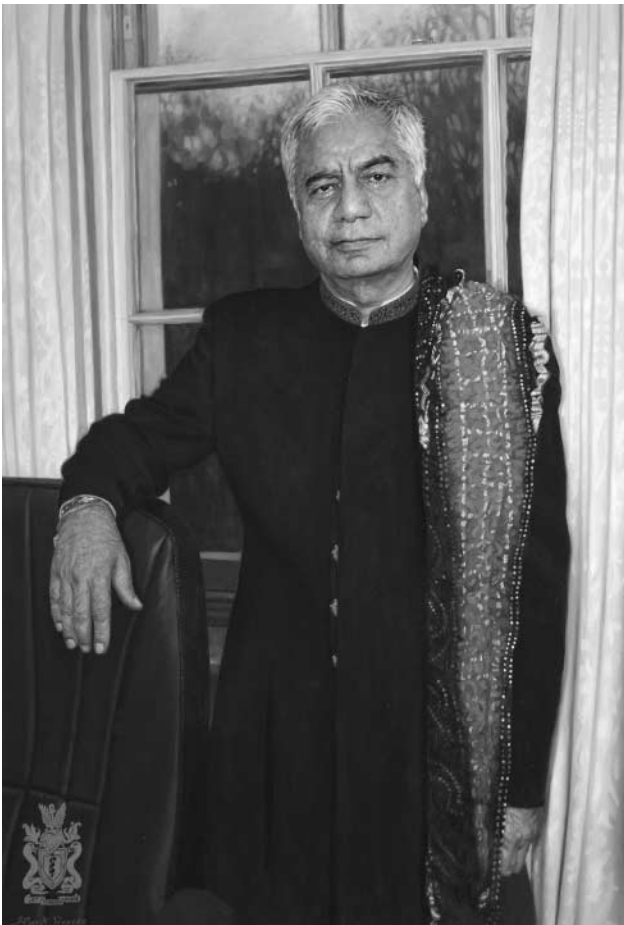
It is a sign of how things have changed when an Indian-born, openly gay man is elected to lead a profession which up until relatively recently classified homosexuality as a disease. But it is apparent that the newly appointed president of the World Psychiatric Association will have his work cut out. In Uganda a recent law has introduced draconian punishments for homosexuality. In India the president of the Indian Psychiatric Society threw her hands up in horror and said, 'We don't talk about that here!' It is a good job then that Professor Bhugra's achievements and experience are immense and having practised psychiatry for more than 30 years, it would be fair to say he is probably the best person for the post.

He adopts a progressive agenda, having published and spoken out for beleaguered patients, overseas doctors, women and lesbian, gay, bisexual and transgender (LGBT) people for many years. The 61-year-old describes himself as an 'optimist', laughing apologetically, as if the concept of optimism somehow excuses the gap between noble aspiration and reality. 'We have to take a stand' is his rallying cry to the profession. 'If we don't, we are sleepwalking over a cliff', he added. He believes unity of voice is crucial. 'If we are seen as divided as a profession, policy makers will take the opportunity to divide and rule', he said. He dislikes the old dreary and pointless internal squabbles between biological and social psychiatry.

Psychiatrists' mental health

He is exercised about the health and well-being of doctors – and especially psychiatrists. He described an interesting consultation the College sent out to over 7000 consultant psychiatrists in 2010, which he presented at the time. The

[†]See perspective on Dinesh Bhugra, pp. 180–182, this issue.



results of the survey were not published since it was felt to be of poor quality.

Professor Bhugra sees self-disclosure, 'coming out' as mentally ill, as a personal choice, but very different from 'coming out' as gay: 'One can hide sexuality but may not be able to hide mental illness.' But he agrees that self-disclosure of mental illness may reduce stigma (Ruby Wax, Stephen Fry, and past president of the College, Mike Shooter, to name a few of the people who have worked to reduce stigma in this way). He thinks doctors need to learn to look after themselves and welcomes the idea of self-reflective practice groups at all stages, including at consultant level, and across specialties.

'If doctors understand the importance of the public mental health agenda as it applies to themselves, things like exercise, meditation and mentalisation, they are less likely to lose their humanity.' And he recommends that the College might repeat the 2010 survey.

Service provision

He agreed that the preventative mental health message is getting lost (for example, £1 spent on child psychiatric services is estimated to save £6 in later health, forensic and social costs). With regard to the services provided for patients, the Health and Social Care Act 2012 with its attendant re-commissioning of services in the direction of the cheap and cheerful was at least partly to blame for

falling standards. 'Only forensic psychiatry is thriving', he says with more than a hint of irony, and 'child psychiatry is being swallowed up into community paediatrics in some areas'. He suggests that the 'conversation' needs to be with the public mental health lead within Public Health England, a separate body from NHS England.

Frustration

Although he is discreet and measured in his language, there is an undercurrent of frustration at stymied initiatives from his period as president of the Royal College of Psychiatrists. His attempts to encourage 'youth psychiatry' for the important 14- to 24-year-old group met with protectionist resistance. 'People feel more comfortable where they are', was his comment on the conservatism and parochialism of the profession, but his irritation was audible. He made the point that when psychiatrists feel devalued, they should engage patients, their families and general practitioners (GPs) as advocates: 'GPs want their patients assessed initially by a psychiatrist, not by a second-year nurse. And families feel the same about their sick family members. This is no disrespect to multidisciplinary teams, just about training and experience', he said.

He has also been frustrated by inflexible psychiatric colleagues, citing the obvious benefits of community mental health teams (CMHTs) being located in primary care: collaboration, cross-referral, more seamless care for patients. It was the psychiatrist who refused to join a primary care centre, when the GPs were ready to welcome them, in one recent instance.

When he started as College president he described the lamentable state of many in-patient wards, which hit the front pages. This was welcomed by patients but 'psychiatrists hated it, feeling criticised'. Interesting to consider the duty to whistleblow in the post-Francis era.

Training

Dinesh Bhugra also has strong views about humanity getting lost in medical training, a characteristic that has to be retained to be a good psychiatrist, in his view. 'What we do now is take the brightest students as medics, drill competition in and drill empathy out. Then we expect them to emerge as team players! If I could change the world, I'd have all the disciplines, medical, nursing, psychology, doing a first year of humanities together, learning anthropology, sociology and literature, before they disappear into their separate silos', he said. 'We need psychiatrists who can put themselves in their patients' shoes, not those whose instinct is to hide behind professionalism. I teach medical students to think about the patient rather than the symptoms', he added. 'Young doctors need to see psychiatry as the most interesting and exciting branch of medicine, and to look after their own mental health from the beginning of their training. If we turn the younger generation into sausage packers, delivering commodified packets of care, we will have let them down.'

Culture and personal life

In an interview with *The Guardian*,¹ he spoke publicly for the first time about his personal life and sexuality. Growing up in northern India, there were constraining cultural expectations. Moving to the UK in the 1970s made life easier, although he identifies with the difficulties of integration experienced by foreign medical graduates. As a former General Medical Council assessor of poorly performing doctors, he knows the awkward fact that 'four or five out of six such doctors are from ethnic minorities'. And as chair of the College's Overseas Doctors' Training Committee for 6 years, he remembers that the most common complaint against these doctors was their culturally inappropriate request to a nurse to 'make me a cup of tea'. Personally, Dinesh Bhugra is an urbane international operator who can play comfortably with his own multiple identities as he jets around the globe, but he fully recognises the complexity around teasing out real poor performance from the experience of discrimination for overseas medical graduates.

He regrets the ending of an imaginative College induction course for overseas doctors, and as we discussed its demise for financial reasons, he decided to write to the diaspora organisations to remind them to look after their own.

It seems, then that Professor Bhugra is not afraid to speak out or indeed to stand out from the crowd. His portrait in the Royal College of Psychiatrists is not an identikit of a suit, shirt and tie. He is dressed in full traditional Indian regalia appearing like a contemporary maharajah surveying his kingdom.

He lives in Brixton with Mike, his partner of more than 30 years, and maintains an office in the Institute of Psychiatry. Sophisticated, smooth and realistic, his message is forward looking and crystal clear: be creative and flexible, work across boundaries, wake up to the new commissioning realities, don't be narrow and protectionist – or prepare to be sidelined.

The visionary Bhugra is soon to have an even wider purlieu: the world, when he takes the presidential reins of the WPA this September. He hopes to combine his ambition with realism. He said his priorities will include domestic violence, child abuse, prisoner mental healthcare, minorities including people with intellectual difficulties, LGBT and mental health promotion. Enough to make mere mortals

giddy at just the thought of what this might imply. But Bhugra knows the WPA can only be a facilitator, potentially useful as a research hub, connecting people. He said: 'Psychiatry does not have the answers to everything but we can find partners, make links and at least make a stand.'

He takes a properly global view of mental health and refuses to assume an attitude which smacks of colonial superiority: 'The tragedy of western psychiatry is that we have been so egocentric, when large swathes of the world are still sociocentric, and we in the West need to learn from other societies. Why aren't Russian or Asian psychiatric textbooks translated into English? Then we might actually learn from them.'

He has seen wonderfully creative solutions abroad with limited resources: the psychiatric hospital in India where there is such a shortage of nursing staff that patients are only admitted with relatives. The relative becomes the informed co-therapist who can monitor the patient after discharge and becomes an educated participant in treatment. Or the school in Pakistan where children are taught to recognise psychosis and epilepsy. They tell their teacher, who then contacts the health professional resource.

Professor Bhugra is a grown up. He is not throwing his toys out of the pram. He is quietly but firmly reiterating the wise, collaborative and creative way forward, and his lack of stridency enhances the appeal of his message. Will the rest of us manage to take up his challenge or are we herding ourselves, lemming like, towards the cliff edge?

Julia Bland, c/o *Psychiatric Bulletin* (pb@rcpsych.ac.uk).

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Personal experience: Diagnosis and dilemmas – what happens when we diagnose patients with the label 'schizophrenia'

Mark Ellerby

At some point during the first onset of schizophrenia, family members are going to ask the question 'What is wrong with him (or her)?' The result is going to be a diagnosis or medical explanation in some form. Even today, with years of first-hand experience of schizophrenia, I am still unsure about how to best approach this thorny issue. The problem is that it is easy to get the wrong first impression from all the terms

and labels that surround a mental illness. What follows here is an account of the mistaken initial impressions I formed once I was diagnosed and a hope that others who read this will not form the same misperceptions as I had.

The diagnosis can be bewildering for all concerned. My family was equally frightened and worried. As there had been some history of mental illness in the family, they knew

that seeing a doctor was the right thing to do. They also had some notion of what a mental illness is. I was much less well informed. Many things about my first diagnosis confused me and mystified the whole subject of being 'ill'. I had no grasp of the distinction between mental illness and physical illness or that I had a mental medical condition. When I was told it might be schizophrenia, the word to me as a layman was about as clear as mud. I was at a total loss as to what this could be. It never occurred to me that it was a form of madness, in fact, it initially rang no bells with me at all. But since a doctor had suggested this, it began to prey on my mind. I looked it up and found that there were four different types of schizophrenia. It did occur to me that in my case it was 'paranoid schizophrenia', but what 'hebephrenic' and 'simple' meant I had no idea, and unfortunately the book did not elaborate. Again, in contrast to these latter types, the idea of being catatonic was readily intelligible. All the same, I asked the doctor about the mysterious classification just to make sure that, in my ignorance, I was putting myself in the right category, to make sure I fully understood what I was being labelled with and whether there were any aspects of the other types of schizophrenia I was experiencing that might have been relevant.

Much later, a community psychiatric nurse said that the fourfold typology is hardly used. In fact, she could hardly believe that I had heard of it at all and regarded it as antiquated. She emphasised that a little knowledge is a dangerous thing, a thought that did not occur to me at the time. Admittedly, the book did make the point that it literally meant 'split mind', which I took to mean a split personality. But in contrast to what it also said about being paranoid, this fact just confused even more. Did I have one part of my personality that was paranoid and the other normal as the delusions came and went, I thought? On the other hand, the word 'psychotic' turned out to be a very common medical expression. My initial thought here was 'Is there a distinction between psychoses and neuroses?', but once again my psychiatrist told me 'I do not believe there is any such thing as a neurosis.' After that I did not dare ask what psychotic was for fear of looking stupid.

So again, at the time I was mystified by the distinction, especially as it appeared in the same book on psychology I had looked schizophrenia up in. I assumed it was because it was a psychology textbook, not a psychiatric one, and that my psychiatrist's response meant it was a technical dispute between the two professions.

The main impression I formed about all of this – when I got to thinking about it more – and that all these terms created for me was that there might be something dangerous about having schizophrenia. Maybe this was a sign of madness after all? I began to get worried. I got the feeling in the back of my mind that maybe I really was a little mad underneath. However, at no point did any professional discuss what my diagnosis meant. It was stated as fact, with no room for dialogue or understanding. I was left on my own to find out more but my reading made me anxious and it was difficult to think through what it all meant for me. What actually prevented me from giving these descriptions a fuller consideration was that I was too caught up with the delusions and voices I had begun hearing. I never got any rest from them and they were

constantly on my mind. Hours seemed to fly by like minutes and in the end I lost all sense of the passage of time. Even when my mind had some opportunity to work on these concepts to do with mental health, and the other psychological terms, I still replied to the psychiatrist who came to visit me at home that I was not ill. By then I had absorbed the idea of having a mental illness, but that did not help my understanding of my situation, as I thought what I was thinking was real. I picked up the notion of illness from looking up medications in a library book and finding antipsychotics in it. Unfortunately, this connection made me even more suspicious of the term psychosis. Was the delusional part of myself seen as a danger by everyone else that needed to be 'got rid of'? This thought caused more anxiety.

In sum, I think an effective explanation to me and my family would have made me more cooperative and could have been instrumental in getting me help sooner. The reason for this is that it is possible to form all kinds of misconceptions about schizophrenia and psychiatry that, if dispelled, could make a lot of difference.

Only in recent years have I been helped to find a personal formulation of my difficulties. This is a framework for understanding the personal triggering and maintaining factors in each person's mental health issues. I have learnt that not everyone with my diagnosis is the same and that my history and personal experiences may have shaped the development of my problems.

First contacts with a psychiatrist

There may be some resistance on the part of the patient to being interviewed. Why should I tell you about my problems? It is necessary to somehow get across the concept of being mentally ill and that people want to help you with it, not to lock you up.

Hospital design is part of the process. In the one I attend, there is coffee available, music playing and art on the walls. The informality of the staff is also important. Plus, pay attention to how psychiatrists and nurses dress – casually? First impressions, or are we too ill to notice? What more can be done to get the message across? Is it all in vain?

The answer here is no. I think people who constantly care for emotionally distressed people – nurses and doctors – demonstrate an ethos of care that manifests itself in their being and behaviour. This, in my hospital, is so visible and you can see the concern for patients' well-being in eyes of the nurses; the above considerations seem to fade into the background. If the patient closes themselves off to the staff, a relationship of trust and confidence will be harder to establish. You might, if you are not aware of these influences (e.g. because you are so caught up by the illness), feel like you are just a part of the system rather than an individual in the eyes of the staff. This is not helpful.

If I were more aware of the buildings, I would have wondered a little about the notorious carceral history of psychiatry. In particular, the example of Bedlam: the magnificent buildings, the awful stories. Although I am doubtful newer buildings would help in this respect (they would just make me think of American sanatoriums).

One important point is that doctors and psychiatrists should know what they are doing when they label someone with 'schizophrenia'. Having a social worker on hand to

explain about the stigma in the media and the connotations the word has, the negative language involved and how it is all just ignorance in that respect would make a huge difference. This is better than just saying it is a chemical imbalance, which may be enlightening only if we are properly educated in this respect and can appreciate that the problems we are experiencing are chemically caused, rather than something that is just happening to us, and that this chemistry really is an illness. My parents also felt there was a general lack of information about the subject. We educate teenagers about war in schools, so why not schizophrenia? It is just about as frightening. In the end, some kind of public programme is needed to underpin initial psychiatric contact. This happens in Norway, where huge public awareness events, like schizophrenia days in Stavanger, give school leavers information from primarily young people who had received help for mental health issues.

People who cope with particularly severe schizophrenia should be awarded the Victoria Cross. This is the best public defence against stigma. However, the illness destroys what could be a fertile mind, to the great loss of our society. There are examples of high achievers, such as John Nash, played in the film *A Beautiful Mind* by Russell Crowe, who have contributed much to the society that excludes them, and it is popularly known that genius can be linked to madness. A more compassionate society could benefit from these contributions and function far better for the welfare for its members, many of whom are likely to have mental health problems at some point in their lives. The world would be a far happier and more creative place if it were more compassionate.

Changing the labels?

As I have stated, I was so confused by all the terms that surround having a mental illness and the wrongful connotations some of them have, I really had no idea what was going on, even when the doctor diagnosed me. This, to me, raises the question of whether changing the labels would make the whole confusing problems of being schizophrenic any clearer from the outset? Ultimately, I do not think the word 'schizophrenia' should be used at all. It may be better to simply describe it as 'paranoia' and hearing voices as 'hallucinating'. These terms are not ideal, but they are far more innocuous and understandable than 'schizophrenia' or 'psychosis'. In the end, you cannot avoid the confusions of explaining the illness without being careful about exactly what you say, and what you might leave out. 'Schizophrenia' is a real umbrella term, covering a number of different symptoms and indeed types of illness. It may be better to divide the diagnosis up on this basis, though often the different symptoms are experienced by the same individual. It has also been shown by research that the biology involved is linked to previous stress and trauma for many. I have often thought that the best thing to say instead of schizophrenia is that 'you are hallucinating' or 'you are having delusions'. Although both of these are far from perfect, they do not have the associations of the label schizophrenia, which a lot of people would immediately connect with a split personality and Dr Jekyll and Mr Hyde.

Hallucinations are often associated with phenomena such as delirium. This happens when someone has a fever, and

I have seen this in a couple of movies too. Hearing voices is often triggered by a loss and is common even in people who are outside the mental health system. I think it is better to start with everyday explanations, not just medical ones.

So this might be a useful first explanatory link and might avoid the first associations with schizophrenia. This is already how I have seen doctors technically denote what lay-people call hearing voices, which they term 'auditory hallucinations'. Hallucinating also sounds a lot better and much less dangerous to me than saying someone hears voices. I am aware that many patient groups would disagree with what I have said here because hearing voices is so common and uses everyday language. However, 'hallucinations' only suggests another more medical-sounding label, which still may not be readily understood, but carries less associations of stigma.

Being 'delusional' again sounds a lot better to me than having schizophrenia. Delusions are in popular knowledge associated with insanity, such as 'delusions of grandeur'. The immediate reaction here might even be humorous, as such ideas seem comical and absurd to the layman. 'Paranoid delusions' is another close association with schizophrenia but in this respect it could be a very counterproductive label. Again, I think there is a suggestion of danger associated with someone who is paranoid about people persecuting them. It is hard to see a way past this problem by simply using new terminology. What label would you suggest for people who believe others are out to get them? It might be helpful to try to give an example here of famous people who have had the same problem. There are lots of popular films, such as *The Madness of King George* and *A Beautiful Mind*. This seems the best way to defuse the connotations which arise from an initial diagnosis.

In the end, the whole issue of how to explain it seems very difficult. Normalising some of the experiences is critical. Being open about discussing people's misconceptions and fears would help prevent those fears escalating. Giving good information to the patient and the family about options for recovery is critical in inspiring hope. Understanding each patient's personal journey into psychosis would be more meaningful than blanket labels. The media has an important role to play in perpetuating stereotypes, which increase fears of the diagnosis of schizophrenia. Finally, raising mental health awareness with young people in a non-shaming way would give them the information they need to recognise issues early on and the courage to ask for support.

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Personal experience: Coming out – the psychotic psychiatrist – an account of the stigmatising experience of psychiatric illness

Aashish Tagore

I am proud to be a psychiatrist. Despite often feeling stigmatised by medical colleagues, I have always derived a great sense of personal reward and satisfaction from my chosen line of work. I believe psychiatrists are blessed to be in a position to assist people at times of great personal distress and emotional turmoil, often when they are at their most vulnerable. As psychiatrists, we are only too well aware of the stigma and negative attitudes our patients face in society in general. There can be no doubt that many of our patients with severe mental illnesses are marginalised to the fringes of society, often leading their lives in depressing isolation. They are often ostracised by others, who treat them with contempt. Our patients are often made to feel like ‘freaks’ by an intolerant and ignorant society. They are rejected as pariahs. To some degree, these attitudes are borne out of a fear of the unknown (or at least, poorly understood), and in the case of psychotic patients, a misperception that they are a danger to society.

I am sure that all psychiatrists, like myself, try to have an understanding of how this must feel for our patients and, in so doing, we strive to treat them with compassion, empathy and humanity. I am also sure that the vast majority of us robustly back the plethora of campaigns that aim to destigmatise mental illness in our society. But what happens when you suddenly find yourself on the ‘other side of the fence’? This is the scenario I have recently been faced with, and that has challenged my genuine dedication to the anti-stigma cause. And so it is after a great deal of reflection and soul searching that I have decided to ‘come out,’ and write this account of my own experience of psychotic illness, and more specifically the stigma I experienced along the way.

How it all began

Last year, I was suspended from work following an allegation of a rather disturbing and sensitive nature (which was later proven to be completely baseless). Needless to say, the entire episode was nothing short of traumatic. The experience was surreal beyond imagination, not least because I had absolutely no clue as to exactly what the allegation referred to. I was not (and still to this date have not) been provided with any more information as to what, when, or where the alleged incident occurred. Perhaps most people presented with a similar set of circumstances would find themselves feeling equally bewildered and bemused. It seems to me, that if one does not have any frame of reference around which to process such an event, an adverse impact on one’s psychological well-being is inevitable. Alas, it was against this backdrop of complete secrecy and a wall of silence, that, perhaps unsurprisingly,

conspiracy theories and paranoid ideas began to take over from rational thought. Before I knew it, I was experiencing highly systematised, persecutory delusions, and was convinced that my life was in grave danger. A precipitous descent into full-blown paranoid psychosis ensued, which culminated in a hospital admission and treatment with antipsychotic medication.

Is openness the right decision?

I have been advised by many people, not least family and close friends, all of whom undoubtedly have my best interests at heart, to remain tight-lipped about both the allegation and my ensuing illness. Perhaps my decision to speak out about my experiences are at least partly driven by a desire to break free from these shackles of secrecy. I feel that other people’s wishes to conceal this whole episode have served to compound and perpetuate my own sense of shame and embarrassment as a result of experiencing a psychotic illness. Perhaps this is a cathartic exercise of candour, designed to enable me to feel liberated from the air of secrecy that has surrounded my illness? Who knows...

Of course, I can understand where they’re coming from. I have no doubt that their main concern is the effect that such openness will have on my future career. They are certain that to openly admit to a psychotic illness would be ‘career suicide’, and that I would never be considered for a senior job. After all, what department would want to hire and work alongside a colleague whose mental stability is a source of constant concern. Surely they would prefer someone dependable and resilient to stress. Of course, I can completely understand this perspective – who would choose to work alongside someone who may end up on protracted periods of sick leave? Who would choose someone who might become paranoid towards them, might start to believe they are being plotted against, or might start behaving bizarrely in some way when at work? Surely it would be easier to simply avoid such potentially awkward situations, and hire someone with a clean bill of mental health? I myself would certainly have thought along these lines. And so did my treating psychiatrist: to some degree, at least. Looking at his correspondence to my employing trust, he clearly attempted to minimise the psychotic quality and severity of my illness, preferring to conceptualise it as a ‘severe adjustment disorder in the context of extreme stress’. He also made a point of explicitly stating that I did not have schizophrenia. There is no doubt in my mind that his objective in euphemising my condition was as a damage limitation exercise for my career prospects. In essence, it appears that many doctors (including

psychiatrists), expect or anticipate that there will be inevitable discrimination against fellow medics who have had a mental illness.

The great leveller

The most difficult time I had to endure during my illness was when I was admitted to a psychiatric unit. Fortunately, I was only admitted for 1 day, but short-lived as it was, the impact it had on me will endure far in to the future. This was when the truth really hit my between the eyes – I was now a bona-fide mental patient. I have never felt such an acute sense of dismay and helplessness as I did at that precise point. Here I was, the newest patient on a ward on which I used to work – it just didn't seem real. It was my worst nightmare realised. Upon reflection, this period was also when the stigma of my illness came to the fore. Not only was I embarrassed to be there, the staff with whom I used to work alongside appeared equally embarrassed for me. The pity was written all over their faces. And I must confess that my own prejudice towards mentally ill patients surfaced. Despite evidently needing acute assessment and treatment, through my psychotic haze, I still felt I was for some reason better than or at least different to the other patients on the unit. I felt the need to distance myself (both physically and psychologically) from the other patients – I needed to reassure myself that I was not one of them. But, alas, I was. I was no better than or different to them – I was just as unwell, and just as human as the rest of them. I was just as vulnerable and susceptible to mental illness as the rest of them. I was just as breakable as they were. I was no longer this superior being, the 'doctor' to their 'patient,' I was their equal. Despite the fact that I hated every moment of my admission, it was a great leveller. Any airs and graces I had all but disappeared in the course of that day.

Self-stigmatisation

In the immediate aftermath of my episode, I felt a sense of deep-seated shame and guilt. I never thought that a life event, traumatic as it was, could have had such an adverse impact on my mental well-being. I felt as if I had let down not only my wife and my family, but also myself. Prior to my illness, I identified with myself as a resilient individual who was able to deal with stress and adversity. However, the illness, perhaps unsurprisingly, knocked my confidence, and with it, my self-belief. I now viewed myself as a 'weak-minded' individual.

And so it is with the concept of 'self-stigmatisation', where the stigmatised individual actually relates to others' negative attitudes towards themselves and their illness. If you yourself share the negativity you might endure, and view such attitudes as 'understandable', then where is the motivation to fight it? I experienced these feelings until fairly recently following my psychotic illness, and almost felt that I didn't deserve to be treated the same as everyone else, or indeed, the same as my pre-psychotic self. It's strange how the stigma of mental illness affects one's self-identity so profoundly.

Another aspect of feelings of shame in the immediate aftermath of my illness, relates to the behaviours and

actions that were integral manifestations of my psychotic experience. For example, at one point I confronted a neighbour because I believed they were spying on me (in fact, I approached the police about this, such was the conviction of my beliefs). Looking back on this incident now, I feel utterly mortified. My sense of embarrassment regarding this particular incident is indescribable. And thus, rather than approach this neighbour and explain that I was mentally unwell at the time, I continue to choose to avoid them. Perhaps I still have some way to go to being at ease and open with my illness after all. That's stigma for you, I guess. I reflect on this particular incident frequently, and wonder how patients must feel when they have recovered from an acute episode of their illness, but can still recall embarrassing behaviours. Consider those recovering from acute manic episodes in particular, many of whose illnesses are highlighted by extreme, reckless, chaotic and disinhibited behaviour. Their sense of humiliation must be profound, and must linger in their minds long after their mania has subsided.

Stereotypes and prejudice

My family and friends must also be certain that people will judge me negatively, just as they do my patients, and that I too, will be labelled a 'freak' or a 'nutter'. And as much as they care for my welfare, I guess there is also an element of shame and embarrassment for my family through association. After all, if they were slightly embarrassed to tell their friends that their beloved doctor son had chosen to become a psychiatrist, how would they feel telling their friends that he had also now become a psychiatric patient. How they must have imagined their friends mocking, 'it's true what they say isn't it, it takes one to know one, I told you all psychiatrists were mad themselves!' After all, it is not an uncommon perception, even among medics, that you either have to be 'mad' to do psychiatry, or that exposure to 'mad' patients will eventually make you 'mad' too. An interesting chicken-and-egg debate among medical students, as I recall from my own university days!¹

I suppose I'm not doing much to dispel that particular myth. Indeed, many of my most stigmatising experiences came from within the medical profession, as opposed to the wider general public. Most of these incidents were borne out of negative stereotyping of mental illness. The most memorable example came when I met with the medical director of the trust in which I was working, with a view to finding out more about the allegation I faced. During this consultation, it became clear that this very senior doctor believed my circumstances were essentially self-inflicted, commenting that such false accusations must be an 'occupational hazard' in psychiatry, and that, as such, I only had myself to blame for choosing the specialty. It became clear that he seriously believed that many psychiatric patients must have a propensity to make deliberately false, malicious allegations, as if this trait is in their nature. I was initially quite taken aback by his prejudiced stereotyped attitude towards psychiatric patients, until I came to realise his opinions were shared by many of my medical friends too. It is this kind of negative stereotyping that contributes hugely to the stigma of mental

illness. That is not to say psychiatrists should take the moral high ground over their medical counterparts on this front. Indeed, it seems that we are the most hypocritical when it comes to prejudiced attitudes towards our own patients. And I include myself in this. I wonder how many psychiatrists can honestly say they treat all their patients with equal regard, irrespective of the diagnostic label with which they come attached? I am certain many psychiatrists hold prejudiced and stereotyped preconceptions, and make negative judgements when they are asked to assess a patient with a diagnosis of borderline personality disorder or drug/alcohol misuse. Most would far prefer to see patients with 'real' psychiatric illness, such as schizophrenia. What is this, if not an extension of the prejudiced attitudes our medical colleagues display towards psychiatric patients as a whole? Are psychiatrists, then, as supposed advocates of mentally ill people, not guilty of the greatest hypocrisy when it comes to challenging the negative stereotypes associated with mental illness?

The stigma differential

As far as wider society's viewpoint of mental illness is concerned, there seems to be a differential degree of stigma and prejudice attached to different mental disorders. Depression seems to be more widely understood and accepted these days, and people with depression seem more at ease in disclosing their illness. Additionally, the 'understandability' of depression, particularly as a reaction to adverse life events, makes it a more palatable proposition to others. By contrast, it seems that psychotic illnesses have a much greater stigma attached to them, partly due to persisting misconceptions (for example dangerous and violent people), and partly because they lack the 'understandability' of depressive illnesses, in that their symptoms are completely alien concepts for many people. Thus, people find it more difficult to put themselves in your shoes.

I experienced this differential stigma at play when it came to being open about my own illness. I have no doubt that I would have found it far easier to disclose to people that I had depression as a result of an extremely stressful period, as opposed to a psychotic episode. However, although I would have been more at ease admitting to depression, I am not so sure that I would have received as sympathetic a reaction from most. In the case of depression, many people, although being able to 'relate' to the condition in such circumstances, will have underlying emotions that the individual needs to 'snap out of it', or 'pull themselves together' or 'get a grip'. They will view this reaction as a sign of weakness and self-pity in the individual, which will in turn elicit feelings of annoyance or irritation, rather than sympathy. Conversely, although the psychotic experience will be far removed from 'normal' experiences, people would be less inclined to view it as a character flaw, and more as a genuine (albeit alien) 'disease'. They may also perceive it to be less under the control of the individual, and thus may be more sympathetic to them.

This differential stigma also extends to my own willingness to open up about my illness. On the other hand, I think that I have only been able to open up about my

illness because it occurred within the context of an extremely distressing situation, and because it seems to have been a transient phenomenon. I have no doubt that had I been diagnosed with a chronic psychotic illness (such as schizophrenia), which did not occur in the context of severe stress, and that had not abated completely, I would not have been able to write this article. Furthermore, had this been the case, I have no doubt that people (friends and family included) would be treating me very differently: with greater caution, wariness and a persisting sense of disconnection and estrangement towards me. It is clear that they have only been able to accept my illness because it was short lived and transitory, a thing of the past, which can be resigned to history: 'As long as you're back to normal now, that's the main thing'.

Accepting a mental health diagnosis

So what have I learnt from my experience of psychosis and the stigma that comes as part of the package with such an illness? Looking back now, the experience felt like the classical stages of the grieving process, as described by Prochaska and DiClemente. For a period of time in the aftermath of my illness, I went through stages of denial, anger, bargaining and depression, and it seems as though the stigma attached to the illness contributed to these stages more than the actual experience of mental illness itself. As the title of a recent article in the Independent newspaper eloquently puts it, 'the stigma of mental ill health is worse than the illness'. Ultimately, achieving a state of acceptance of one's illness in reality means learning to overcome the stigma that is attached to it. For only then is one able to embrace the illness, process it positively, and move on with one's life with some degree of confidence. Based on my own experience of psychotic illness, it seems clear to me that the many people who have a mental illness would have a far better prognosis if they didn't have to deal with the associated stigma and negative attitudes from society at large. For it is this aspect of mental illness that proved the most difficult to overcome. Long after the acute psychotic symptoms have abated, it is the stigma that is the residual source of persisting distress, and functional impairment. For stigma has the power to irrevocably destroy one's sense of self-worth, and to grossly distort one's self-identity.

Concerns for the future

I am relieved to say that I am enjoying a period of sustained mental stability, that I can only hope continues. Interestingly, the issues that might impede my recovery to full functioning seem to relate to issues of stigma. For example, I have recently returned to work on a phased basis. It is with some trepidation that I have resumed my training, perhaps unsurprisingly, after such a protracted period of sickness. Prior to returning, I had a long discussion with my clinical supervisor about the possibility of becoming unwell again while at work. How would this be picked up at an early stage, so as to minimise the distress to myself and, of course, to avert any potential for patient harm. It was something

that I had hitherto not given much consideration. I had to admit to her that I may well find it difficult to actually openly disclose any paranoid ideas or other thoughts that may be suggestive of a relapse (working on the massive presumption that I would be able to identify such thoughts as symptoms of illness in the first place!). I tried to imagine how I would actually go about informing my supervisor that I was experiencing 'abnormal' thoughts, if such an eventuality arose. It was at this point that I realised admitting to such 'symptoms' continues to be a source of embarrassment to me. The thought of approaching my consultant and saying something along the lines of, 'Hi there, I think I might be developing paranoid ideas, and I think I'm hearing voices', makes me cringe to my core. But why? If I had returned to work after a long lay-off following a bout of physical illness (for example heart problems), would I have any issues informing her that I was experiencing chest pain? Of course not. So what is the difference? It comes down to the shame and/or embarrassment of admitting to mental ill health as compared with physical, and this is another facet of the stigma associated with such illness. And so we can see that if such issues around stigma impede one's ability to seek help in a timely manner, surely they could potentially have an adverse impact on one's future prognosis. And so it must be for many of our patients – they don't seek help proactively because of feelings of shame and embarrassment regarding their illness, as opposed to deliberately disengaging because of a poor therapeutic alliance with their team, or lack of insight in to their illness. For myself, at least, I have realised that I will always find it difficult to openly admit to symptoms suggestive of a relapse, purely as a result of the way I perceive others will view my illness.

Stigma can rear its ugly head in the most subtle of ways, even in situations where people mean no ill will. When I go to the pharmacy to collect my prescription, I notice the chemist's double-take at the list of medications, followed by a sly glance at me and a whispered conversation with their colleague. Of course, they mean nothing by this, but one can't help wondering what they are thinking about you. I do not recall the same pharmacists batting an eyelid when the only medications I was prescribed were lansoprazole and ferrous sulphate – no stigma attached to indigestion or anaemia, then. Such changes in behaviour towards oneself aren't particularly upsetting in and of themselves, but they do contribute to the general air of negativity one feels when living with mental illness. You just know that people view you differently than they did before.

So, you may ask, why did I come to the decision to share my experience of psychotic illness, particularly in the face of advice to the contrary from so many quarters. At the end of the day, I surmised, all my anti-stigma support for my patients wouldn't mean a thing, unless I was willing to

practise as I preach, and to put my money where my mouth is. After all, what kind of a psychiatrist would I be if, after preaching to my own patients not to be ashamed or embarrassed about their conditions, I chose to conceal my own illness? To my mind, this would make me nothing short of a hypocrite. I would like to think this decision came in the form of an enlightened 'Eureka' moment, but alas, this is not the case. Rather, it has been a constant struggle with mixed and ever-changing emotions, and I still don't know how it will affect my future. It is very likely that potential employers and concerned relatives will view this as a foolhardy exercise, rather than one of personal dedication to the cause of destigmatising mental illness. However, should that be the case, I have concluded that this would reflect negatively on them, and not me.

So now that I have learnt to accept my psychotic illness, I hope that I may be able to use it to my advantage in my clinical practice. I genuinely believe the experience has improved my capacity to understand what my patients are experiencing on a much more personal level. In essence, I would like to think it will help me become a better psychiatrist. Like mental illness, the stigma that comes with it is a multifaceted and complex concept. From my own personal experience, the stigma associated with mental illness is just as debilitating as the symptoms. For although most patients will usually get some (albeit temporary or partial) relief from their undoubtedly distressing symptoms, there is no such reprieve with stigma – it is unrelenting in its negative impact. Stigma has the power to smother you with its secrecy and prejudice. The word may be used metaphorically in the context of mental illness, but it sometimes makes you feel as if you are literally marked or stained.

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