

Images of psychiatry and psychiatrists

Stuart H, Sartorius N, Liinamaa T, the Images Study Group. Images of psychiatry and psychiatrists.

Objective: This study surveyed medical teaching faculty to determine their attitudes toward psychiatry and psychiatrists.

Method: We conducted a multisite survey of a probability sample of 1057 teaching medical faculty members from 15 academic teaching centers in the United Kingdom, Europe, and Asia stratified by early, middle, and late career stage. The average response rate across countries was 65%.

Results: The outstanding findings were that 90% of respondents considered that psychiatrists were not good role models for medical students, 84% thought psychiatric patients were unsuitable to be treated outside of specialized facilities, and 73% thought psychiatric patients were emotionally draining. We noted statistically significant differences by country, gender, career stage, and specialty.

Conclusion: These results highlight why recruitment into psychiatry is problematic in many countries and suggest that greater attention should be given to improving the perception of psychiatrists as good role models and the efficacy of psychiatric treatments.

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Key words: stigma; attitudes to psychiatry; attitudes to psychiatrists; psychiatric recruitment

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Significant outcomes

- The vast majority of respondents in this survey held negative views toward psychiatry as a discipline, psychiatrists, and psychiatric patients.
- Enhancing the perception of psychiatrists as good role models for medical students and the efficacy of psychiatric treatment could improve perceptions of psychiatry as a career and increase psychiatric recruitment.
- There were notable differences in the number of scale items endorsed by country that should be explored in future research.

Please also see editorial comments to this paper in this issue by C. Blanner Kristiansen et al. (Acta Psychiatr Scand 2015;131:8–9), W. Gaebel et al. (Acta Psychiatr Scand 2015;131:5–7), F. Kapezinski et al. (Acta Psychiatr Scand 2015;131:7–8), J. Read (Acta Psychiatr Scand 2015;131:11–12), D. Wasserman (Acta Psychiatr Scand 2015;131:13–14), D. Bhugra et al. (Acta Psychiatr Scand 2015;131:4–5) and G. Parker (Acta Psychiatr Scand 2015;131:10–11)

Limitations

- Because there were differences noted across countries, the results of this study are not generalizable beyond the sample included.
- The index we used assumes all items are equally weighted, and they may not be. Further psychometric testing is warranted.
- It is not known to what extent negative views are well founded or the extent to which they may reflect biased or stigmatized views of psychiatry and psychiatrists.

Introduction

Over the last several decades, studies conducted in different parts of the world have consistently demonstrated that medical students and young graduates do not consider a career in psychiatry as particularly desirable (1–9). Criticisms made by medical students include psychiatry is too narrow in scope; it does not draw on all aspects of medical training; it is ineffective and unscientific; it is too emotionally demanding; and psychiatrists are unattractive role models. Once established, these attitudes are particularly resistant to change, even after contact with psychiatric educators and clinical rotations (4, 5, 10, 11). In the United Kingdom, where lack of recruitment into psychiatry has been described as a ‘crisis’, less than one in twenty medical students reported they intended to enter psychiatry. The factors that most discouraged them were the poor prognosis of psychiatric patients (20%), the poor scientific basis of psychiatry (18%), and the perceived lack of an evidence base (14%) (8).

Negative attitudes toward psychiatry and psychiatrists may be well established before medical school enrollment. For example, denigrating fictional images of mental illness are frequent in the media and potent. Media portrayals do little to convince the viewing public that people with a mental illness are generally not violent or that they can recover. Media images of psychiatry are equally as negative, with images of psychiatric treatments as oppressive and controlling, and popular depictions of mental health professionals as unethical, exploitative, or mentally deranged (12). Population-based studies of public attitudes between 1990 and 2005 show that misconceptions about the empirical basis for psychiatric interventions and negative perceptions of people with mental illnesses persist although there are intercultural differences and differences by disorder category (13).

In addition to these factors, medical students may also be influenced by opinions held toward psychiatry and psychiatrists by their medical teaching faculty (14). Opinions expressed to medical students by

their teaching faculty may reinforce misconceptions about psychiatry and dissuade students from considering psychiatry as a potential career choice. Despite the importance of medical faculty in career choices, research focusing on their opinions toward psychiatry is unavailable. Indeed, using conventional search strategies, we could not locate a single study that surveyed the attitudes of medical teaching faculty toward psychiatry or psychiatrists.

Aims of the study

Given the lack of research focusing on the opinions of medical teaching faculty, our goal was to fill this gap. Second, our goal was to examine whether perceptions differed by gender, career stage (early, middle, or late), medical field, site, and country location.

Material and methods

Setting

The study was conducted as part of the scientific activities of the World Psychiatric Association’s Stigma and Mental Health Scientific Section. It was developed with the participants attending an international course on leadership skills for young psychiatrists organized by the Association for the Improvement of Mental Health Programs, a not-for-profit organization based in Geneva.

The study included 23 academic teaching sites from 15 countries: Belarus, China, Croatia, India, Indonesia, Iran, Japan, Portugal, Romania, Russia, Scotland, Singapore, Thailand, Turkey, and the Ukraine. Medical schools from North America, Australia, and Western Europe were not included, as participants from these sites did not attend the international course on leadership skills. The smallest medical schools represented admitted less than 10 first-year undergraduate medical students each year, whereas the largest admitted over 1000. The youngest Department of Psychiatry was 13 years old. The oldest was established in 1893. Three sites did not have formalized clerkships

(rotations) in psychiatry. Of those that did, the length of the clerkships varied from 2 weeks to over one year, but most frequently they were 4–8 weeks. The number of psychiatric residency positions offered each year also varied from under 5–100. In all but six sites, undergraduate medical students were allowed to see psychiatric patients on their own, usually in the later years of their training (4th, 5th, or 6th year).

Subjects

In each participating site, all non-psychiatric medical faculty members were enumerated from staff directories and their career stage (early, middle, or late) was determined. Individuals were considered to be in the early stage of their career if they were Lecturers, Assistant Professors, under 10 years in practice or under 40 years old. They were defined as in mid-career if they were Associate Professors, had been in practice 11–25 years, or were 41–55 years old. Individuals were considered to be in late career if they were Full Professors, Emeritus Professors, in practice more than 25 years or over the age of 56 years. A stratified random sample of 10 faculty members from each career stage (approximately 20% overall) was then drawn from each site. Some sites oversampled to support more detailed country-specific analyses.

Survey questionnaire

We developed a 37-item self-administered survey. Items were adapted from existing survey instruments developed by Balon and colleagues in 1999 (15) [which was an adaptation of a survey originated by Nielsen and Eaton in 1981 (16)] and by Burra and colleagues in 1982 (17). Additional items were added to address gaps in areas of interest for this research. Items measured perceptions of psychiatry as a discipline (5 items), perceptions of the effectiveness of psychiatric treatments (7 items), perceptions of psychiatrists as role models (5 items), perceptions of psychiatry as a career (7 items), perceptions of psychiatric patients (7 items), and perceptions about the quality of psychiatric training (6 items). Following the scoring approach recommended by Balon et al. (15), items were rated on a 4-point Likert-type agreement scale ranging from strongly agree to strongly disagree, with no neutral option to avoid non-committal responses. Several items were reversed to avoid response patterns. Instead of asking for personal opinions, respondents were asked what they thought other teaching faculty in their medical school would endorse. This approach has been

used extensively in population studies of stigma to avoid social responsibility bias that can emerge when asking people to make declarations of negative personal opinions (18). Site investigators were responsible for the process of translation-back translation. The principal authors reviewed all back translations and made suggestions for revisions as appropriate to ensure comparability of meaning across settings. A copy of the survey is available upon request.

Data management and analysis

Completed surveys were returned via email (scanned.pdf files) or by courier to the Principal Investigator to be entered and analyzed. Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board granted ethics clearance. In addition, where required by local rules, study sites also obtained local ethics reviews and clearances. To adjust for the stratified sampling design, results were weighted to the site-specific population proportions from which the samples were drawn. Weighted percents and 95% confidence intervals were calculated for each item. Non-overlapping confidence intervals reflected statistically significant differences.

In the absence of a psychometrically validated scale, we created an index by counting the number of items that indicated a strong agreement or agreement with a negative response (taking reverse coding into consideration). Two items were eliminated from the index as they referred to psychiatric rotations, which were not available in three medical schools. Creating an index in this way assumes all items are equally weighted and unidimensional. The index had a possible range of 0–35 with higher scores indicating higher stigma. Cronbach's alpha was 0.77, indicating that the index had good reliability in this sample. Weighted hierarchical linear regression with clustering by country, specialty, and by site was used to assess associations between stigma scores, gender, career stage, and specialty. Clustering by specialty (2% variance across specialties) and site (4% variance across sites) was small, so these were subsequently eliminated as clustering variables. Standard errors were adjusted for country only. All analyses were completed using STATA 13 (19) with a statistical significance level of 0.05.

Results

A total of 1057 survey questionnaires were returned for an average response rate of approximately 65%. Table 1 shows the site-specific and

overall response rate. Nine of the fifteen sites had response rates in excess of 65%. Two sites had low response rates of 50% or less. Response rates were not associated with scale scores ($F_{1, 1057} = 0.32, P = 0.57$) as measured using the constructed index.

Table 2 shows the weighted percents for each survey item. Responses have been grouped according to those who ‘agreed’ or ‘strongly agreed’ with the statement. Overall, respondents considered that their medical school culture did not view psychiatry as an exciting, rapidly expanding, intellectually challenging, or evidence-based branch of medicine. The majority considered that it would be most appropriate if patients with psychiatric disorders were treated in specialized facilities outside of the general hospital setting. Approximately one in five thought that psychiatrists have too much power over their patients and considered that psychiatric treatments were not efficacious. The overwhelming majority thought that psychiatrists in their medical schools were not good role models for medical students. One in five thought that psychiatrists did not pay enough attention to physiology. Approximately one in ten thought that they were difficult to talk to, not clear or logical thinkers, and that the discipline was filled with people whose medical skills were of low quality.

Considering psychiatry as a career, the majority indicated that students in their medical school were not interested in pursuing a psychiatric specialization. Over a third thought that their colleagues generally did not speak well of psychiatry, and almost a third thought that a bright student would not be encouraged to enter psychiatry by their mentors or teachers. As a career, psychiatry was seen as having low prestige relative to other specialties. Approximately one in five thought that students were attracted to psychiatry because of their own problems or that students chose psychia-

Table 1. Site-specific response rate

Country	Sampling frame	Returned surveys	Response rate (%)
Belarus	102	95	93
China	59	41	70
Croatia	210	158	75
India	32	26	81
Indonesia	60	37	62
Iran	300	169	56
Japan	30	30	100
Portugal	30	15	50
Romania	180	75	42
Russia	318	176	55
Scotland	57	35	61
Singapore	30	20	67
Thailand	162	128	79
Turkey	29	25	86
Ukraine	30	30	100
Total	1629	1060	65

Table 2. Agreement by survey item (N = 1057)

	Weighted %
Perceptions of Psychiatry as a Discipline	
Psychiatry is not a rapidly expanding frontier of medicine	27.4
Psychiatrists make less money than other specialists	24.0
Psychiatry is not intellectually challenging	10.2
Psychiatry is unscientific	8.9
Psychiatry is not a genuine, valid branch of medicine	8.0
Psychiatry is not evidence-based	7.7
Perceptions of Psychiatric Treatments	
Patients should be treated in specialized facilities	84.4
Patients should not be treated in general hospitals	57.4
Psychiatrists have too much power over their patients	25.0
Treatments are not as effective as in other branches of medicine	22.6
Most who receive treatments do not find them helpful	20.4
Psychiatric hospitals are little more than prisons	20.2
Psychiatrists can do very little for their patients	10.2
Perceptions of Psychiatrists as Role Models	
Most psychiatrists are not good role models for medical students	90.1
Psychiatrists are not attentive enough to physiology	22.2
Psychiatrists are difficult to talk to	13.7
Psychiatrists are not clear, logical thinkers	10.4
Psychiatry is filled with people whose medical skills are of low quality	8.2
Perceptions of Psychiatry as a Career	
Many students at this medical school are not interested in pursuing psychiatry as a career	75.4
Colleagues generally do not speak well of psychiatry	33.0
I would not encourage a bright student to enter psychiatry	28.6
Psychiatry has low prestige	24.3
Students are attracted to psychiatry because of their own personal problems	22.0
Students who cannot get into other specialties enter psychiatry	16.2
Entering Psychiatry is a waste of a medical education	3.9
Perceptions of Psychiatric Patients	
Psychiatric patients are emotionally draining	73.6
Psychiatric patients are not highly appreciative of the care they receive	48.4
Psychiatric patients are often less interesting to work with than other patients	47.5
Working with psychiatric patients is not rewarding	36.6
Psychiatric illnesses do not deserve as much attention as physical illnesses	7.2
Perceptions of Psychiatric Training	
Psychiatric training at this medical school is not of the highest quality	38.9
Students do not think their psychiatric training has been valuable	27.4
Psychiatry is so vague and imprecise it cannot be taught effectively	13.7
Less time should be spent teaching psychiatry to medical students	8.0

N sizes are not shown, as they will not correspond to the weighted percents. Responses reflect those who strongly agreed or agreed with each statement.

try because they could not get in to other specialties. Four percent thought their colleagues would consider that entering psychiatry was a waste of a medical education.

Most considered that psychiatric patients were broadly considered to be emotionally draining. About half considered that they were not viewed as particularly appreciative of the care that they received or were less interesting and less rewarding to work with compared to other patients. Almost one in ten considered that psychiatric illnesses should not be afforded the same attention as physical illnesses. Over a third considered that the psychiatric training offered at their medical center was not of the highest quality and that students did not think that the psychiatric training had been valuable. One in ten considered that psychiatry was too vague and imprecise to be taught effectively and agreed that less time should be spent teaching psychiatry to medical students.

Actual count scores ranged from 0 to 28, with a mean of 9.8 (SD = 4.7), and the distribution was approximately normal. Table 3 summarizes the mean scores and 95% confidence intervals by each site’s country location. It shows statistically significant variation from the mean of sites in three countries, ranging from a lower than average in China (mean = 8, 95% CI = 6.9, 9.1) to higher than average in the Ukraine (mean = 12.2, 95% CI = 10.6, 13.8) and Russia (mean = 11.8, 95% CI = 11.1, 12.5). Although not reported in the table, a review of t-statistics and p-values confirmed no other statistically significant results.

Table 4 examines whether opinions were associated with gender, career stage, controlling for clustering by country. A variance partition coefficient of 1.97, with a corresponding 95% confidence interval of 1.25–3.1, (which does not include the null value), indicates that the variance explained in the mean scale score by country was statistically significant. It corresponded to 18% of the variance explained. Gender and career stage were available for a subsample of 636 respondents. The model indicates that, on average, respondents in this reduced sample endorsed 8.7 items (slightly less than the average across the full dataset). Females and those who were in middle or late career stages endorsed significantly fewer items. There was also some variation between specialties. Those in community medicine, emergency medicine, neurology, pediatrics, radiology, and surgery endorsed significantly more items. The model explained 6% of the variance in the index indicating additional variables would need to be included in order to fully explain respondents’ views.

Discussion

This study examined images of psychiatry from the perspective of individuals who are responsible for

Table 3. Mean index scores by site location

Country	Mean	95% confidence interval
Ukraine	12.2	10.6–13.8*
Russia	11.8	11.1–12.5*
Belarus	9.9	9.0–11.0
Singapore	9.7	7.7–11.6
Thailand	9.7	8.9–10.5
India	9.7	7.7–11.6
Croatia	9.5	8.7–10.2
Portugal	9.4	6.7–12.1
Indonesia	9.4	8.1–10.6
Iran	9.1	8.4–9.8
Japan	9.0	7.3–10.6
Romania	8.7	7.8–9.6
Scotland	8.2	6.2–10.3
Turkey	8.2	6.6–9.8
China	8.0	6.9–9.1*
Average	9.8	9.5–10.1

*Non-overlapping confidence intervals indicate a statistically significant effect.

educating medical students. Results highlight the extent to which non-psychiatrist medical faculty hold negative opinions of psychiatry as a discipline, psychiatric treatments, psychiatrists as role models for medical students, psychiatry as a career choice, psychiatric patients, and psychiatric training. The most outstanding findings were that psychiatrists were not considered to be good role models for medical students, and psychiatric patients were considered to be emotionally draining and unsuitable to be treated outside of specialized facilities or in general hospitals. We noted statistically significant differences by country, gender, career stage, and specialty. These results highlight why recruitment into psychiatry is problematic in many countries.

An important strength of this study was that the sample was large and representative of the participating sites. The average response rate of 65% was good. In addition, we attempted to control for social desirability response sets and did this in several ways. First, by eliminating a neutral category in our scales, respondents were required to choose from either a positive or negative option. Second, we used a measurement approach advocated by Link and Cullen (18) to reduce social desirability bias. This is important because one might expect that medical faculty would be particularly savvy about reporting negative opinions when asked straightforwardly about their own views. Link and Cullen have demonstrated that it is possible to avoid social desirability responses by tapping into a deeper level of attitudes reflective of the ambient culture by asking respondents to indicate how they think ‘most people’ would respond. To assess medical school culture, we asked respondents how they thought most of the colleagues in their medi-

Table 4. Weighted hierarchical linear regression results

Factor	Coefficient	Standard error	t statistic	P-value
Mean (constant)	8.7	0.78	11.14	<0.001
Gender				
Male	Baseline			
Female	-0.65	0.16	-4.07	<0.001
Career State				
Early	Baseline			
Middle	-0.94	0.16	-5.74	<0.001
Late	-0.81	0.19	-4.36	<0.001
Specialty				
Anesthesiology	Baseline			
Community Medicine	3.3	0.65	5.0	<0.001
Dermatology	-1.5	0.78	-1.9	0.054
Emergency Medicine	8.2	0.80	10.2	<0.001
Family Medicine	0.1	0.54	0.2	0.825
Laboratory	2.6	0.56	0.5	0.640
Neurology	1.9	0.61	3.2	0.001
Oncology	0.9	0.80	1.1	0.283
Pathology	-0.4	0.62	-0.6	0.548
Pediatric	1.4	0.56	2.4	0.015
Perinatal	0.8	0.57	1.5	0.147
Radiology	1.2	0.61	2.0	0.045
Specialist	0.7	0.51	1.4	158
Surgery	1.9	0.53	3.6	<0.001

R-squared = 0.063. Standard error adjusted for clustering by country. The variance partition coefficient for Country indicated that variation between countries was 18%. The Country coefficient was 1.97 (95% CI = 1.25, 3.1). Results were weighted to account for the stratified sampling design.

cal school would respond. Item endorsements ranged from 4% to 90% (median = 22%), with considerable variation between these extremes, suggesting that a social desirability bias may not be strong in our data. Reverse scoring of some items also avoided response sets.

An important limitation of our approach (and indeed all attitudinal research) is that it does not allow us to know the extent to which negative views are well founded in fact and experiences, or, alternatively, the extent they may reflect stigmatizing views toward psychiatry and psychiatrists. For example, with respect to the perceived efficacy of psychiatric treatments, there has been an unprecedented development of new generation antipsychotic medications (over 40 now). However, the data from comparative clinical trials have been discrepant, and the information provided in various educational programmes has been inconstant. This has led to some confusion among both clinicians and researchers about the safety and tolerability of some of these agents (20). Therefore, negative views concerning the efficacy of psychiatric treatments may be rooted, at least in part, in this uncertainty.

A second limitation of our approach is that we do not know the practical importance of the differences we noted in the scale scores (21). Thus, scores may be statistically significant but practically unimportant in terms of predicting outcomes

such as student recruitment. This would have to be addressed in future research.

Our results showed that emergency physicians reported significantly more negative opinions compared with any other specialty. It may be because psychiatric patients typically do not fit into the treatment norm of emergency departments. They may present with vague or non-specific symptoms and take much longer to assess (22). In addition, considerable research has demonstrated the importance of prosocial contact with people who have a mental illness as a means of promoting positive social relationships (23). Emergency specialists see many acutely ill psychiatric patients when they are at their worst, psychotic, violent, or suicidal. In some countries, neurologists also see many acutely ill patients and this may account for their higher scores. Community medicine, radiologists, surgeons, pediatricians, and laboratory specialists also had higher scores. In these cases, contact and interaction with people who have a mental illness may be limited, so members of these specialties may be more likely to hold more negative views. Community medicine specialists may also be exposed to community disputes over the placement of mental health services and supports. Greater contact with students and colleagues who have a mental illness may also explain why medical faculty members in their middle and late career stages held fewer negative opinions about their educational environments. They may also have had more exposure to colleagues and students who have recovered from a mental illness.

We also noted that men held more negative views about the environment in their medical schools. This is consistent with past research (24). Male notions of masculinity, which view mental health problems as reflecting weakness and vulnerability, have been linked with increased stigmatization and unwillingness to seek care (25). One strength of this study was that research sites were solicited from countries that are usually underrepresented in this type of research. However, our weighted hierarchical regression results (calculated on a subset of the data) indicated significant clustering by country, which accounted for 18% of country variation. As a result, no conclusions can be drawn about the generalizability of findings beyond the sample studied. Medical schools in two countries (Ukraine and Russia) had higher than average scores, and one country (China) had a statistically lower than average score. These findings highlight the importance of future research to examine local and country-specific patterns in more detail. Understanding why some countries are more positive toward psychiatry and psychia-

trists, and the socio-cultural, political, and historical antecedents of this, may be helpful in reorienting medical school training to encourage greater recruitment into psychiatry. For example, it may be that the negative attitudes of medical faculty toward psychiatry and psychiatrists are a reflection of the type of exposure and training or experiences they have had (26). Understanding the nature and impact of these influences may help improve psychiatric training.

A considerable amount of medical training occurs outside of the classroom through non-didactic interaction with faculty, residents, and other students. Mentoring—an important aspect of this training—can influence career development and career choice. Research has shown that a proportion of students will change their career options due to negative comments. In a survey of 1114 senior students, for example, 76% reported hearing some negative comments about their particular career choice, usually occurring early in the first and second years of undergraduate medical education. Seventeen percent of these students indicated that they had decided against their initial career choice because of these comments. The faculty, residents, and students within their career choice were almost never the source of the negative comments, but rather it came from those in other specialties: 57% from the faculty, 74% from residents, and 72% from students. Ten percent of the students reported that they rejected psychiatry as a career choice because of negative comments (27).

Although the impact of negative comments on career choice has not been widely studied in relation to psychiatry, these findings suggest that any such informal influences are likely to be negative. In a survey of 390 clinical and academic staff in the National Health Service in the UK found that 57% thought that negative attitudes toward psychiatrists from other doctors and health professionals were a main reason why students were not entering psychiatry as a career. Just over a third (37%) identified poor teaching and role modeling from psychiatrists. This included too much reliance on self-directed learning, less visibility of psychiatrists in undergraduate teaching generally, and poorly organized psychiatry rotations (or attachments) with little exposure to patients, careers, and services. Twenty-six percent thought that psychiatry was not medical or scientific enough (28).

One of the most common suggestions for improving recruitment has been to enhance formal undergraduate teaching in psychiatry (28, 29, 30). However, in light of our findings, it seems that enhancing the perception of psychiatrists as role

models for medical students and increasing the efficacy of psychiatric treatments may be of greater importance.

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