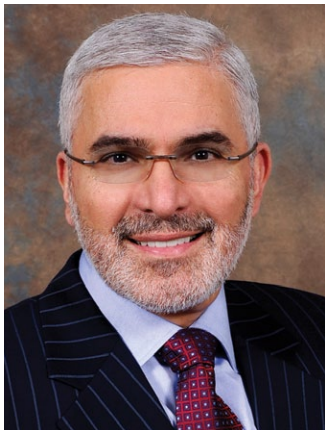

Henry A. Nasrallah, MD
Editor-in-Chief

Invisible tattoos: The stigmata of psychiatry

Have you noticed the tattoo craze sweeping the country? It seems many of the younger generation are impulsively rushing to ostentatiously brandish various patterns and/or phrases on the most visible part of their bodies. For now, they proudly display their permanent stigmata (Greek for "to mark" or "puncture with a pointed instrument") but no one knows how they will feel when the tattoos persist long after the fad dissipates, like many other fads before it.

Stigma affects not just our patients, but also our profession

In contrast to fad-obsessed youth, our psychiatric patients never sought or wanted the stigmata imposed on them: the invisible yet palpable tattoos of mental illness. Unlike the superficial dermatological versions, the invisible tattoos (ie, the stigmas of mental illness) are burnt deep into the soul of those unfortunate persons afflicted with psychiatric brain disorders. No greater injustice occurs every day in our country than the prejudice, scorn, ostracism, avoidance, fear, intolerance, and prejudgment attached to the subset of medical brain disorders that affect thinking, emotions, behavior, or cognition. If mental illness is the injury, then stigma is the insult.

If employers, neighbors, police, landlords, or the public would treat mentally ill individuals with half the sympathy, compassion, and understanding they bestow on persons with physical disability, life would be much more bearable for those with a disabling psychiatric illness. Instead, they are cursed with disdain and avoidance, and the additional stigma of becoming "felons" caged in prisons and jails instead of being afforded the dignity of being cared for in a health care facility like other sick individuals.

But the stigma does not stop with patients: it spills over to psychiatry itself. We all can feel the invisible tattoos imposed on our medical discipline, a bizarre "guilt by association" despite our professional role and service. Consider the following examples of subtle and not-so-subtle discrimination toward psychiatry:

- Our families and friends think we are not "real" doctors, although our medical training and education are practically identical in rigor and duration to that of our colleagues in surgery, cardiology, or neurology.
- Psychiatric services are devalued by third-party payers with ridiculously low reimbursement, high co-payments, and arbitrarily meager annual or lifetime caps. Insurance executives often foolishly decide

To comment on this editorial or other topics of interest, visit http://www.facebook.com/CurrentPsychiatry, or go to our Web site at CurrentPsychiatry.com and click on the "Send Letters" link.

psychotherapy is not worth paying for despite its enormous value to many patients.

• Managed care invented the diabolical concept of "carve out" to exclude psychiatric services from parity with other medical/surgical services to relegate mental health to a lower tier (ie, less important) reimbursement. And how absurd is the one-size-fits-all 15-minute check?

• Insurance companies discriminate against the "high cost" of the latest psychiatric drugs, yet happily pay for much costlier drugs for nonpsychiatric disorders. For example, they consider $5,000 a year for an antipsychotic too high—as if our patients are not worth it—and demand that cheaper, 45-year-old drugs such as haloperidol continue to be used, although numerous studies have shown haloperidol is neurotoxic.[1-4] Yet the same insurance company does not hesitate to pay $50,000 a year for the latest multiple sclerosis drug, $60,000 a year to prolong a terminal cancer patient's life by just a few months, $120,000 a year to treat patients with hemophilia, $200,000 a year for Fabry's disease, $350,000 a year for hereditary angioedema, etc.

• Despite the serious shortage of psychiatrists, the law of supply and demand does not seem to apply to psychiatrists' compensation. Many believe psychiatrists should receive significantly higher compensation than they currently do, given the severe shortages around the country.

• Psychiatrists are experts in determining whether patients are a danger to themselves and require involuntary hospitalization and pharmacotherapy. Yet those medical decisions are made by the courts. Can anyone imagine the courts usurping the right of cardiologists or neurologists to hospitalize or rapidly medicate an unconscious heart attack or stroke patient?

• Despite the fact that rates of response, remission, and recovery observed in psychiatry are similar to those seen with many medical or surgical treatments, the perception persists that psychiatric therapies have minimal efficacy, an insidious devaluation of what we can do for our patients. The antipsychiatry movement never ceases to viciously attack the scientific validity and benefits of antidepressants,[5] antipsychotics, or mood stabilizers.

Stigma is like an old, ugly, unwanted tattoo that's hard to shed. My research-oriented brain is hopeful the unwanted stigmata will rapidly fade away when the physiological causes of psychiatric disorders finally are discovered. The most effective antidote for stigma is relentless research. A cure for mental illness will undoubtedly erase our invisible tattoos.

Henry A. Nasrallah, MD
Editor-In-Chief

References

1. Galili R, Mosberg, Gil-Ad I, et al. Haloperidol-induced neurotoxicity—possible implications for tardive dyskinesia. J Neural Transm. 2000;107(4):479-490.
2. Post A, Rücker M, Ohl F, et al. Mechanisms underlying the protective potential of alpha-tocopherol (vitamin E) against haloperidol-associated neurotoxicity. Neuropsychopharmacology. 2002;26(3):397-407.
3. Ukai W, Ozawa H, Tateno M, et al. Neurotoxic potential of haloperidol in comparison with risperidone: implication of Akt-mediated signal changes by haloperidol. J Neural Transm. 2004;111(6):667-681.
4. Wei Z, Mousseau DD, Dai Y, et al. Haloperidol induces apoptosis via the sigma2 receptor system and Bcl-XS. Pharmacogenomics J. 2006;6(4):279-288.
5. Pigott HE, Leventhal AM, Alter GS, et al. Efficacy and effectiveness of antidepressants: current status of research. Psychother Psychosom. 2010;79(5):267-279.

Current PSYCHIATRY

Editorial Staff

EDITOR **Jeff Bauer**
SENIOR EDITOR **Erica Vonderheid**
ASSOCIATE EDITOR **Sara Fiore**
CONSULTING EDITOR **Alice V. Luddington, ELS**

Art & Production Staff

CREATIVE DIRECTOR **Mary Ellen Niatas**
ART DIRECTOR **Pat Fopma**
DIRECTOR, JOURNAL MANUFACTURING **Michael Wendt**
PRODUCTION MANAGER **Jaime Serra**

Publishing Staff

PUBLISHER **Scott A. Dattoli**
ACCOUNT MANAGER **Sharon J. Spector**
MARKETPLACE ACCOUNT MANAGER **Julian Knight**
ADVERTISING SALES COORDINATOR **Maria Walsh**
DIRECTOR OF NEW MEDIA **Amy Park**
WEB EDITOR **Denise Swedeski**
WEB ADVERTISING MANAGER **Lee Schweizer**
VICE PRESIDENT AND DIRECTOR, CUSTOM PROGRAMS **Carol J. Nathan**
DIRECTOR, MARKETING RESEARCH **Lori Raskin**
DIRECTOR OF EVENTS **David Small**
CONFERENCE MARKETING MANAGER **Kathy Wenzler**
CORPORATE DIRECTOR OF AUDIENCE DEVELOPMENT **Donna Sickles**
Subscription Services: (800) 480-4851
DIRECTOR OF CONTENT SALES **Dina Conway**

Editor-in-Chief Emeritus

James Randolph Hillard, MD

Quadrant HealthCom Inc.

CHAIRMAN **Stephen Stoneburn**
PRESIDENT AND CEO **Marcy Holeton**
CFO **Douglas E. Grose**

Quadrant HealthCom Inc.
7 Century Drive, Suite 302
Parsippany, NJ 07054
Tel: (973) 206-3434
Fax: (973) 206-9378
www.quadranthealth.com

Published through an educational partnership with UNIVERSITY OF Cincinnati