Physician Self-disclosure of Lived Experience Improves Mental Health Attitudes Among Medical Students: A Randomized Study

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ABSTRACT

INTRODUCTION: Depression and suicidal ideation are common among medical students, a group at higher risk for suicide completion than their age-normed peers. Medical students have health-seeking behaviors that are not commensurate with their mental health needs, a discrepancy likely related to stigma and to limited role-modeling provided by physicians.

METHODS: We surveyed second-year medical students using the Attitudes to Psychiatry (ATP-30) and Attitudes to Mental Illness (AMI) instruments. In addition, we asked questions about role-modeling and help-seeking attitudes at baseline. We then conducted a randomized trial of an intervention consisting of 2 components: (a) a panel of 2 physicians with personal histories of mental illness speaking about their diagnosis, treatment, and recovery to the students, immediately followed by (b) small-group facilitated discussions. We repeated the ATP-30 and AMI after the active/early group was exposed to the panel, but before the control/late group was similarly exposed.

RESULTS: Forty-three medical students participated (53% women). The majority of students (91%) agreed that knowing physicians further along in their careers who struggled with mental health issues, got treatment, and were now doing well would make them more likely to access care if they needed it. Students in the active group (n = 22) had more favorable attitudes on ATP-30 (P = .01) and AMI (P = .02) scores, as compared with the control group (n = 21).

CONCLUSION: Medical students can benefit from the availability of, and exposure to physicians with self-disclosed histories of having overcome mental illnesses. Such exposures can favorably improve stigmatized views about psychiatry, or of patients or colleagues affected by psychopathology. This intervention has the potential to enhance medical students’ mental health and their health-seeking behaviors.

KEYWORDS: medical student, mental health, stigma, self-disclosure, lived experience

ABSTRACT

Introduction

Depression and suicidal ideation are common among medical students, a group at higher risk for suicide completion than their age-normed peers. A culture of maladaptive perfectionism exists among physicians, which filters down to the youngest trainees in the earliest days of medical school. At matriculation, students have better psychological health relative to age- and education-matched peers. But as early as the second year of training, their mental health deteriorates.

Not only do medical students and physicians have higher rates of depression and burnout than the lay public, but they are also less likely to get help when they need it. Postmortem analyses reveal that fewer physicians who die by suicide access mental health care than individuals who kill themselves in the general population. Furthermore, and contrary to risk factors among nonphysicians, doctors who die by suicide are more likely to have had a work problem or an allegation of a medical error rather than a personal issue. This distinction implies that an affront to the professional identity of a physician makes a deeper wound closer to the core of their self-concept. To stem further stress-driven attrition from the profession and the tragedy of physician suicide, medical students must be shown from the time of matriculation that it is acceptable to struggle and seek help, that treatment works, and that imperfection is what makes us human, just like our patients.

Unfortunately, medical culture and an implicit hidden curriculum make trainees feel like there is no room for mistakes in medicine nor space for flaws in the personal makeup of physicians. Given that medical school is a high-pressure environment where for the first time students may experience not being at the top of their class, the stage is set early on for possible impostor syndrome, narcissistic injury, and the fear of being “outed” as somehow lacking. Developing such newfound insecurity within a culture short on role models exemplifying that it is acceptable to need support can create barriers to help-seeking once students struggle.

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“How do we destigmatize physicians seeking help?” was the question most audience members voted to have then surgeon general Vivek Murthy answer at the inaugural American Conference on Physician Health in 2017.\(^{10}\) A year later, approximately 70% of residents in a large Medscape survey endorsed that there was stigma against seeking help.\(^{11}\) A study of more than 2100 female physicians on Facebook, aptly titled “I would never want to have a mental health diagnosis on my record,” found that more than two-thirds of them did not access mental health care due to stigma.\(^{12}\) It is no surprise then that more than half of burned out medical students agreed that a mental health issue (like anxiety or depression) would cause residency directors to pass over their application.\(^{13}\)

Stigma in mental illness has been a long-recognized phenomenon and has a well-documented effect on trainees and physicians with depression, burnout, and suicidal ideation.\(^{10}\) This negative perception of mental illness encompasses how an individual feels about being mentally ill and receiving treatment, how others judge those with mental illness or those who seek mental health treatment, and how one anticipates being treated by others after getting a diagnosis or receiving treatment. Studies show that medical students and physicians are negatively affected by all 3 aspects of stigma around mental illness.\(^{14,15}\) In fact, stigma-related concerns are oft-cited reasons for medical students, residents, and physicians not to access care.\(^{16,17}\)

The hidden curriculum, or what is implicitly taught to trainees through observed attitudes and actions, has a prominent effect on what medical students feel “fits” with their identities as doctors in training. Medical students will remain unlikely to develop healthy and realistic expectations of themselves, nor change their help-seeking behaviors, unless they see their superiors emulate these values and behaviors. Regrettably, the opposite is more often the case. For example, in a recent large study of burnout, between 10% and 15% of medical students reported witnessing superiors judge other students with known mental illness more critically, violate their confidentiality, and extend them fewer opportunities than offered to their unaffected peers.\(^{13}\) Almost a third of respondents reported noticing their peers socialize less with medical students with mental health issues.

The medical adage to “see one, do one, teach one” also rings true for judgment and self-care around mental health. However, most medical students do not see their attendings talk as casually about how an antidepressant or psychotherapy helped them get over depression as when a steroid injection or physical therapy helped their tennis elbow. In turn, they then do not comfortably admit feeling depressed, and in turn will not teach the next generation of trainees to get support when needed. As a result, stigmatized views about mental illness become entrenched and internalized, and each new class of trainees is flooded with lots of talk about self-care, without the commensurate role-modeling walk by their superiors. The power of mentorship by senior faculty is well documented in other realms: medical students with supportive faculty relationships are more likely to ask for academic help, admit errors, seek feedback, and even get mental health treatment.\(^{8}\)

We hypothesized that if these same trusted supervisors, attendings, deans, and senior lecturers openly shared past struggles and the treatments that helped them recover, more students would be comfortable getting mental health care. When respected physicians do not openly model how normal it is to struggle, get help, and go on to be successful doctors, medical students become disproportionately aware of only those physicians with mental illness who go on to have poor outcomes.

Our study was informed by the contact hypothesis theory, as applied to shared lived experiences. Specifically, the contact hypothesis theory, first introduced by Allport,\(^{18}\) explores the benefits of positive interaction between members of historically divided communities (in this instance, medical students and their physician-instructors), particularly on outcomes related to prejudice reduction (in this instance, regarding mental health, frailty, and vulnerability).\(^{19}\)

The aim of this study was to test empirically whether senior physicians openly disclosing their lived experiences with mental illness can shape medical students’ attitudes and decrease stigma around mental health treatment and of individuals with mental illnesses. Our ultimate goal is to improve the learning environment by making a positive impact on the self-concept and help-seeking behaviors of trainees at an early and impressionable stage of their medical careers.

Methods

Study design, participants, and ethics approval

We conducted a randomized trial of an educational intervention. Participants were informed that the purpose of the study was to explore their attitudes about psychiatry, mental health treatments, and people with mental illness. Participants were second-year medical students at the Tel-Aviv University Faculty of Medicine’s New York State Program, who completed assessments at 2 time points: one at the start (baseline) and another after completion (endpoint) of their core curriculum’s week-long intensive course in preclinical psychiatry. We obtained institutional review approval from the Yale Human Investigations Committee and the Tel-Aviv University Institutional Review Board before starting data collection. The study was deemed exempt of review, with completion of the survey representing tacit consent. To track individuals’ responses over time, each student provided a de-identified and anonymous unique code. We did not ask about sex or gender as part of baseline demographics; sex composition of the sample, obtained from the registrar’s office, is provided only for descriptive purposes of the class as a whole. Participants were assured that their responses would remain confidential, and that neither their willingness to participate nor their specific responses would have any bearing on their evaluation.
**Study intervention**

The study intervention was embedded within the required preclinical psychiatry course, consisting of a curriculum spanning 30 didactic hours across 5 contiguous days. The course included traditional didactic, flipped curriculum, small group, and team-based learning components. The study intervention was designed to enhance the knowledge base of clinical practice in psychiatry and to target stigmatized perceptions about psychiatric treatments and about patients with mental illnesses. The intervention consisted of 3 components:

1. A 1-hour panel of 2 physicians openly sharing their personal histories as consumers of mental health services, including recognition, diagnosis, and treatment of their respective conditions (recurrent major depression for 1 physician, generalized anxiety disorder and attention deficit/hyperactivity disorder for the other). The panel was deliberately placed near the end of the course, and the physician-consumers were 2 instructors who by that time had taught the students for more than 20 hours.
2. Contiguous 1-hour, small group sessions, each comprised of 8 students and 1 faculty moderator. The small groups were lightly structured, with suggested topics if none emerged during spontaneous discussion, including: disclosure, confidentiality, credentialing, impairment, and treatment. Emphasis was explicitly placed on the competencies, strengths, and recovery of the affected physicians, rather than on aspects of their underlying illnesses.
3. A 1-hour lecture focused on mental health and other support resources available to students, including affordable, confidential, and offsite options in the local community. This presentation took place after the second (and final) assessment, with both active and control groups together.

**Procedure and instruments**

At baseline, participants completed a personal information survey that included 10 questions about role-modeling and help-seeking attitudes, as well as select items from a published study by Dyrbye and colleagues. They also completed 2 self-report questionnaires at both time points: the Attitudes to Psychiatry (ATP-30) and the Attitudes to Mental Illness (AMI). The ATP-30 consists of 30 items and was originally designed to measure medical students’ attitudes toward 8 different attitudinal domains: (a) psychiatric patients, (b) psychiatric illness, (c) psychiatric treatment, (d) psychiatric institutions, (e) psychiatric knowledge base in clinical practice, (f) psychiatry as a career choice, and (h) psychiatrists. The AMI consists of 20 items and was originally designed to measure medical students’ attitudes to mental illnesses and, more specifically, toward their causes, treatment, and impact on individuals and society. Each item in both questionnaires is rated on a 5-point Likert-type scale ranging from “strongly agree” to “strongly disagree.” Some items are negatively phrased to minimize the likelihood of social desirability bias. Higher composite scores in both instruments indicate more favorable (less stigmatized) attitudes toward mental illness. Both the ATP-30 and the AMI have been shown to have good psychometric properties, and the 2 instruments have been translated broadly and used worldwide.

Students were randomly assigned to active or control groups, which differed only in the timing of their exposure to the disclosure and small group discussion components of the intervention: before or after the endpoint assessment, respectively. This design required the active components to be repeated twice, to ensure that all students were equally exposed, in keeping with best practices in medical education.

Students completed surveys through their preferred, Wi-Fi-enabled personal device. We collected information securely through Qualtrics (Provo, UT) and analyzed data using SPSS version 25 (Armonk, NY). We first used chi-square tests to compare categorical variables between active and control groups. We next explored ATP and AMI total scores for normality using the Shapiro-Wilk test. Having found both measures to be not normally distributed ($P < .012$), we went on to use nonparametric Wilcoxon signed rank tests to compare total, subscale, and individual item scores before and after the intervention. We conducted the pre-/post-comparisons between control and intervention groups. We consider significance at the traditional level of $P < .05$.

**Results**

All students in the second-year class course ($n = 47$, 53% women) were invited to participate; 43 of them (92%) completed both the baseline and endpoint assessments. Table 1 summarizes characteristics across participants randomly assigned to active ($n = 22$) or control groups ($n = 21$). Half of the students (52%) were 24 years of age or younger. Many had experiences with mental illness: in a friend or relative (65%) or personally themselves (9%). Almost one-fourth (23%) had already been involved in the care of patients with mental illness. Students reported substantial interest in psychiatry as a
possible specialty, with only 37% of them ruling it out altogether.

As summarized in Table 2, at baseline all but 4 students (91%) agreed that knowing physicians further along in their careers who struggled with mental health issues, got treatment, and were now doing well would make them more likely to access care if they needed it. More than two-thirds (73%) agreed that they would reach out to those physicians if they knew they were receptive to sharing their own experiences, and that contact of that kind could be helpful in seeking treatment for themselves. However, only a fifth of students knew of physicians with a mental illness (23%), and of note, it was not specified whether these physicians had fared well or not.

Even though only 12% of students agreed that it was a sign of weakness or inadequacy to receive help as an abstract concept, signaling they would not judge others so harshly, they assumed others (residency directors, supervisors, and fellow students) would judge them much more negatively for receiving such support (75% on average). More than two-thirds (73%) agreed that they would reach out to those physicians if they knew they were receptive to sharing their own experiences, and that contact of that kind could be helpful in seeking treatment for themselves. However, only a fifth of students knew of physicians with a mental illness (23%), and of note, it was not specified whether these physicians had fared well or not.

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The intervention was well received by students, who gave it the highest scoring of any component of the course (a 4.4 average on a 1-5 scale); 42 out of 43 students (98%) rated it as “effective” or “highly effective.” Salient free-text comments from participants included the following: “Hearing their personal stories of struggle was probably the highlight of the course, and that experience, along with the following discussion in small groups moved me deeply”;

**Table 1. Characteristics of second-year medical students (N=43).**

| VARIABLE | CATEGORY | CONTROL (N=21) | ACTIVE (N=22) | \( \chi^2 \) | DF | P |
|----------|----------|---------------|--------------|---------|----|---|
| Age, y   | 24 or under | 13 62 | 10 45 | 2.2 | 2 | ns |
|          | 25-29 | 6 29 | 11 50 | | | |
|          | 30-34 | 2 10 | 1 5 | | | |
| Would consider a career in psychiatry | Yes | 6 29 | 0 0 | 7.4 | 2 | .03 |
|          | Maybe | 9 43 | 12 55 | | | |
|          | No | 6 29 | 10 45 | | | |
| Experience with mental illness | Involved in the care of a patient with | Yes | 4 19 | 6 27 | 0.4 | 1 | ns |
|          | No | 17 81 | 16 73 | | | |
|          | Have a friend or relative diagnosed with | Yes | 15 71 | 13 59 | 0.7 | 1 | ns |
|          | No | 6 29 | 9 41 | | | |
|          | Ever been diagnosed with | Yes | 2 10 | 2 9 | 0.1 | 2 | ns |
|          | Prefer not to respond | 1 5 | 1 5 | | | |
|          | No | 18 85 | 19 86 | | | |

Total scores on the ATP-30 and AMI improved between baseline and endpoint in the active (\( P \leq .02 \)) but not the control group (Table 3). Within the ATP-30, only the Treatment and Institutions subscales changed significantly for the group as a whole (\( P<.001 \) and \( P = .016 \), respectively). These subscale-level analyses were secondary and not sufficiently powered to determine differences between intervention and control groups.
and there was only 1 concrete suggestion toward improving it, specifically around its timing within the overall curriculum: “My one recommendation is to have this content about mental health and its ramifications in regards to medical school at the beginning of first year, so that students can be mindful for themselves and their peers.”

**Discussion**

As hypothesized, we found that exposure to senior physicians who openly shared their lived experiences with mental illness had a measurable impact on medical students’ attitudes about psychiatry in general and about individuals with mental illness in particular. In keeping with best antistigma practices, our
intervention incorporated direct interaction with individuals with lived experience—fellow physicians in this instance—whose personal testimony emphasized recovery and the breaking of common misperceptions. Importantly, the intervention consisted not only of the physicians’ disclosures but of facilitated discussions in small break-out groups immediately following, during which students could process and generalize from the emotions evoked during the encounters. Finally, it was critical to provide specific resources for students to be able to access confidential and affordable mental health care within their own communities. Given that suicidal ideation has been shown to increase dramatically in the first 3 months of internship, and that effective treatments exist to decrease suicidal thinking through even short-term online cognitive behavioral therapy (CBT), it is imperative we help students and trainees feel more comfortable to access care.

Our study was informed by the contact hypothesis theory, which suggests that bringing people together is not in itself sufficient to address the prejudice, stereotyping, and discrimination that can occur between groups. In addition to contact, other variables of importance include institutional support for activities; recognition of equal status among participants; positive expectations of outcomes; a cooperative atmosphere; an understanding of role similarities and differences; participants working together as equals; and participants viewing others as typical of their group, rather than exceptional.

We incorporated several of these variables into our initiative, and particularly in our deliberate choice to have fellow physicians, as opposed to nonphysician individuals with mental illness, share their lived experiences. Moreover, we considered an integral component of our design for the sharing physicians to be instructors known to the students, rather than ones appearing out of context. In keeping with recent critiques of the theory, contact of individuals with lived experience who the students may not be able to relate to (such as nonphysicians with a chronic mental illness in recovery) could in fact have a paradoxical effect of further distancing and alienating different groups with underlying commonalities.

The intervention we tested is not an entirely novel idea; others had thought of or implemented it before, but to the best of our knowledge, had not tested it empirically. For instance, the comment by Dr Lia Logio is paradigmatic. In her role as training director for internal medicine at Weill Cornell School of Medicine, Dr Logio summarized the idea succinctly in a NEJM podcast:

In some of the best practices that I have heard since having this dialogue around the country with people, it is about having a revered faculty member during orientation stand up and say, “Yes, I had depression, and I got help and don’t think any less of me because . . . I was smart enough to get help and get treatment and I am good to go,” and that’s really eye-opening for new interns who have their own biases that society has labeled to some of these problems.

Medical schools are increasingly aware of the troubling incidence of mental health issues among trainees and active in efforts to increase the wellbeing of their students. Such initiatives include dedicated advisors, social opportunities, wellness activities such as meditation and yoga, retreats, and greater access to mental health resources. Two national conferences in the fall of 2019 highlighted the importance that the topic of medical student mental health and wellbeing has garnered at the national level. Welcome as these efforts are, we suggest that a key ingredient may have been missing from earlier initiatives: one pertaining to culture. The late Peter Drucker is attributed with having said that “culture eats strategy for breakfast.” In the context of this discussion, the many promising initiatives now underway may fall short unless the medical culture changes toward greater role-modeling of self-care and acceptance of the humanity of its clinicians. This may be especially relevant as students transition into the later, clinical years of training, and as they prepare to move into graduate medical education, developmental epochs during which the learning environment can become especially fraught and perceived as less emotionally supportive.

Medical school curricula need to address the multifactorial contributors to maladaptive perfectionism in trainees, the hidden curricula that shape them, and the systemic barriers which keep senior physicians from modeling proactive self-care that can prevent progression to impairment. Exposure to friends, family members, or patients with psychiatric illnesses can open the door to a more nuanced and less stigmatized understanding of mental illness. But medical students will take exception to this shift unless those same attendings who evaluate them and whose professional behavior they want to emulate also normalize managing psychological struggles successfully. In this study, we sought to expose students to patients with mental illness in whom they could truly see themselves—a crucial aspect for any wellbeing intervention that intends to decrease internal judgment and destigmatize accessing mental health care.

The culture of medicine has long been entrenched with judgment of self and colleagues with mental health histories. With the advent of a burnout epidemic among physicians, greater space has been created to more openly discuss struggle without shame, partly related to the rightful externalization of burnout’s etiology lying in the system rather than with the individual. Experientially, it seems that more young physicians are willing to break an unspoken medical code of silence, as evidenced by several online campaigns such as “I solemnly share,” and medical student initiatives where self-disclosure occurs. However, it seems unfair to expect our youngest and most vulnerable colleagues to expose themselves to the judgment that older physicians further along in their careers are still afraid and unwilling to take on. Instead, we physicians should lead the way, as medical students are sure to follow in a natural virtuous cycle bravely described by Dr Rahael Gupta:
Limitations

We should be comfortable to share our experiences with mental illness and recovery, and to do so not in the name of self-centeredness, certainly not of eliciting sympathy, not even of presuming to be able to better understand another’s plight, but simply to become better calibrated and humbler healers who recognize commonality with those we are privileged to serve.40

There are many examples in the literature of physicians who have self-disclosed in the service of their patients and students (we provide a representative sampling in Appendix 1). In fact, American physicians may be lagging behind the antistigma and disclosure wave among their British and Australian counterparts: the United Kingdom has long had Doctors Support Network (dsn.org.uk), and Australia’s Beyond Blue resources include support groups specific for physicians (beyondblue.org.au).

In medicine, an aura of shame and stigma still surrounds imperfection.41 Indeed, the system is structured in a way that can expose and potentially weed out those who have sought psychological help in the past, through intrusive and discriminatory questions on licensing applications and hospital credentialing forms.42,43 In states where medical licensing boards have not yet followed recommendations of the Federation of State Medical Boards, American Medical Association, National Academy of Medicine, or the American Psychiatric Association to only inquire about current impairment rather than past diagnosis or treatment of a mental health condition, physicians are 20% less likely to access care.44 During his 22 years as residency program director of pediatrics at the Wisconsin School of Medicine and Public Health, Dr Norman Fost provided an honest and practical approach to thwarting intrusive and discriminatory questions when filling out recommendation letters for graduates seeking hospital privileges:

All of our residents and faculty have emotional problems. Some are sensible enough to seek professional help. If I believed Dr. X’s problems interfered with his/her ability to perform the duties of the position he/she is applying for, I would tell you.45

Conclusion and implications for medical education

In summary, and despite these acknowledged limitations, we found that medical students can benefit from the availability of, and exposure to physicians with self-disclosed histories of living with and having overcome mental illnesses. Such exposures can favorably improve stigmatized views about psychiatry, about patients with mental illnesses, and most importantly, about students’ own struggles and human fallibility. This intervention has the potential to help improve a medical culture of perfectionism and silence and ultimately to enhance medical students’ mental and emotional health and their help-seeking behaviors. We believe that efforts such as this are timely and sorely needed, as the field of medicine seeks to better care of its own.

Author Contributions

AM, JC, DG and DA contributed to the design and implementation of the research, to the analysis of the results and to the writing of the manuscript.

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Moreover, the nature of the problem can be further explored in "Ann Intern Med" (2010;153:235-241), which discusses the prevalence of depression and anxiety among medical students and residents.

The importance of mental health education is underscored in "Acad Psychiatry" (2014;59:S19-S26), highlighting the need for effective interventions to reduce mental-health-related stigma and discrimination.

The experiences of medical students who self-disclose lived experiences of mental illness are valuable, as presented in "BMC Psychiatry" (2012;12:62). This research is pivotal in shaping a more inclusive and supportive learning environment in medical school.

Furthermore, the_bc01 setting the river on fire:_a study of genius, mania, and character_and_this close to happy:_reckoning with depression_(book forum)_in "J Am Acad Child Psychiatry" (2015;54:1123-1132) offers insights into the challenges faced by individuals with mental health conditions.

In conclusion, improving mental health education and reducing stigma are essential for the well-being of medical students and residents, as highlighted in "JAMA" (2017;316:2214-2236) and "Acad Psychiatry" (2014;59:S19-S26).
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