Overcoming Social Stigmas and Fear: Normalization of Mental Health in the United States

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On my honor as a University student, I have neither given nor received unauthorized aid on this assignment as defined by the Honor Guidelines for Thesis-Related Assignments.

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According to the National Alliance on Mental Health (NAMI), 19.1 percent of people experience some form of mental illness (NAMI, 2019). Mental illness is being defined as a condition that affects a person's thinking, feeling or mood: examples being: eating disorder, obsessive-compulsive disorder, and depression (NAMI, 2019). Among the mentally ill people, many do not recognize that they have a mental disorder, or they deny that they have one (Bharadwaj 2017). Reasons could be that disclosing mental illness can threaten employment or reduced access to health care (Thornicroft, 2016). Young et al. (2019) have also found that the average person considers people with mental illnesses "more dangerous," and that the average person would have the "tendency to avoid individuals with mental illness." This enables people to prevent seeking help in fear of isolation from society. Advocacy groups like theWorld Health Organization (WHO) and the National Alliance on Mental Illness (NAMI) push for larger coverage on mental health care. Government agencies like the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) create bills that can aid the mental health agenda but also provide free information to the public to allow for informed decision making. Business owners and companies also must think about the costs of mental health care insurance. Small groups such as the friends and families of those with mental illnesses also have a voice in how healthcare is handled and seen

by others. How mental health is stigmatized in the US is based on its accessibility to the mentally ill.

Review of Research

Thornicroft et al. (2016) found that many people with mental illness avoid support due to fears of “loss of income, unemployment, reduced access to housing or health care.” According to Bharadwaj (2017) “36% of individuals whom we observe with a diagnosis of depression self-report as not having a mental disorder,” causing underreporting. Such denial can impair relationships and education (Thornicroft, 2016). As another point, Crowe and Littlewood (2018) found the self-stigma of finding mental health a stronger “predictor of mental health literacy compared with self-stigma of mental illness; thus, a person’s self-stigma about seeking counseling services has a greater impact on his or her mental health literacy than does the self-stigma of having a mental illness.” This shows that the mentally ill are more willing to learn about their mental illness on the idea that they are looking for help over merely knowing that they have a mental illness.

Manning and Gregoire (2006) stress mental illness awareness at home because parents with mental illnesses can impart them to their children, risking “psychiatric disorders in childhood, adolescence, and later adult life.” Maybery and Reuperd (2009) find support in the workforce for mental health concerns, there are barriers and issues for those that have families and children in their life too. The training and psychiatric assistance do not identify those who are parents and therefore do not respond properly for those needs also include that the workforce needs to include family members and dependent children in treatment plans accordingly

(Maybery and Reupert (2009). Because many mental health problems begin in childhood, Ryan and et al (2017) urger support for parents to assist in early prevention.

Cleary et al (2020) recommend self-care in the workplace. Without it, workers risk "burn-out, compassion fatigue, and an increased vulnerability to vicarious trauma." They advise self-care against considering indulgence; it is "an essential component of professionalism." Goetzel et al (2002) advise employers to offer support for mental care in the workplace to prevent worker depression and consequent productivity losses due to "absenteeism, short-term disabilities, higher turnover, and suboptimal performance." They contend investments in mental care yields productivity gains in the long term (Goetzel). They recommend that businesses "combine medical and behavioral health care services as it could save the US $37.6 billion to 67.8 billion a year" (Goetzel).

Workspace Mental Health

America's workplace can develop a mental illness in its workers. Businesses have been pressing to deal with these issues by placing it as one of their top priorities. Workers gain plenty of stress from working at a job, and these stress levels heavily depend on the environment. These factors also decide worker retention. Oaklander found that in the workplace "62% of people ages 20 to 37 who report feeling comfortable discussing their mental health at work 32% of people ages 54 to 72 who say they are comfortable discussing the same 75% of Gen Z'ers who report leaving a job at least in part because of mental-health reasons." This is due to imparting a generation gap between older to newer generations. The expectations of the workplace requirement that new generations require is something that is needed to handle the stresses of the

current day and age. Brohan and Thornicroft (2010) found reasonings of why people disclosed their mental health openly in their workspace was due to “experiencing symptoms 32%, feeling that employment was secure 32%, feeling disclosure would not lead to negative circumstances 29%, and experiencing hospitalization 20%.” This shows that people will most likely reveal their illness when in cases of emergency or when they feel valued and protected in the workplace. Workplace culture is what defines how open a business usually is to employees and there are some steps executives can do to help create a friendlier environment. Perry-Jenkins et al saw when “parents [of newborn children had few] workplace policies, such as schedule flexibility or child care supports.” In accordance, he also found that greater child support and schedule flexibility related to fewer depressive symptoms in this specific case. If management offers proper support to its employees, employee retention rates can also benefit the costs of business by focusing on the quality of life of its workers. This is further contributed by Goetzel providing information that supporting mental health in the workplace could save the US billions per year (Goetzel). APAF’s mission is to “improve workforce mental health” by ensuring that mental health “management programs are designed and managed to produce the best possible outcomes” (APAF, 2019).

Personal Life: Family, Friends

In-home life, many mental illnesses can spawn in members, particularly children. Aali and Reyhane found “there is a significant relation between family poor performances and the risks for physical disabilities, anxiety, sleep disorders, depression, and disorders in social functions in children.” Dysfunctional homes due to reasons such as divorce, domestic abuse, and

parental ignorance can lead to mental illnesses in children. Groups like the American Counseling Advocacy push for greater counseling usages for family groups stating that it "empowers diverse individuals, families, and groups to accomplish mental health wellness, education, and career goals." It has also been found that mental illnesses are partially hereditary too. According to Jones (2020):

> It had long been known that these conditions have a genetic basis, and are highly heritable. Huge twin studies have estimated the heritability of schizophrenia, for example, at nearly 80 percent, and major depression at about 45 percent. But having a parent or sibling diagnosed with a given condition doesn't just increase the odds that you will experience it. It also increases the likelihood that you will be diagnosed with a different condition. For instance, if a parent has schizophrenia, your risk of developing bipolar disorder doubles, and vice versa.

Mental health inside of the home should be given proper care from the parents over their children and, if needed, outside sources such as therapy provide alternatives. This opportunity is not readily available for most families and communities. Racial background can also determine the mental help given by others. Racial culture is a factor that primarily affects younger generations due to the limited resources available to them. "'Growing up in an Asian family, we didn't really acknowledge invisible illnesses,' says Chai, 22. 'I was so scared about being found out.' She withdrew from her friends and thought about dropping out of college." (Oaklander) Families are a primary source of stress for younger people if they are not given resources to discuss their emotion, and if that is taken away, then their only choice early on is to reside in themselves which mostly result in developing symptoms of mental illness. Racial disparity in mental health services is also different between races. Kim et al (2017) found that all people that needed mental health assistance non-Hispanic white tended to receive the lowest unmet need

rates at ~63.5% feeling like their need was unmet. The national average of unmet needs is 67.33%. The other races of black, ~81.6%, Asian ~82.6%, and Latino, ~78%, all sit solidly higher than the unmet need average (Kim 2017). What this shows is possible that the culture and the people around do not handle mental health properly or quite possibly do not take it seriously enough as a real-life problem compared to something like a physical injury. Alang (2019) looked into the mental health of black people in America and found that “10.2 percent reported that they did not get the treatment or counseling they needed, compared to only 5.1 percent of the general population.” Homelife for the mentally ill is difficult, usually forcing them to ignore their needs. Groups such as the National Alliance on Mental Illness aim to remove the social stigma from the general population by allowing more opportunities and knowledge for families and communities. Through more efforts, the availability of persons with mental illness will be more accessible.

Faith and Connection

Religion is a connecting line people usually use as an alternative, or even as a primary, to physician care. Religion may be an option for the mentally ill due to how accepting it is to people. Adams et al (2018), however, found that Christian fundamentalism, but not Christian Orthodoxy was a predictor of stigmatizing a person with mental illness. This means that in America at least, there is a moderate stigma towards people with severe mental illness. This could provide a point of negativity to wanting to include religion for patients with mental illnesses. Schmitz and Woodell (2018) found that persons in the LGBTQ found that religion was a good resource to them stating that it provided “sources of resilience” It must also be mentioned that other adults found it as a source of stigma too as a negative area (Schmitz & Woodell, 2018).

Ignoring the social stigma however, Rajabi et al (2015) suggest there exists a negative relationship between depression symptoms and religious engagements and found that people with inner religious orientation experience less depression. Zagożdżon and Wrotkowska (2017) also found that religion could be a key way is the recovery of some individuals. Russinova and Cash (2007) add to this by stating that persons with serious mental illnesses would incorporate "alternative healing practices into their recovery process." Koenig et al (2020) offer a counter-point stating veteran's "religiosity is positively related to hope, independent of demographic, military, social, and psychological factors, it does not buffer the negative relationships between hope and PTSD, depression, or anxiety." Hope in this case being the belief that they can get better. For severe cases of when religion is not enough, more help is needed for these individuals. To suit the needs of all those who are hoping to get better, more options being readily available to people would benefit communities. People tend to stray away from attempting to fix their mental health if there is no option readily available for them and offering help to people.

Teaching Young Minds of Mental Health

It has been found that many mental health issues are developed at very young ages leading up to adulthood. To deal with this, awareness for those with illnesses should be given knowledge or assistance as most do not have the availability until much later in life. During the earlier portion of adolescence, it is a difficult time for adolescents with rapid changing of lifestyles between school switching and them discovering who they are. Kessler et al. (2005) found that 50% of lifetime mental illnesses begin at age 14, which coincides with American

students transitioning into High School. Makover et al (2019) found that students that transfer into high school have heightened depression and anxiety levels which all do decrease over time. They tested a High School Transfer Program to assist students in the transition which did prove results such as a moderate decrease to the rate of depression in students and a small decrease to the rate of anxiety in students (Makover). There is a possibility that these stressors for some students never ended up decreasing thus leading to lifetime illnesses. After high school, students then move onto college where the opposite effect is true. The number of lifetime illnesses increases to 75% being developed by age 24 (Kessler et al, 2005). İlhan et al (2019) found college students have a "significant correlation between mental health and economic status, smoking status, and satisfying the basic needs of survival, power, fun, and freedom." They also have found that, as opposed to high school, stress levels increased as they progressed through the years. A study over many different countries found that students from high schools and colleges like being educated on mental health issues as a group rather than through direct intervention, but despite the preference, four weeks later, it was discovered that those improvements were diminished or lost (Thornicroft, 2016). College students differed in that they retained a favorable attitude and knowledge (Thornicroft, 2016). As mental health care is offered to younger generations, receiving mental care will become normalized and this also gives the benefit of possibly stopping early cases of long term mental illness in individuals.

Integration Back into Society

The US's systems for integrating veterans and prisoners back into society are mostly ill-equipped to service the needs of their participants, but they are slowly getting better. Veterans

usually come home with mental illnesses such as depression, anxiety, anger, alcohol misuse, functional impairment, and sociodemographic characteristics (Murphy, 2018). Deahl and Klein (2011) state “a lack of understanding of the military culture, ethos, specific problems of service life, and transitional adjustment issues” is a barrier that blocks the help veterans need for supporting themselves in business. Deahl et al (2011) also stated that there is a barrier in that, as much as we understand PTSD, we are lacking focus on “less dramatic [but] more salient” problems that can lead to other mental illnesses. Possemato et al (2018) found that veterans are interested in having choices in their treatment such as “specifying treatment preferences, such as patient-centered care, peer support services, and open-access scheduling, and presenting concerns, such as anger and core symptoms of PTSD.” Murphy (2018) found “71.3% belonged to three classes showing positive treatment responses, and 1.2% showed initial improvement but later relapsed.” He also found that 27.5 percent showed treatment resistance; these individuals have shown little change in their mental health. Suicide prevention is a critical component of veteran mental health care and most likely affects the treatment-resistant group. Amato et al (2017) found that even when treatment is “accessible, it may not be acceptable” and mentions that to assist in the risk of suicide, a spiritual expression may also be a factor that may be added to the mental therapy given to veterans. Veterans overall need specific help to their needs as they are usually detached from society and need personalized help as their situation differs from non-combatant mental health. Providing competent and personal help may produce the results that are needed in assistance for them.

The prison system in the US is not one that is aimed towards rehabilitation but one for punishment: “keeping criminals off the street.” The culture of prisons and rehabilitation centers

are drastically different from one that needs to keep inmates healthy and mentally to enable them to change their criminal behaviors through their initiatives (Kriminalomsorgen). Al-Rousan et al. (2017) found that of prisoners with mental illnesses, 99 percent were first diagnosed in prison. This could be because prisoners developed illnesses such as PTSD, depression, and anxiety during their time in prison. Currently, prisons are not good housing facilities in terms of helping prisoners. Gabrynsch et al. (2019) Ahalt et al. (2020) found through a correctional officer survey that "45% reported having hypertension, 30% reported symptoms of posttraumatic stress disorder, 40% had a positive screen for depression, 32% said a loved one had expressed concern about their drinking, and 13% said they had thought about or attempted self-harm. Moreover, while 84% believed rehabilitation should be a goal of their work, only 45% felt they made a positive difference in incarcerated people's lives." Ahalt and others then sent these correctional officers on a multi-day training regimen created by Norwegian Correction Service trainers. When they come back, a post-training survey found that "78% of participating staff said Norwegian correctional concepts will enhance officer safety. 94% said the training provided new perspectives on how prisons could change for the better" (Ahalt et al. (2020). The prisoners they managed also improved in terms of relationship and character: violence rates went down, inmate depression levels lowered, and a prisoner stated "these people treated me like anyone in society would treat me rather than being a burden. This ultimately has made me feel like I'm equally worthy of returning into society with confidence and for this, I am truly grateful" (Ahalt et al). The result of this is that the culture of the prison system needs to be redone in a way that is meant to be focused on the future of the people that live in it, criminal or not. Society is difficult

to adjust to when a person has been segregated from people for months or even years, and there must be support for these people to help the mental state of those people that return to society.

Conclusion

Mental health in the US has grown to be a pressing issue that is constantly being charged with many attempts to minimize problematic impacts it places on people. The stigma that exists around the mentally ill still hurts them but many steps have been taken to minimize the impact it has. With many improvements to the accessibility of mental care, the normalization in the US has been improving with more and more people reaching out for help. It currently still hasn't reached a level where it is “good enough” but even if it was, it should not stop there. Advocate groups and victims of mental health are still pushing to further the rights and needs of mental illness protection. Advancements to the accessibility and early actions prove to be advantageous to preventing further severity in cases. As more opportunities for good mental health care become available, the normality of going to receive mental health will become commonplace which will save many lives. There still lies faults where mental health can reach. Advancing the number of opportunities will most likely not solve every issue such as racial cultures, or all suicide cases, but some steps can be taken to at least attempt help the ones that are on the line of choosing between getting help or not.

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