recently, a friend struggling through her unsuccessful battle with uterine cancer said after months of pain, bleeding, chemotherapy and radiation therapy, “It is so isolating to be sick.” Despite having a caring, attentive husband, a supportive family and a plethora of friends, she still felt that, in the end, the pain and deterioration were her own—and the experience an intensely personal one that only she had to withstand even as everybody tried to help.

From the mundane cold to the life-threatening cancer, illness isolates its victims, encapsulating them in a swirl of symptoms that pulls them away from normal human interaction. Perhaps no disease is more isolating than mental illness. Like other illnesses, mental illness can devastate its victims with debilitating symptoms. Unlike other illnesses, mental illness and its thought disturbances can distance a patient even further from others. And as is the case with any illness, the physician’s job is to breach that capsule, meeting the patient wherever they can to treat and to comfort.

Whether they are diagnosed with mild anxiety or seemingly refractory schizophrenia, people with mental illness encounter barriers when relating to the daily world and to the medical world. Depression and anxiety can skew perception and fog concentration. Delusions and hallucinations frequently hamper all communication. So letting doctors know what it’s like inside their capsule is a problem for the mentally ill and for their doctors.

The problem physicians face in treating mentally ill patients is echoed across the health care system. It seems like mental health treatment approaches go through more changes than the public school curriculum. Yesteryear’s institutional incarceration of the seriously mentally ill gave way to the push to get them out into the community, a strategy currently being questioned by some. As revelations of the chemical basis of many mental illnesses surfaced and drugs that altered those chemicals emerged, psychiatry moved from the talk of psychotherapy to the pills of psychotropic medications—a trend now being challenged by those who have realized the limitations of “pill pushing.” And psychiatry’s coding system, the DSM, has just undergone a radical revision that will change what psychiatrists diagnose and, perhaps, the way they think. Even the definition of recovery from mental illness is being debated.

Perhaps that is why it is so difficult to get anybody to pay for the care of psychiatric problems. Insurance companies construct elaborate controls and restricted capitation structures to limit their coverage of mental illness’s admittedly costly treatments. In part because of the inadequate reimbursement of psychiatric services, psychiatry as a professional choice for medical school graduates has experienced a steady decline until this year’s 3.4 percent uptick in the residency match statistics.

Despite the promises of neuroscience, psychiatric disease is not going to get simpler and the debates will not likely evaporate. Yet mental health professionals agree that early identification is crucial. To identify those who are afflicted, the medical community needs to challenge the stigma, mention the unmentionable and bring up the topic.

So physicians of all stripes need to be capsule crackers, reaching into the silent world of patients suffering from illness—physical or mental—and trying to understand so they can treat. MM

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