EDITORIAL

The Stigma of Mental Illness

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The concept of disease held by primitive peoples is totally different from ours. They do not, with a few exceptions, have mental illnesses in our sense. Disease is to them a monistic concept; there is no division between diseases of the body and the mind such as we know it, but the nature of disease is the same, whatever the symptoms. Almost all illnesses are attributed to the intervention of supernatural forces; such as evil spirits, gods, witches or magicians. Illnesses of all kinds are frequently explained on the basis of possession by evil spirits, and this is particularly so in the case of mental illnesses.

The methods of treatment used are of the greatest interest to the modern observer. Primitive societies are familiar with several effective drugs and several effective physical methods of treatment; such as massage, and some surgical procedures. These are, however, used only within the framework of magico-religious therapeutics which consist of conjuring, magical charms, invocations, songs and dances. But the study of foreign cultures has shown that all these so-called symptoms can, under different circumstances, be regarded as normal, just as the so-called -"pathological tissues" can be normal in a different place and at a different time. For instance, ideas of persecution are normal among the Dobuans, grandiose ideas among the Kwakiutl, and hallucinations are normal among the Mohave or Takala. Ecstatic states are normal among the Siberians and the Zulus. Homosexuality is regarded as normal by many tribes who even give their transvestites a legal status, known as Berdache.

Pharaonic Psychiatry:

No known physician's title in the pharaonic times suggests specialization in mental disease, although psychic and mental symptoms are mentioned in many clinical observations, mainly in the "Book of the Heart" (Ebbell, 1926).

In Ebbell's translation of Eber's papyrus, the words heart and mind occur in 14 prescriptions, but it must be added that whereas this author translates "ib""" by mind and "ha,tj" by heart, Grapow (vol. IV) translates both by heart, so it seems that the heart and the mind meant the same thing in Ancient Egypt. One of the psycho-therapeutic methods used in Ancient Egypt was "incubation" or the "Temple sleep". This was associated with the name of Imhotep, the earliest known physician in history . He was worshipped at Memphis and a temple was constructed in his honor on the island of Philae. The temple was a busy centre for sleep treatment. The course of treatment depended greatly on the manifestations and contents of dreams which

were , of course,highly affected by the psycho-religious climate of the temple, or the confidence in the supernatural powers of the deity and on the suggestive procedures carried-out by the divine healers (Baasher, 1975).

In Ancient Egypt, the concept of hysterical disorders was known and ascribed to the movement of the uterus, long before Hippocrates described it under the term hysteria. (Kahoun's papyrus). The therapeutic approach to this disorder was physical rather than mystical.

Depression, dementia, psychomotor retardation, negativism and subacute delirious states and thought disorders similar to schizophrenia were described in details in the Book of the Heart in Eber's papyrus. The heart and the mind were synonymous, and the aetiology of all these states was ascribed to vascular causes, purulency, faecal matter, the poison and only in two conditions was spiritual aetiology alleged.

Because mental illness was not known as a separate entity and that it is a part of somatic illness, there was no stigma or ostracism to mental patients who were not known also under this term.

Greco-Roman Psychiatry

The Greco-Roman outlook survived unchanged until the eighteenth century, and even today we still use a large part of the Greek nomenclature. While the great cultures of old, such as those of Egypt and Mesopotamia, vacillated between naturalistic and supernatural explanations of diseases, the Greeks declared themselves outspokenly in favour of naturalistic explanations and thus became the founders of scientific medicine and of psychiatry.

Unfortunately for us, there is a great poverty of Greco-Roman documents relating to mental illnesses. It is hard to say whether this is attributable to the loss of manuscripts or to a lack of interest in these diseases.

Summarising the views and comparing them with those of others, we can say that Soranus, like Celsus and Aretaeus, recognised three main mental diseases: phrenitis, mania and melancholia. He did not even mention hysteria, which was described by Aretaeus. All three writers were extreme somaticists. The body soul dualism which predominated among Greek philosophers was to them an alien concept.

Their analysis and general treatment of the three mental diseases is based on the assumption that they are dealing with physical illnesses, only homosexuality is regarded by Soranus as an illness. Although mental diseases were regarded as physical illnesses, the brain was rarely mentioned.

Soranus's treatment consisted essentially of isolation, moderate bloodletting, diet, massage, and local treatments applied to the head and the oesophagus. In complete contrast to his basic assumptions, he also made use of psychotherapy.

Greek psychiatry presents us with the first clinical observations and with the first attempts at a classification of mental illnesses. It was never a slave to its own theories.

Treatment was essentially physical, sometimes psychological, and always empirical.

Mental Illness in the Islamic Era

The approach of Islam to mental illness can be traced to two main sources:

1- The basic connotations of the most common word in the Koran used referring to the mad person i.e. insane or psychotic "majnoun". This is mentioned five times in the Koran to describe how prophets were perceived.

2- The different uses of this word by the masses to describe the perceived eccentricity of all prophets when they first attempt to guide their people to enlightenment. It is sometimes coupled with being a magician or a poet or a teacher. In a sense, there seems to be a positive connotation to madness that would flatter the antipsychiatry concept of madness that flourished in the mid sixties. The word "majnoun" is originally derived from the word "jinn" (which in Arabic has a common origin with overlapping words with different connotations and can be traced in reference to a shelter, screen, shield, paradise, embryo and madness).

At the time of Islam, the concept of the insane was the possession by a "jinn". This is not necessarily a demon i.e. an evil spirit. It is a supernatural spirit lower in rank than angels and has the power of assuming human and animal forms that can be good or bad. Some jinns are believers, listen to the Koran and help human fairness. Moreover, Islam is not a message to human beings alone but to the spiritual world at large. In the Koran, almost always, the jinn and the human being are mentioned together. This has altered the concept and the management of the insane and that there is no place to generalize punishment or give to condemnation unconditionally.

The second positive concept is that the insane is taken as the one who dares to be innovative, original, creative or attempts to find alternatives to a static and stagnant mode of living.As such it is related to the condemnation of prophet Mohamed and other prophets as insane. It is also to be found in various attitudes towards certain mystics such as sophis where the expansion of self and consiousness has been taken as a rationale to label some of them psychotic. The autobiographies of some Sophies reveal the occurrence of psychotic symptoms and many mental sufferings in their paths of self salvation (Rakhawy, 1989).

The third concept of mental illness is the consequence of the disharmony or constriction of consciousness which non-believers are susceptible to. It is related to denaturing of our basic structures (Al Fitrah) and disruption of our harmonious existence by egoism, detachment or alienation partly presented by the loss of integrative insight. This level is more understood if we become aquainted with the essence of Islam as an existential mode of living, behaving and relating to nature and the basic belief in the beyond - not necessarily supernatural.

The prevailing concept of mental illness in Islam at a particular stage depends on the dominance of development or deterioration of genuine islamic issues. For instance, during deterioration, the negative concepts of the insane as being possessed by evil spirits dominates whereas periods of enlightenment and creative paths, the disharmony concept dominates, and so forth.

We find an interesting analogy between the seven stages of human development on the Sofi path and psychosexual Freudian and psychosocial Eriksonian development which lag behind the Sofi development (Shretti, 1985).

The teaching of the great clinician Rhazes had a profound influence on Arab as well as european medicine. The

two most important books of Rhazes are the "Mansura" and the "Al Hawi". The first consisting of ten chapters, includes the definition and nature of temperaments the dominant humours and comprehensive guide to physiognomy. Al Hawi or Continens, is the greatest medical Encyclopedia produced by a moslem physician and was translated into Latin in 1279 and published in 1489. It is the first clinical book presenting the complaints, signs, differential diagnosis and the effective treatment of the patient. One hundred years later, "El- Canon" of medicine by Avicenna was a monumental, educational scientific book with better classification, mental organization and logical approach and was the basis of medical education in Europe for many centuries. The "Canon" of Medicine by Avicenna superceded another remarkable work , the Royal Book (El-Maleki or Liber Regius) by Ali Abbas, constitues, like the Continens, a monumental work on the theory and practice of medicine.

The first Mental Hospital to be built was in Baghdad in 705 A.D. The 14th century Kalawoun hospital in Cairo is extremely interesting in regard to psychiatric care. It had four separate sections for surgical, medical, ophthalmological, and mental diseases. The generous contributions to hospital funds by the wealthy of Cairo allowed a high standard of medical care and provided for the patients during convalescence until they were gainfully occupied. Two features are striking--the care of mental patients in a general hospital, which anticipated modern trends by approximately six centuries, and involvement of the community in the welfare of the patients.

Renaissance Psychiatry (Middle Ages)

There is almost nothing to say about mediaeval psychiatry, because we know very little about mediaeval medicine, and because, in contrast to achievements in other spheres, little of positive value emerged in the field of medicine during the Middle Ages. On the contrary, much occurred that was harmful. The worst was probably the disintegration of medicine. Surgery fell into the hands of barbers and their assistants, psychiatry into the hands of exorcising priests and clergy witch hunters. Hospitals for the insane were built: (Metz, 1100; Braunschweig, 1224; Bedlam, 1377), above all, by the Arabs: (Fez, circa 700; Bagdad,705; Cairo, 800: Damascus and Aleppo, 1270) as mentioned before .

The clock was put back by a thousand years. For over a thousand years, the mentally ill were again regraded as possesssed by the devil and by evil spirits, or were considered to be witches or sorcerers who could produce the illness in others. "Apparitions" and hallucinations were thought of as the work of the devil. From the psychiatric point of view the Middle Ages are also notable for the frequency of psychic epidemics or mass psychoses; such as the flagellationist movement, dancing mania, childrens' crusades, persecution of the Jews and "possession" of total communities of people, particularly in monasteries." On the contrary, it was at this time that the lunacy of the sane reached its climax.

The Stigma

For decades, psychiatrists have been subjected to jokes and ridicule because of their seemingly mysterious and incomprehensible ways of understanding the human mind and human passions. The complexity of mental illness and its often bizarre presentation are distressing to the layperson. One way an individual or society often deals with something that is frightening and distressing is to segregate it, alienate it, and set it outside

the framework of one's personal society. This process results in stigma against patients and providers, and has manifold meaning and ways of expression.

We define stigmatization of mental illness as the marginalization and ostracism of individuals because they are mentally ill. This ostracism often also extends to the families of mentally ill individuals and to the professionals who treat persons with mental illness .

Problems of Stigma

1. Stigma associated with mental illness can cause those afflicted to delay seeking treatment or to conceal the illness in an attempt to escape the shame and isolation of being labeled "disturbed" and "other" .

2. Insurance benefits often do not adequately cover mental health care, and fear of losing health insurance coverage deters people from obtaining help.

3. Employment and housing discrimination are just two other examples of the devastating effects that stigma can have on the lives of individuals. To combat the destructive effects of stigmatization, professionals must recognize and work to overcome the stigma associated with mental illness in our society.

Psychiatric units are established with the expectation of bizarre, aberrant, and out-of-control behavior. For instance, when patients come into a psychiatric hospital, the system is structured for them to earn privileges. Programs are not designed with the focus of making the hospital experience as normal as each person's everyday routine outside the hospital. Instead, patients are placed in various levels of restriction until they demonstrate that they are not dangerous.

Stigma of other physicians:

Many physicians developed jaundiced views of psychiatry because in medical school their psychiatry rotation was in a state hospital or in a Veterans Administration hospital. As a result of this experience, they developed the belief that all psychiatric illness is chronic and that psychiatry has very little to offer patients.

Stigma Related to Treatment

We often tend to stigmatize many of our treatments. Electroconvulsive therapy is an effective, at times lifesaving treatment modality that until recently has been repeatedly stigmatized by the lay press and by members of the psychiatric profession. As a result, many patients do not avail themselves of this extremely effective treatment and develop chronic depressions that do not respond to medication but would respond to electroconvulsive therapy if they would allow themselves to receive this treatment. Even the use of psychiatric medications causes concern, namely dependence, cardiotoxic, extra pyramidal, hepatic and obesity.

Social Stigma

Perhaps the most pernicious of all myths is that of the dangerousness of psychiatric patients. While less than 3% of mentally ill patients could be categorized as dangerous, 77% of mentally ill people depicted on prime-time television are presented as dangerous. This perpetuates the mythology that if one is mentally ill, one is by definition dangerous. This myth is further perpetuated by the sensationalistic headline news both in newspapers and on television when murders are committed by former mental patients. Interestingly no reporter is interested in the failures of the mental health treatment

system that has often allowed these patients to go for long periods of time untreated and, in may instances, be forced out of hospital settings into the community against the recommendations of psychiatrists.

A major problem in combating stigma is the lack of public awareness of the advancements that have occurred in psychiatry over the past 25 years. There is vast public ignorance as to the advances that have been made in psychiatry, which in combination with the pervasive stigma would prevent people from seeking and obtaining help.

Family and stigma

Families have continually borne the prejudicial effects of stigma. While it is true that the patients suffer because of the painful symptoms of mental illness, the stigma of this illness becomes like an infectious disease to members of the family. Often the family unrealistically feels blamed and responsible for having brought on the illness . This burden is further perpetuated by certain members of the psychiatric community who continue to suggest that biological illnesses are really a result of dysfunctional, inadequate parenting.

Mental illness can destroy families. Couples may get divorced if they have a family member who is mentally ill. Often family funds are seriously compromised in the effort to take care of a mentally ill member . Because the lingering myth of the family being at fault continues, many families focus exclusively on mental illness being a brain disease, leaving out the mind. Psychiatrists must play an important role with these families, emphasizing that treatment involves not only biological intervention but also social rehabilitation and environmental manipulation.

Stigma is a pervasive national and international problem, an insidious problem that is destructive to families, mentally ill patients, and the profession of psychiatry. We can and we must change this course.

Stigma and Shame

In a historical examination of "stigma," it is important to consider the history of the term. It is a Greek noun (stigma), coming from roots that mean to make a "point" or a "mark". It was probably most widely used to designate tattooing, whether decorative, religious, or to indicate ownership (such as on a slave). In earlier Greek usage, while this term could be used for a brand mark on a slave, it did not seem to have the automatic negative connotation it has acquired today. It had some usage in referring to wounds inflicted in military service, more like a badge of honor.

In the New Testament and in early Christian Rome, the term stigma only gradually became associated with the wounds of Christ, which are called stigmata in the Gospels. An important usage in late antiquity is that of a tattoo mark signifying that the person is dedicated to a particular god (i.e.,a mark of service). When Paul writes, "I bear on my body the stigmata of Christ" (Gal. 6:17), he seems to refer to two metaphorical usages, the first being the sign of service to a god, and the second, the sense of a wound inflicted in the course of serving as a soldier of Christ. The more negative connotation of the term appears in Latin, where the Greek word is taken over, and metaphorically denotes a mark of shame or degradation, a mark placed on criminals or slaves so that they could be identified if they ran away. According to the Oxford English Dictionary, its clearly pejorative metaphorical use appears in the English in the late 16th and early

17th centuries.

The ancient Greek world was puzzled by the orgins and treatment of severe mental illness, as we are today. The interwoven elements of shame, of pollution, and of the erratic, unpredictability of the behavior of the severely mentally ill person contributed to stigmatizing that person and the illness. But, at the same time, the culture provided an array of practices, some considered "scientific" and some considered "religious" or "magical,". In the Middle Ages, although mentally ill persons may have been accepted with a reserved tolerance, two other groups did not fit into the overall scheme of the great chain of beings: one was represented by the lepers (Brody 1974; Ell 1986; Richards 1977) and the other by the Jews (Cohen 1986; Marcus 1986; Stow 1986). The difference between the two was obvious: in the first group, the "otherness" was patently manifested through physical, ugly deformities; in the latter, the "otherness" was due to psychological, not visible, reasons. Both groups, thus, justified an attitude of stigma, no matter how much influenced by ambivalence: in the first instance, the interplay between human disgust and Christian pity; in the latter, the subtle, but no less pervasive feeling that Judaism was, indeed, the background from which Christianity sprang. Moreover, also not fitting into the great chain of beings, were, in a different way, two other groups: the heretics (Cullen 1985;Russell 1986) and the Moslems (Donner 1985).

The recent atrocities, terrorism, violation of human rights by some Islamic fundamentalists have created a stigma on Moslems again, that made the world public opinion rather neutral in the ethenic cleansing of the Serbs to the Bosnian Moslems. Thus, stigma existed in the Middle Ages as well as in the Renaissance, although it did not elicit guilt, for it was an intrinsic part of the prevailing Christian ideology rather than a matter of individual responsibility.

We conclude that stigma has significant effects on many important aspects of patients' lives. We believe that future research on stigma should set aside the question of whether stigma is important. This question has dominated too much research for too long. Instead, we need to ask, "How can we overcome stigma?".

Homeless mentally ill persons are doubly stigmatized . As homeless people, they are perceived as failures in a success- oriented society. In addition, they are portrayed as the bizarre products of deinstitutionalization, discharged from the hospitals into the streets. Mental patients constitute about 30-50% of the homeless (Leff, 1993).

The Baltimore Homeless Study revealed that many stereotypes of homeless individuals are not true. People who are homeless are not primarily transients; they are not dirty and lice-infested. They are people in poor health, on the fringe of society.

Because stigma is fostered by ignorance, the development and dissemination of knowledge about mental illness and homelessness is one vital effort in the campaign to reduce stigma.

Stigmatization of Psychiatrists

Stigmatization of mentally ill persons is obvious in our society. What is less immediately obvious is the stigmatization of psychiatrists who treat mental illness. However, prejudice and stereotyping of psychiatrists are entrenched aspects of western culture. The catharitic cure may be psychiatric myth, but it is good drama. Obviously, the "showbiz"

value of any treatment is of much more importance to film makers than its clinical accuracy. It is of interest in this regard that the effective prescribing of psychotropic medication and its role in treatment are virtually unheard of in American or world films. Psychiatric treatment is almost always depicted as psychotherapy. Notable exceptions, of course, are barbaric depictions of electroconvulsive therapy in films such as The Snake Pit (1948), Shock Corridor(1963), and one Flew over the Cuckoo's Nest (1975). But it is clear that the biological revolution in psychiatry has yet to reach the screen.

Cross-Cultural Aspects of Family Stigma

The cross-cultural literature indicates that stigmatization of mentally ill persons and their families is less pronounced in traditional cultures (Lefley 1985b,1987b). Nevertheless, a number of cross-cultural observers have proposed that stigma is less prevalent in cultures that attribute psychiatric symptoms to somatic or supernatural causes (Lin and Kleinman 1988) or even, in some contexts, endow these symptoms with positive religious value.

This view tends to free both patient and family of blame , generating less social rejection and self-devaluation of patients. In the Orient, psychotic patients have a better outcome, not only because of family cohesion but because of the ability of the society to tolerate and assimilate them in the communitiy. It is not that they are rarely stigmatized but sometimes even revered. Actually they are not dislocated from the community.

Myers, (1992) examines the issues of denial, shame disruption of family homeostasis, and fear and avoidance of treatment, with a focus on issues that apply particularly to physicians and their families. His brief case histories dramatically highlight his observation. Dr. Myers recommends that the treating psychiatrist become more aware of the ignorance and naivety about psychiatric illness in doctors and their families. Too often families are left uninformed because the psychiatrist assumes their understanding and knowledge. He also recommends a family-system approach to the understanding and treatment of these families. Such an approach uncovers the "shaming system" that operates as a form of behavioral control. The family systems perspective facilitates treatment that includes spouses, parents, and children of disturbed patients. He concludes with an assertion that psychiatrists must be advocates for both the mentally ill patient and the entire family.

Recommendations for Combating Stigma

To help reduce the stigma surrounding physician impairment and mental illness, a) sociocultural, b) professional, c) situational, and d) personal factors must be confronted. The factors on which we as educators can most greatly have an impact are those related to medical education and training .

Physicians characteristically have been reluctant to confront psychological distress, especially distress perceived as being caused by the medical system itself (Arnstein 1986). However, in order to effectively reduce the stigma surrounding psychological disorders, the issues of stress and distress must be openly discussed and normalized (Shapiro et al. 1987). This open discussion should begin at orientation and continue throughout training , it should include information about wellness, techniques for stress management, and encouragement to seek treatment when needed (Dickstein and

Elkes 1986; Mentink and Scott 1986).

There should be available visible in-house support groups (e.g., Dickstein 1982) that allow trainees or their significant others a chance to find out that their feelings of self-doubt and inadequacy are shared by many and that these feelings are not a sign of weakness. Hopefully such sharing will reduce the emotional isolation felt by so many medical students and residents and make it easier for them to ask for more formal psychiatric treatment if needed.

One way to reduce stigma would be to increase the status of psychiatry in the eyes of medical students. In order to do this it clearly must be demonstrated that psychiatry has considerable scientific merit, that psychiatric treatments are effective, and that psychiatrists have a unique role as mental health professionals (Das and Chandrasena 1988; Doyle 1983; Singer et al,. 1986). Singer and colleagues (1986) suggest that assigning courses in the behavioral sciences to psychiatrist-instructors is necessary to show students how psychiatry is a unique mental health profession.

In our lectures during all years of medical education we should certainly teach about psychoses, but we should emphasize what is usually, because of lack of time, glossed over: the less dramatic problems that outpatients bring to treatment (e.g. depression, anxiety, somatoform, somatization and personality disorders) that constitute the majority of disorders that non psychiatrist physicians will see and diagnose-that is, if we teach them how to do so rather than leaving them unprepared and, therefore, frustrated with so-called uncooperative, "chronic" patients. The WHO is in the process of having a multinational study of primary health care classification using flow charts and one drug treatment, emphasising the role of somatization and unexplained somatic symptoms. The success of its implementation will have a great influence on the stigma of mental illness.

We should send students off independently to assume responsibilities for psychiatric patients only after they have worked at our sides, watched us, and observed our attitudes toward psychiatric illness and psychiatric patients. Students should be actively taught to treat the psychiatric patient as a whole person, to ask all of the appropriate questions, and to obtain complete medical histories before thinking about prescribing a psychotropic medication. In the USA in 1968 12% of medical students chose psychiatry, it dropped to 4% in 1976, then 3% in 1979. Our American collegues may tell us the figure in 1993.

The stigma of mental illness for physicians stems from factors related to the sociocultural status of physicians and from the denial and suppression of emotions characteristic of premedical students that is reinforced throughout medical training. The medical profession is built on the belief that to express feelings is weak and that one's own needs should be denied and only patients' needs met. Within the medical profession, psychiatry is looked upon with a mixture of contempt, fear, and awe; it is seen as less scientific and of lower status than other medical specialities.

In order to reduce the stigma surrounding mental illness that makes it difficult of physicians to refer themselves and their colleagues for psychiatric treatment, all of these factors- sociocultural, professional, personal, and situational-must be addressed. The easiest way to confront the stigma of mental illness and psychiatric treatment is by addressing it directly in classrooms and clerkships.

However, in order to do this, educators must first examine their own attitudes and values so that they can provide an open, nonjudgmental atmosphere for an ongoing and humane dialogue on medical training distress and stigma.

The studies in the three areas reviewed (i.e., 1: the social degradation of mental patients, 2: the deleterious effect on the patients of this degradation, and 3; the socially disliked characteristics of the patient population)show why psychiatric patients find it difficult to return to the community.

A large number of studies have compared the effect of routine full-time hospitalization to alternative care (AC) procedures, particularly day care, but also home treatment and visits at home by public health nurses. The results consistently show that the effect of AC treatment is at least as good and typically better than that of traditional psychiatric hospital treatment. Kiesler and Sibulkin (1987) have recently reviewed 14 such studies and come to the same conclusions reached by previous reviewers. A review of the comparative studies on day treatment as an alternative modality to traditional full-time hospitalization reveals impressive evidence of its superior effectiveness in facilitating the adjustment and reintegration of patients into the community.It is evident that the treatment of ECT is efficacious and has relatively few side effects. The history and nature of this treatment, however, have left it with a legacy of negative image and underutilization. What can the psychiatric community do to overcome or improve this situation ? One way is through education and dissemination of correct information. It is important to convey that a series of biological disease may occur in the brain for which there are biological treatment, including ECT. It is also important to explain that when an individual is biologically depressed, the same organ (the brain) that is ill may be dysfunctional to the point that the individual will not perceive (mind) that he or she needs treatment. A person with diabetes in which the mind is unaffected may more easily bring himself to treatment than the biologically depressed in which the organ that is ill is the one that is used to make the decision of whether or not to go for help. It is possible that individuals who become outraged at the prospect of treatments such as ECT may have confused true mental illness with the ditress of problems of life.

The symptoms of depressive disorder are well known in psychiatry, but are not well known by the general public. In the same way that the 8 warning signs of cancer are well publicized by media and relatively well known by the population, it would be helpful if the symptoms of major depressive disorder were easily identifiable and remembered. To this end a two-word mnemonic has been developed by Hay (1989) to help with this task: CEASE SAD. The letters of the two words spell out the 8 important symptoms of major depressive disorder as follows:

1- Concentration decrease
2- Energy decrease
3- Anxiety increase
4- Spontaneous crying
5- Early morning or other insomnia
6- Suicidal ideation
7- Appetite decrease or change
8- Deprecatory thoughts of self; guilt feelings

There are many vehicles for promoting this knowledge. These include presentations at public lectures, appearances on radio and television shows, and articles in local newspapers, magazines, and newsletters. There are several textbooks on ECT and an extensive literature of re-

search and studies (Abrams 1988; Abrams and Essman 1978; Fink 1979).The cure for stigma is education. The resources are available. The responsibility is ours.

An expanded role for psychiatrists will result in both reduced stigma for the psychiatrist and better care for patients. other suggestions include:
a) lobbying for funds
b) affiliating with medicine
c) increasing the scope of residency training, and
d) working with patient and family advocates.

Together, these activities comprise a forceful attack on stigma .

Much progress has been made in the treatment of persons who are chronically mentally ill. Model community treatment programs are maximizing patients' independence through the use of flexible coordination of an array of outpatient community resources. Families are being taught to cope and adapt to the problems engendered by living with a chronically mentally ill relative. New medications are being used to treat formerly resistant patients. However, the current treatment system does have some limitations that must be recognized and presented to the family. These include the facts that treatment is long-term and has accompanying side effects, and there is likely to be a relapse despite compliance to recommended medical regimens.

Raising salaries is a direct means of destigmatizing this profesional group, since salary is related to status. Higher salaries and better-funded programs will attract and maintain higher caliber psychiatrists in the public sector. In this way, the self-fulfilling prophecies described earlier will be reversed.

The role of the psychiatrist has become unclear because it is difficult to differentiate medical treatment from social services. For instance, when family and staff plan for the care of a suicidal patient, it is unclear whether such planning is primarily a social (social worker) or medical (psychiatrist) responsibility. This lack of clarity is unavoidable, and leadership is required that can encompass many disciplines.

However, the administrative role is essential for the psychiatrist in the community mental health center system.

Some of the responsibilities of the psychiatrist as an administrator include medical screening, supervision of other physicians, assuring quality of psychiatric services, and developing educational programs . An important aspect of the administrative role is working with the executive officer to develop and review programs and budgets. Also, the administrative psychiatrist might work as the liaison with other hospitals and medical personnel.

Conclusion

The atmosphere of the hospitals has been transformed by the disappearance of violent excitement made possible by the advent of pharmacotherapy, furthermore the neuroleptics, by alleviating the symptoms of the schizophrenics and delusional patients, have enabled many of them to avoid protracted or even permanent hospitalization, epitomized by the idea of confinement, and to adapt themselves socially to an extent that allows them to live, for spells of variable length, in the community.

Apart from the fact that the number of psychiatrists and their density both in the general and the medical population-has increased considerably, the structures

have been altered. Even if psychiatric hospitals continue to exist, their character has been transformed in regard to their atmosphere and the legal conditions attached to hospitalization. On the tide of public opinion the demand for psychiatric care has greatly increased (it is estimated that in the United States 5% of the population has a psychiatric contact every year) and in many countries " mental health" is held to be a "priority objective".

The "anti-psychiatric" movement is not a new phenomenon but, in the 60s, it assumed worldwide proportions and became manifest in a number of forms: denial of the existence of "mental diseases" and consequently of the legitimacy of a medical speciality claiming to treat them. Attacks on the "Coercive" aspects of psychiatric practice and, more generally, on the function of the psychiatrist, who was accused of imposing, on the pretext of readaption, the values of the social class to which he belongs; and more specific attacks on certain types of therapy. Some of these criticisms were not without foundation and have had beneficial results (particularly those concerning the function of outworn psychiatric hospitals with an "asylum" character) but in general they reflected extremist ideological prejudices and were part and parcel of a movement of ill-formed ideas which became focused on a theme that mobilized popular myths and lent itself to cheap demagogic exploitation.

Of more importance perhaps for the future of psychiatry as a medical speciality in the long term is the weakness of its position within medicine. One must not be deluded by its growth. Reference has been made to its "demedicalization" by the ever larger cohorts of psychologists and non-medical "mental health workers", and the stress laid at present by international organizations on "primary health care", however well meant, has had the same consequences. The technicalization of biological research has, quite naturally, produced the same effect in another domain.

Under these conditions one can understand the fear, expressed by John Romano, that "there may be no good reason for us to survive as a medical speciality", for "if the discipline of psychiatry does not offer the challenge and excitement necessary to attract and sustain the interest and attention of young men and women of intelligence and sophistication it will be replaced by other disciplines which do and can offer the appropriate challenge. If psychiatry is to suffer from limited imagination and from restricted resources, workers in psychology, biology and biochemistry and the social sciences, as well as physicians in disciplines other than psychiatry, will respond to the deficit and pursue new knowledge in new strategies developed by them".

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