
Mental Health Communication:

What We Know and
What We Can Do Better



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Executive Summary

Twenty-percent of American adults experience a mental health condition every year, and 1 in 25 Americans lives with a serious mental illness. Despite the prevalence of mental health issues, negative stereotypes and stigmas about mental illness persist, causing some individuals to resist seeking treatment and preventing some providers from delivering the most appropriate care. Changing the way Americans talk about mental health conditions can have an impact on how we think about these issues. When considering who can have a significant communicative impact on attitudes about mental health diagnoses/mental illness, we know that journalists reach large, varied audiences, and subtly and overtly influence the way Americans talk about mental health and mental illness. Similarly, the interpersonal encounters healthcare providers (physicians, nurses, pharmacists, specialists, technicians, etc.) have with numerous patients every day—as well as with other healthcare professionals—are very powerful, and help shape patients' beliefs about mental health, mental illness, recovery, and well-being. Further, we think that people who train such professionals can have the largest influence on the national conversation, since these professors, teachers, and other leaders reach large numbers of future professionals every semester. Therefore, in this whitepaper, we address one overarching question: **What are the best ways to train healthcare professionals and journalists about mental health and mental illness communication... and why should we?**

After reviewing extant research around mental health communication, we believe that changing the way our society communicates about mental illness can help reduce stigma, which, in turn, can:

- (a) reduce self-stigma;
- (b) educate people to properly recognize symptoms of mental illness in themselves and others;
- (c) increase the number of people who feel comfortable seeking treatment and support; and
- (d) improve the quality of care they receive.

Based on our review of extant research, we make five evidence-based recommendations for training future journalists and healthcare providers, in order to provide more appropriate, accurate, and respectful language around mental health and mental illness:

1. Increase opportunities for direct contact with mental health consumers.

In the context of mental illness, direct contact with a person who is living with mental health issues has been shown to be more impactful in changing harmful stereotypes than message-heavy, educational approaches (Corrigan, Michaels, & Morris, 2015) such as printed materials or in-class lectures. Medical students and future journalists need direct experience with mental health challenges to fully understand the trials and humanity of mental illness.

2. Encourage students to understand their own mental health, and how mental health issues touch their friends and family.

If students are unwilling to seek their own mental health assistance, they will be less likely to talk about it with patients and will not accurately be able to represent mental health challenges in others.

Plus, when we realize that mental health challenges are all around us—and that people we know and love are living with such diagnoses in a way that goes against negative stereotypes—we begin to chip away at our own stigma.

3. Teach about mental illness in a clear, medical way, and talk about it using person-centered language.

Providing technical, clinical terms and definitions of psychiatric conditions will help students understand that mental illness is, in fact, an illness that should be treated as seriously and thoroughly as strictly-physical conditions. Research suggests that appropriate clinical knowledge leads to better care for patients with mental illnesses like bipolar disorder (King, 2014). However, when talking about and to people experiencing mental health issues, person-centered language (such as "She was diagnosed with schizophrenia" versus "She's schizophrenic.") fosters a sense of respect, individuality, and empowerment.

4. Create a “safe” place for students to discuss perceptions, fears, and biases of mental health.

By giving future physicians, journalists, and other professionals a place to safely express their concerns, ask questions without judgement, and face their implicit biases against mental illness before they go out into the world and begin communicating about mental health on a large scale, we can provide accurate information and positive messaging, which will empower individuals to change their own stigma. When we address our personal biases, stereotypes, and misconceptions, we begin to understand what is true—and what is holding us back from the truth.

5. Help students understand the structural, cultural, and psycho-social determinants of, and factors around, mental health.

By learning how economic and political conditions produce health inequalities between populations, students of all disciplines will develop a more holistic view of mental health, and understand (a) the societal and environmental factors that contribute to mental illness; (b) why some people do not or cannot seek traditional “treatment” for mental health issue; and (c) why and how some individuals must work harder to achieve recovery than others.

In summary, after poring over the past two decades' worth of academic research around mental health communication, education, and stigma, we've come to believe that the more we effectively fight negative stereotypes and stigmas around mental illness, the easier it will be for those in need to seek and receive help. Changing the national conversation—especially by helping providers communicate more clearly with patients and showing journalists how to responsibly frame their stories—is not easy, but it's worthwhile work.

Introduction

01

Introduction:

A message from Mike Mackert

Within healthcare and public health, effective communication is increasingly being recognized as an important factor in improving health outcomes. I was excited for the Center for Health Communication to undertake this project on mental health, because it's an issue where better communication can make a big difference in people's health and lives.

There are no simple answers for how to communicate about mental health the “right” way. Even allies in advancing issues related to mental health can have different and valid views on the use of particular words and language. If this was easy, we would not have had reason and much-appreciated support from the Hogg Foundation for Mental Health to pursue this work.

Instead, it is our hope that through this whitepaper-and associated evidence-based curriculum materials—we can share what we know (and don't yet know) about mental health-related communication. This can contribute to more thoughtful training, practice, and research around how we communicate about mental health.

I hope this whitepaper is useful to those working and teaching in two domains we primarily focused on: healthcare and journalism. More broadly, I also hope it is useful to anyone communicating about mental health to community audiences. By synthesizing and sharing current research about mental health-related communication, we intend to help reduce the stigma around mental health issues, normalize the act of talking about mental health, and help break down barriers to effective mental health treatment and wellness. In this manner, we seek to improve peoples' lives in substantial ways.

It's been an exciting and humbling experience to take on this project. Everyone involved in the work is confident it can contribute to future health communication research, practice, and education in the context of mental health.

Mike Mackert, Ph.D.

*Director, Center for Health Communication
University of Texas at Austin*

WHO WE ARE

This whitepaper was produced by The Center for Health Communication (CHC) at the University of Texas at Austin, funded by a generous grant from the Hogg Foundation for Mental Health, in Austin, Texas.

The Center for Health Communication (CHC) was established in 2014 to bring together researchers and experts on many diverse areas of health communication into one organizational unit where they can collaborate, share ideas and innovations, and advance their scholarship and its impact to the highest possible level. Our mission is to mobilize an interdisciplinary group of scholars and practitioners to create evidence-based health communication research, education, and public health practice.

The CHC is officially a joint academic center of the Moody College of Communication and Dell Medical School. The Center is supported, in part, from the Excellence Endowment established by a generous gift from the Moody Foundation to The University of Texas at Austin.

RESEARCH/WRITING TEAM

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A SPECIAL THANKS

While creating this resource, we tapped into the expertise of educators, media professionals, program administrators, and mental health consumers who generously shared their time and insight. Some of them are quoted directly throughout this whitepaper, while others informed its tone, direction, and content. We thank the following for their time and feedback:

Courtney Aklin, Ph.D
Babette Apland
Stephany Bryan
Magdalena Caballero-Phillips
Kari Cobham, DNP, MPH
Mary Crawford
Nicole Cross, Ph.D.
Tracy Dahlby
Rene Dailey, Ph.D.
Diana Dawson

Erin Donovan, Ph.D.
Ashley Garling, Pharm.D.
Syeda Hasan
Katherine Jones
Lynda Kraxberger
Jung Kwak, Ph.D.
Xiaoshan Li, Ph.D.
Jaime Loke, Ph.D.
Maggie Luna
Michelle Mata

Mia Moody-Ramierz, Ph.D.
Tracey Moore
Charles Nemeroff, M.D., Ph.D.
Uche Onyebadi, Ph.D.
Janet Paleo
Jose Ruben Parra-Cardona, Ph.D.
Deborah Rosales-Elkins
Eileen Rose
Sharon Rush, R.Ph.
Samantha Vogel, Pharm.D, BCPP.

This whitepaper was funded by a grant from the Hogg Foundation for Mental Health. Established in 1940, the Hogg Foundation for Mental Health envisions a future in which the people of Texas thrive in communities that support mental health and well-being. Using a variety of approaches, including grantmaking, convening, research, and public policy, the foundation works collaboratively to transform how communities promote mental health in everyday life.

WHY WE ARE CREATING THIS WHITEPAPER

The Center for Health Communication is an evidence-based, research-driven organization that specializes in collecting, analyzing, and utilizing scientific best practices to create audience-centered communication. In other words, we specialize in using proven tactics to craft messages that resonate with a variety of audiences—not just scientists and researchers. We believe that communication has the power to change minds, policies, circumstances, and lives—and that the most effective messages are properly translated and tailored to meet audiences where they're at. Ultimately, we want to advance the health and wellbeing of people and populations through communication.



artwork by Lucy Miller-Downing, courtesy of the UT Institute for Excellence in Mental Health

Accordingly, from previous research and experience, we know that changing the way people talk about mental health can reduce negative stigma and stereotypes, encourage more people to seek the support they need, and improve overall health outcomes. Communication is not a panacea—simply changing the words we use and the messages we send will not solve all of the political, structural, and social issues around mental health—but using more accurate, sensitive, person-centered language to discuss mental health, mental illness, care, and recovery, and framing mental health issues in a more positive, accurate light, can make a difference. This encompasses large and small goals, from being careful not to inadvertently blame incidents of mass violence on mental illness, to eliminating offensive slang like “nutty” and “cukoo” and helping physicians become more comfortable with and responsive to patients experiencing mental health crises. Clearly, this is no simple task.

To address it, we're focusing on two groups of professionals who regularly communicate with large audiences, and are therefore capable of making immediate and important impacts: healthcare providers and journalists. We're taking a thorough look at how these individuals—whose professions entail unique responsibilities and opportunities to advance how large groups of individuals communicate about mental health—are currently trained to talk about these important topics. Using extant literature and established best practices, we are making educated recommendations for training. Our goal is to provide pragmatic, approachable solutions, so we can begin to change the way everyone thinks and talks about mental health.

FOR TEXAS...AND BEYOND

The Center for Health Communication (CHC)—based at the University of Texas at Austin—has often partnered with local organizations on evidence-based campaigns that improve the health of people in our area. However, while Texas' geography, culture, and policies create mental health issues and solutions that are unique to our state, we realize that some challenges override boundaries. The research summarized and recommendations proposed in this whitepaper can benefit everyone, regardless of geographical or cultural nuances, and will help people around the country think differently about mental health communication.

Further, though this whitepaper focuses on journalists and those who educate future healthcare providers, our recommendations can be easily modified for mass communicators of all types: community organizers, religious leaders, coaches, teachers, etc.

Parameters

02

This Paper's Parameters

» PROBLEM STATEMENT

The way a society views and communicates about a topic is reflective of how it collectively feels about the topic. Communication can impact the way a society perceives virtually any issue. Therefore, changing the way Americans talk about mental health and mental illness can have an impact on how we think about these issues, which can go a long way to influence how we treat those experiencing mental health issues, change policies, and improve access to mental health services. Real change starts with—and leads to—communication changes.

When considering who can have a significant communicative impact, we know that journalists reach large, varied audiences, and subtly and overtly influence the way Americans talk about mental health. Similarly, the interpersonal encounters healthcare providers (physicians, nurses, pharmacists, specialists, technicians, etc.) have with numerous patients every day—as well as with other healthcare professionals—are very powerful, and help shape patients' beliefs about mental health, mental illness, recovery and well-being.

Therefore, in this whitepaper, we address one overarching question:

What are the best ways to train healthcare professionals and journalists about mental health and mental illness communication... and why should we?

The phrase “why should we” may strike some as flippant, but research shows that simply instructing people on what to say or how to act doesn't effectively change behavior. We can't just tell people this work is important: we need to tell the story of why it's important and demonstrate that mental health issues affect everyone—hence, everyone has a role to play in changing the national conversation and fighting the stigma.

In this whitepaper, we first emphasize the importance of this topic by summarizing current facts and statistics about adult mental health conditions in America. Then, we synthesize recent research on stigma, framing, providers' perspectives, and training (or lack thereof) around mental illness. Lastly, we make evidence-based, pragmatic recommendations on how to improve the American conversation about mental health and mental illness.

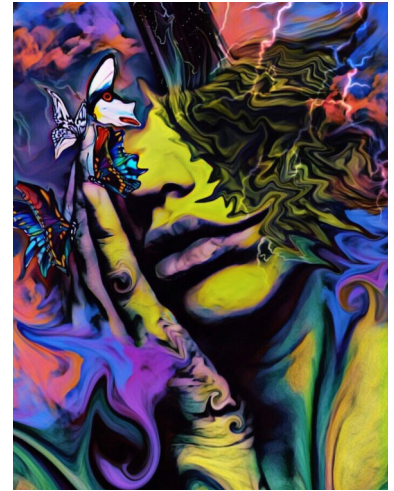
A note on language

“Meeting people where they're at” means acknowledging words, slang, concepts, and framing that currently exist in order to “speak the language” of your audience, and eventually move people away from problematic terms and concepts. For example, the Hogg Foundation for Mental Health has evolved its mission from

¹ We do not include pediatric mental health in this whitepaper, as that field encompasses a unique set of factors, consequences, and solutions. The mental health of children and adolescents deserves more room and consideration than we are able to give it within this whitepaper.

treating mental illness to supporting community environments that promote positive mental health in everyday life. The switch from talking about “mental illness” to talking about “mental health” may seem subtle, but is important.

In addition, there is important work being done within the medical community and beyond to recognize, diagnose, and treat mental illness while also promoting mental health. Though the Hogg Foundation and others on the forefront of this work are phasing out words like “disorders,” “mental illness,” “patient,” and “treatment,” we often employ such terms throughout this whitepaper to mirror language commonly used in research and the medical field. In this manner, we attempt to stay true to words familiar to our audiences in an effort to create an accessible resource, though we also acknowledge that we do not have all the answers, either. This is not an easy topic, and we bring it to light with good intent and the openness to learn.



artwork by JDM, Courtesy of the UT Institute for Excellence in Mental Health

» WHAT WE'RE COVERING — AND WHAT WE'RE NOT

We fully acknowledge that there are biological, structural, political, environmental, economic, and cultural causes of mental illness. Further, there are systematic and institutional barriers to an open, inclusive, effective mental healthcare system. Access to care is dishearteningly unequal, depending on a variety of factors: socioeconomic status, education level, geographic location, ethnicity, employment status, and more. Within this whitepaper, we do not deny the existence of such issues. We focus on the importance of communication and its great potential to change the way our society thinks about mental health, since that is our area of expertise.

To that end, we also chose to home in on issues and solutions concerning traditional, mainstream journalists, and did not include bloggers, social media influencers, or other “citizen journalists” in our research or recommendations. Though these individuals have power and responsibility to shape the national conversation (on a variety of topics) in an accurate and sensitive way, their processes, motivations, and challenges are often different than employed journalists, and they have different resources. While we believe our recommendations (see Recommendations, page 34) are broad enough to apply to many audiences, and we cite several studies focused on the power of social media, we intentionally limited our scope, in the interest of time and readability.

Methodology

To get a holistic picture of what is already known about mental illness prevalence, treatment-seeking, stigma, outcomes, and mass communication about mental health, we searched through several major academic research databases, including:

- MEDLINE
- PubMed
- PsycINFO
- Communication and Mass Media Complete (CMMC)

We also utilized national online resources, including websites and materials, such as:

- National Alliance on Mental Illness (NAMI.org)
- World Health Organization (who.int)
- American Psychiatry Association (psychiatry.org)
- National Institutes of Mental Health (nimh.nih.gov)
- Substance Abuse and Mental Health Services Administration (samhsa.org)

To understand what leading journalism and medical programs are teaching students—and what lessons are lacking— regarding mental health, mental illness, and issue framing, we reached out to the following organizations:

- The University of Texas at Austin, Moody College of Communication
- Texas Christian University, Bob Schieffer College of Communication
- Baylor University, Department of Communication
- Baylor College of Medicine
- Missouri School of Journalism, University of Missouri
- New York University, The Arthur L. Carter Journalism Institute
- Northwestern University, Medill School of Journalism, Media, and Integrated Marketing Communications
- Spectrum News, Austin
- KERA News, Dallas
- American Public Media
- The Carter Center’s Mental Health Program
- National Institute on Minority Health and Health Disparities (NIMHD)

DEFINITION OF KEY TERMS

Considering this project is focused on communication and that we believe word choice is important, it’s important to define and clarify a few of the key terms used throughout this document.

» **Mental Health:**

More than the mere absence of a mental illness, the World Health Organization (WHO) defines mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2004).

» **Mental Illness:**

The American Psychiatric Association (2018) defines mental illness as: “health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work, or family activities.” The National Alliance on Mental Illness (NAMI) defines mental illness as “a condition that affects a person’s thinking, feeling, or mood,” and uses the term to refer collectively to all diagnosable mental disorders that significantly change one’s thinking, emotion or behavior, and creates problems functioning in social, work, or family activities.

» **Mental Health Condition:**

This term, along with “mental health diagnosis” or “mental health issue” is often favored over “mental illness” by individuals experiencing conditions such as schizophrenia, depression, bipolar disorder, or other psychiatric conditions.

» **Behavioral Health:**

Behavioral health is a blanket term that describes how behaviors and habits impact someone’s physical and mental well-being. As a discipline, behavioral health encompasses mental health, psychiatry, neurology, marriage and family counseling, and addiction treatment and therapy.

» **Any Mental Illness (AMI):**

AMI describes any condition that is considered a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness as defined below; NIMH, 2019).

» **Serious Mental Illness (SMI):**

SMI is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. (NIH, February 2019)

» **Health Communication:**

Health communication is the science and art of using communication to advance the health and well-being of people and populations.

» **Stigma:**

The dictionary definition of stigma is “a mark of disgrace associated with a particular circumstance, quality, or person”. Stigma is an act of physical or emotional social distancing that happens when we perceive a group as “other” and “not like us.” Stigma arises when two key ingredients are present: 1) a negative stereotype about a group of people or condition; and 2) actions people take to distance themselves from being associated with that group or condition. In this whitepaper, we acknowledge that mental illness has long been a misunderstood, taboo topic, which has contributed to a stigma around people who experience conditions such as depression, schizophrenia, bipolar disorder, and obsessive-compulsive disorder.

» **Self-Stigma:**

Self-stigma occurs when a person with a mental health diagnosis becomes aware of public stigma, agrees with those stereotypes, and internalizes them by applying them to the self (Corrigan, Larson, & Kuwabara, 2010). The consequences include diminished self-esteem, self-efficacy, and confidence in one’s future.

» **Consumers:**

Different terms have been used to describe individuals who receive treatment for mental illness, including “patients,” “users,” “clients,” and “consumers.” In this whitepaper, we use “mental health consumers” as people who are actively seeking mental health services, such as counseling, medical help (including psychiatric treatment and prescriptions), mental health-related community resources, or other such services.

» **Patients:**

This term is used in health contexts to describe a “patient-provider” environment or relationship and is used within this paper to designate individuals who are actively seeking treatment from healthcare professionals.

» **Treatment:**

Though the term treatment is still used in research and clinical settings and by medical professionals, some individuals living with mental health issues consider the term outdated. We use it in this whitepaper when it is the term chosen by authors or organizations we are quoting and when summarizing research, to represent physical, psychological, psychiatric, holistic, or otherwise therapeutic therapy used to manage or alleviate symptoms of mental illness and/or to promote better mental health. It is worth noting that not all mental health consumers opt for treatment, and treatment-seeking is not always the ideal outcome for someone with mental health concerns.

» **Healthcare Providers:**

The National Institute of Health Policy (2017) identifies six groups of healthcare providers: doctors of all specialties; nurses; pharmacists; technologists and technicians; therapists, such as physical therapists, occupational therapists and speech therapists; and administrative staff in a doctor’s office, clinic, or hospital. In this whitepaper, our research and recommendations directly apply to the first five groups, whose main responsibility is to provide front-line care to patients and less to administrative staff.

» **Media/Journalists:**

For the purpose of this whitepaper, we are focusing on “traditional” media and journalists—print, radio, and television journalists and editors— rather than social media and social influencers or bloggers. While we recognize the power that social media leaders have in molding conversations around mental health and mental illness, many social media influencers are not formally trained in communication or journalism, and are often not guided or overseen by organizations that have specific stylistic, ethical, and topical guidelines. Therefore, while the concepts and recommendations presented in this whitepaper can readily be applied to social media, they are presented with traditional media creators in mind.

» **Community Leaders:**

All communities have leaders, both formal (city council, school principals and teachers, heads of non-profit groups, etc.) and informal (coaches, preachers, avid volunteers, volunteer community organizers, etc.).

In this whitepaper, we do not directly address the unique concerns, responsibilities, and privileges of community leaders. However, we recognize their important role in communicating to large groups about mental health and mental illness, and we value the contribution they can make in changing the national discussion about mental health. Our recommendations can easily be modified—and in some cases, directly applied—to these important allies.

Context

03

Context & Background

» MENTAL ILLNESS IN AMERICA

Mental health issues are common, yet often unseen

According to the National Alliance on Mental Illness (2019), in 2018, 47.6 million adults aged 18 or older reported experiencing a mental health condition at some point during the previous year (defined as any mental, behavioral, or emotional disorder that meet DSM-IV criteria), including 11.4 million adults who experienced a serious mental illness (SMI). This means that 1 in 5 American adults experience a mental health condition every year, and 1 in 25 lives with a serious mental illness.

Though mental illness is often invisible, people with mental health issues are not: they are your friends, your neighbors, your family members. There are more people at work with mental health conditions than ever before; according to a 2017 U.K. report, it is believed that approximately 15% of people in workplace settings have symptoms of an existing mental health condition (Stevenson & Farmer, 2017). Since 1981, mental illness has become the second-most common cause of disability in the United States, as indicated by Social Security disability claims (2013) and has long been tied to higher rates of premature death (Thornicroft, 2013).

It is estimated that 70% of those diagnosed with a mental health condition also experience a co-morbid condition (Kessler et al., 2004), such as poor cardio-metabolic health, higher rates of obesity, diabetes, and metabolic syndrome—and in higher rates than in the general population (Firth et al., 2019). Additionally, a 2019 meta-analysis (Sprah et al., 2017) found that patients with mental disorders are at increased risk of hospital readmission.

Note: Until fairly recently, premature mortality was mainly thought to be connected to the higher suicide rate amongst those with mental health conditions (Chesney, Goodwin, & Fazel, 2014). However, in recent years, studies have suggested that a significant portion of the cumulative years lost to mental illness are due to poor overall physical health and comorbidities (Reilly, Olier, & Planner, 2015; Thornicroft, 2011).

» SPECIFIC RATES OF MENTAL ILLNESS

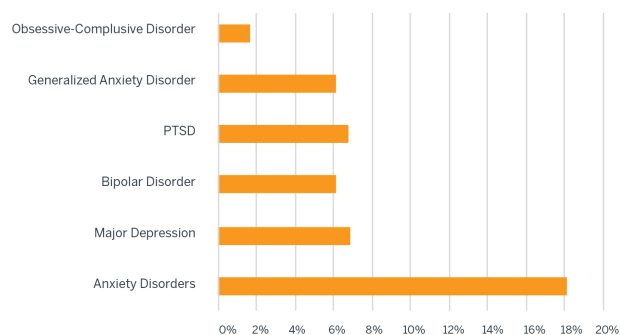
The 2018 rate of mental health conditions in American adults (19.1%) held steady from the prior year, but these last two years were slightly higher than most years from 2008 to 2016 (SAMHSA, 2019). Between 2018 and 2019, the number of adults reporting serious thoughts of suicide increased by 200,000 (4.04%, or over 9.8 million).

Anxiety disorders are the most common mental health conditions in the U.S., affecting 40 million adults in the United States age 18 and older, or 18.1% of the population every year. According to NIMH, 16 million American adults (6.9% of the population) have major depression, while 6.1 million (2.6%) are diagnosed with bipolar disorder. A 2005 report (Kessler et al., 2005) estimated that 6.8% of Americans have experienced

post-traumatic stress disorder (PTSD) in their lifetimes, 4.7% of Americans have experienced generalized anxiety disorder at some point, and 1.6% of American adults will experience obsessive-compulsive disorder.

These statistics only tell the overarching story; however, upon further inspection, mental illness rates for various groups have been changing in the past decade.

Rates of Mental Health Conditions in America



Sources: NIMH (2018); Kessler et al., (2005)

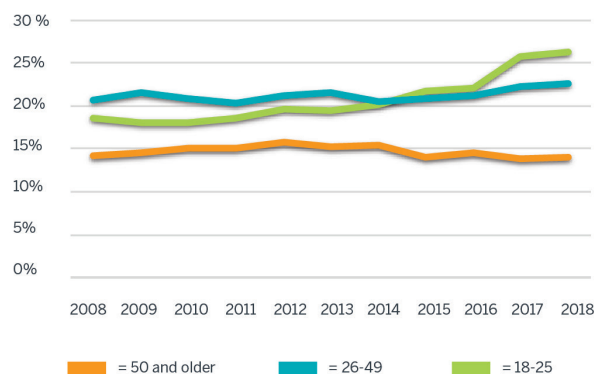
» SPECIAL POPULATIONS

Though rates of mental health conditions are lower in Black individuals (16.8%) and Hispanics (15.3%) than in White individuals (19%), people who identify as being two or more races (24.9%) are most likely to report any mental health condition within the past year than any other race/ethnic group (American Psychiatric Association, 2017). Though Asian-Americans report the lowest rate of mental health conditions (13.4%), they are least likely to receive services (22%; see "Mental illness treatment and barriers," below).

Youth

The rate of youth experiencing a mental health condition continues to rise. The rate of youth experiencing Major Depressive Episodes (MDE) increased from 11.93% in 2017 to 12.63% in 2018 (Mental Health America, 2019). This is in line with a disturbing trend; according to a 2019 report by Twenge et al., the rate of individuals reporting symptoms consistent with major depression in the prior 12 months increased 52% in adolescents from 2005 to 2017 (from 8.7% to 13.2%) and 63% in young adults age 18 to 25 from 2009 to 2017 (from 8.1% to 13%). There was also a dramatic increase in young adults experiencing serious psychological distress in the previous 30 days from 2008 to 2017 (from 7.7% to 13%). The rate of young adults with suicidal thoughts or other suicide-related outcomes increased 47% from 2008 to 2017.

Any Mental Illness in the Past Year among Adults Aged 18 or older: 2008-2018



Age	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
18-25	18.5%	18.0%	18.1%	18.5%	19.6%	19.4%	20.1%	21.7%	22.1%	25.8%	26.3%
26-49	20.7%	21.6%	20.9%	20.3%	21.2%	21.5%	20.4%	20.9%	21.1%	22.2%	22.5%
50 or older	14.1%	14.5%	15.1%	15.0%	15.8%	15.3%	15.4%	14.0%	14.5%	13.8%	14.0%

Source: SAMHSA (2019), Results from the 2018 National Survey on Drug Use and Health

Seniors

The CDC (2008) estimates that 20% of people age 55 years or older experience some type of mental health concern. The prevalence of depression is higher in elderly individuals living in nursing homes and is thought to vary between 14% and 42% (Gerety et al. 1994; Evers et al. 2002). The most common mental health issues in seniors include anxiety, severe cognitive impairment, and mood disorders (such as depression or bipolar disorder), while SMI's such as schizophrenia and bipolar disorder are less common in old age. According to Twenge et al. (2019), these rates are holding fairly steady over time; between 2005 and 2017, there was no significant increase in the percentage of older adults experiencing depression or psychological distress. In fact, researchers saw a slight decline in psychological distress in individuals over 65.

Rural populations

A 2017 report by the Substance Abuse and Mental Health Services Administration noted that 19.1% of adults in non-metropolitan/rural counties, or roughly 6.8 million people, reported any mental illness (AMI) that year. In addition, 4.9%, or nearly 1.7 million, of residents of non-metropolitan counties experienced serious thoughts of suicide during that year. Though some studies have reported that the risk of serious mental illness is higher in urban areas than in rural communities, there is no solid evidence to confirm that causal link (Breslau, Marshall, Pincus, & Brown, 2014), and sociological and environmental factors must be considered when making such an assumption (Gruebner et al., 2017).

» MISDIAGNOSIS AND UNDERDIAGNOSIS

A 2013 study from researchers at Johns Hopkins Bloomberg School of Public Health (Mojtabai, 2013) suggests more than 60% of people who receive a diagnosis of major depression don't actually have it. The study observed more than 5,600 patients who received a depression diagnosis in a non-hospital setting and found that 6 out of every 7 participants did not meet the major depressive episodes criteria authorized to diagnose individuals.

One reason for misdiagnosis is a lack of cultural understanding by healthcare providers. Language differences—or differences in the terms and phrases various cultures use to describe symptoms—can complicate the diagnosis process. For example, a “sinking heart” is a common way that Punjabi Indians describe social and emotional distress (Krause, 1989), but idioms or descriptions of seemingly physical issues can hinder physician’s recognition of mental health issues (Bhui et al., 2004). The way that various cultures understand mental health can also be a barrier to accurate diagnosis and treatment; in interviews with 30 Anglo-Australians and 28 Indian-Australians (Brijnath & Antonaides, 2018), researchers found that while Anglo-Australians perceived their depression as a chronic illness that would be with them for the rest of their lives, Indian-Australians thought of depression as a short-term problem. Therefore, when months passed without relief of their depressive symptoms, the Indian-Australians noted that their depression worsened, because they felt that regular life could not resume until they were “cured.” Stigma against mental illness among minority groups can prevent some people from even seeking help in the first place (APA, 2017).

Lastly, variations in presentation of symptoms—as well as implicit provider biases—may also complicate diagnosis. For instance, African Americans, especially women, are more likely to experience and mention physical symptoms related to mental health problems, but physicians may not recognize these symptoms as mental health-related (NAMI, 2019). In a 2015 report by SAMHSA, Hispanic respondents were more likely than White individuals, African Americans, or American Indians to cite prejudice and discrimination as a major reason they do not use mental health services.

Mental illness treatment rates and barriers

According to Mental Health America (2019), 43.3% of U.S. adults with any mental illness received treatment in 2018, while 64.1% of U.S. adults with serious mental illness received treatment in 2018. This means that more than 24 million American adults with a mental health issue are going untreated. Anxiety disorders, in particular, are highly treatable, yet only 36.9% of those living with one receives treatment. People from racial/ethnic minority groups are less likely to receive mental health care than White individuals; in 2015, among adults with any mental illness, 48% of White individuals received mental health services, compared with 31% of African Americans and Hispanics, and 22% of Asian Americans.

According to Mental Health America (2019), more than 20% of American adults with a mental illness reported that they were not able to receive treatment they needed—this number has not declined since 2011. Major treatment hurdles include: (a) no insurance or limited coverage of mental health services; (b) lack of available psychiatrists; (c) low availability of treatment types; (d) a disconnect between behavioral health systems and primary care systems; and (e) insufficient funds to cover costs, including co-pays.

Another sizeable issue that prevent people from seeking mental health care is attitudinal factors. In the 2011 National Comorbidity Survey (Mojtabai et al 2011), 72.6% of adults who in the past 12 months “felt that

they might have needed to see a professional for problems with their emotions, nerves, or mental health” said they instead desired to handle the problem on their own, and thus did not seek treatment. (That was also the most common reason cited for dropping out of treatment.)

» CHANGING ATTITUDES, CHANGING COMMUNICATION

Western society has long struggled with how to talk respectfully and accurately about mental health and mental illness. Researchers, practitioners, and advocacy groups are constantly evolving our understanding of what mental illness is, where it comes from, and how we can best support those who experience it.

Historically, mental illness was treated as a moral deficiency, or a sign of a weak character. This perception implied that mental health was under a person’s complete control and that mental health problems could be stopped or “cured” anytime the individual chose. This attitude is problematic for several reasons, including that it encourages blaming people facing mental health issues for their “bad choices” and promotes forcing such individuals into ineffective treatments for their “own good.” Further, when the onset of mental illness is viewed as being within an individual’s control, others are more likely to avoid them and/or withhold support (Corrigan et al., 2003).

As our understanding of mental health evolved, we began to understand that mental health issues were not simply moral failings of the individual. However, we still sometimes incorrectly attribute mental illness: for example, as late as the 1970’s, mental health issues—particularly schizophrenia—were frequently credited to poor parenting (Harrington, 2016).

In the mid-1950’s, Dr. Shirley Star began an important line of research around mental health conditions and stigma. Through one extensive mixed-methods study, she concluded that people typically use three criteria to decide if someone’s behavior qualifies as “mental illness”:

- 1) there is a loss in cognitive functioning, or the person does not consciously know what they are doing;
- 2) a loss of self-control, in that the person cannot be held responsible for his or her actions, and
- 3) the behavior is inappropriate, unreasonable, or unexpected in that context (Link & Stuart, 2017).

This paved the way for a new attitude about mental health: in the 1980s through the early 2000s, there was a push to re-frame mental illness as a brain disease, a disorder like diabetes or cancer that has physical causes, rather than a moral flaw or lack of character. There is some evidence that this approach decreases personal blame for psychiatric issues and reduces others’ social avoidance of people experiencing mental health challenges (Corrigan & Watson, 2004). However, framing mental illness as a brain disorder that is not someone’s “fault” and cannot quickly and easily be cured by them “sucking it up” or “snapping out of it” may have the unintended effect of creating benevolence stigma (Brockington et al., 1993), in which the patient (and others) thinks of him/herself as ineffectual and in need of constant help. This may promote the idea that mentally ill people are dangerous, unstable, and out of control (Read & Law, 1999).

» WHY IS IT IMPORTANT TO TALK ABOUT MENTAL HEALTH IN A RESPECTFUL WAY?

It’s clear that talking about mental health issues is not easy; the topic is nuanced and highly personal. But if we use research, compassion, and a person-centered attitude to guide our national conversation around mental health, we can begin to make significant change in how our society understands mental illness and supports individuals living with mental health challenges in the following ways:

We can reduce the stigma around mental health conditions

One of the biggest challenges around mental health conditions is stigma, or the social distancing that happens when mental health consumers are perceived as a negative and “different” group. The stigmatization discourages open conversation about mental health, implies that mental illness is shameful, perpetuates incorrect myths about those experiencing serious mental illness (e.g. that they are dangerous), and enforces the idea that people with mental health issues should be avoided. De-stigmatizing mental health conditions and serious mental illness can change these attitudes.

Changing the national conversation about mental health can also alleviate and/or prevent self-stigma. A study of YouTube videos created by patients with severe mental illness found that sharing their stories with other SMI patients empowered them, helped normalize SMI, and served as a chance to give and receive social support.

We can teach people to properly recognize symptoms in themselves and others

Stigma can prevent people from fully understanding mental illness and impact peoples' ability to recognize symptoms of mental health issues. A recent study (Hahm et al., 2019) explored the connection between stigma and admission of cognition problems (which are an initial sign of mental illness). In people who had no prior contact with a person who had mental health issues, the more strongly they held specific stigmatizing attitudes (i.e., people with mental health issues are different, they are not treatable), the less attuned they were to their own poor performance on a concentration test. In other words, if they did not have prior contact with someone experiencing mental health issues, they tended to stigmatize mental illness, and were therefore less sensitive to their own symptoms. This indicates that interventions that aim to reduce stigma may help facilitate the accurate and early diagnosis of mental health issues.

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We're not looking for people to cure us, we're looking for the answers to heal ourselves. The more information we're given to do that, the more we can pick and choose what works for us.

—Deborah, Peer Counselor at Integral Health in Austin, TX, and Individual Living With Mental Health Consumer

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To fight stigma and misinformation—which, in turn, will help people truly understand and recognize mental illness—it is imperative to use proper language and talk about mental health in more accurate ways. For example, people commonly joke about being “depressed” about things like rainy weather or Monday mornings. Such inaccurate slang perpetuates a dramatic misunderstanding about what clinical depression is, what it “looks like,” and when to seek help for it.

According to the American Psychiatric Association (2019), depression (or major depressive disorder) causes feelings of sadness and/or a loss of interest in activities once enjoyed and can lead to a variety of emotional and physical problems, as well as decrease a person's ability to function at work and at home. Symptoms of clinical depression include loss of interest in activities once enjoyed, change in appetite, trouble sleeping, fatigue, and thoughts of death or suicide. For a clinical diagnosis of depression, symptoms must last at least two weeks.

However, being sad is not the same as having depression. Losing your job, ending a relationship, or dealing with the death of a loved one can bring about feelings of sadness or grief. Though people experiencing situations like this say they are “depressed,” we should take care not to interchange these terms. Depression affects approximately 1 in 15 adults (6.7%) in any given year; about 1 in 6 people (16.6%) will experience depression at some time in their life (American Psychiatric Association, 2019).

If we describe everyday sadness as “depression,” we confuse a normal human emotion with a serious clinical illness, and people experiencing depression may assume they're “just sad,” or that they'll “snap out of it,” thus avoid seeking professional help.

We can improve the rate of treatment-seeking amongst those with mental health issues

According to previous research, “...stigma has been identified as one of the primary barriers to access care and to receiving equitable quality of care” (Abbey et al., 2011; Schulze & Angermeyer, 2003; Schulze, 2007; Stuart et al., 2012). This can contribute to greater internalization of stigmatizing beliefs and self-silence among persons living with mental illness, inadequate access to proper treatment, less treatment compliance, breakdown of the therapeutic relationship, and greater avoidance of healthcare services (Byrne, 2000, 2001; Corrigan, 2004; Ross & Goldner, 2009; Schulze, 2007; Schulze & Angermeyer, 2003; Thornicroft et al., 2007).

But there is hope. By communicating more effectively and accurately about mental health and mental illness, we can help fight the self-stigma that often comes with such diagnoses. For example, a program called Honest, Open, Proud (HOP) is a peer-led group-based intervention for those who self-identify as living with mental health issues. In a randomized experiment of 118 college students at three universities in 2019,

HOP-College was shown to: (a) reduce internalized harm from self-applied stereotypes; (b) improve students' beliefs about their resources to cope with stigma-related distress; and (c) improve self-efficacy about disclosure of their mental health status.

Once people do seek treatment, we can improve the care they receive.

According to one meta-analysis (Luoma, Martin, & Pearson, 2002), approximately 75% of people who died by suicide had contact with their primary care provider within the year before their suicide, and one-third had contact with mental health services, specifically. More disturbingly, on average, 45% of people who died by suicide had contact with primary care providers within one month of their suicide.

There may be a host of reasons for this disconnect between people who are considering suicide and the healthcare providers who could help them: suicide is not always planned out well in advance, not all symptoms of depression are visible, people suffering from mental health issues sometimes hide or downplay their symptoms, etc. But clearly, patients and physicians are often missing important conversations around mental health. Opportunities for mental illness screening and suicide prevention are there—we're just not taking advantage of them.

Another factor that contributes to ineffective mental health diagnosis and care is "diagnostic overshadowing" in which a clinician blames symptoms on a patient's underlying psychiatric disorder, rather than accurately tying symptoms to a physical illness (The Lancet, 2019). For example, if a patient diagnosed with bipolar disorder mentions that she has been gaining weight despite a lack of appetite and always feels overly tired, a physician may assume that these symptoms are tied to the mental health issues rather than accurately diagnosing the patient as suffering from hypothyroidism. The result is that their other health problems can go undiagnosed and untreated.

By giving physicians—particularly general practitioners—a more specific, accurate, and bias-free way of understanding, diagnosing, and talking about mental health issues, we can improve the quality of care that people receive when they seek treatment or assistance for mental health conditions.

Research

04

Extant Research:

What we know about Mental Health Communication

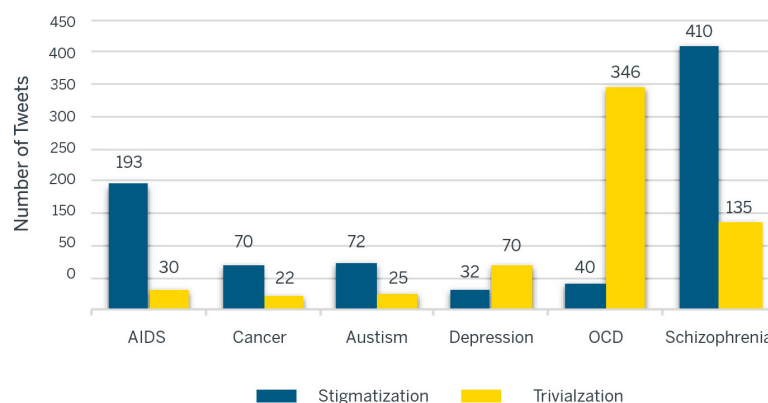
Social scientists, researchers, and medical professionals have long studied our perceptions and communication around mental health and mental illness. Below is a curated summary of relevant, peer-reviewed research, which can not only help us understand issues like mental illness-related stigma and bias in a holistic way, but also and lead us toward evidence-based solutions.

» STIGMA — WHAT IT IS, WHAT IT DOES

Stigma is the “othering” of a group of people who have traits considered to be “undesirable.” To the person who is stigmatized, it can feel like blame, judgement, or discrimination. Communication creates and reinforces stigmas (e.g. Link & Phelan, 2001; Smith, 2007), but stigma can be felt by anyone who believes that part of their identity is considered undesirable by others.

Though mental illness stigma is found among people of all races, ages, and cultures, older, non-White males with fewer years of education have been shown to hold greater endorsement of stigmatizing beliefs (Corrigan & Watson, 2007; Parcesepe & Cabassa, 2013), perceived public stigma, self-stigma, and decreased initiation of mental health services (Wu et al., 2017). A 2019 study of ethnically and socioeconomically diverse sixth-grade students (DuPont-Reyes et al., 2019) found that after reading vignettes describing a fictional peer’s experience with bipolar disorder and social anxiety, Black boys reported less knowledge about—and less positive attitudes about—mental illness than Black girls or White girls and boys. Similarly, Black boys and Latino boys had more discomfort around mental illness than White girls, and Black and Latino girls and boys wanted more social separation from those experiencing mental illness in comparison to White girls.

Stigmatization and Trivialization on Twitter



Source: Robinson, Turk, Jilka, & Cella (2019)

There is evidence that stigma against mental illness is diminishing; a 2014 survey of Californians (Collins et al., 2014) suggests that negative attitudes toward people experiencing a mental health condition (such as “I would be unwilling to move next door to someone with a mental illness”) are 30 to 50 percent lower in young adults than in older Californians. However, researchers are unclear what is leading to these results: perhaps social attitudes toward mental health are changing, or maybe people become more negative about mental illness as they age.

There is also the problem of trivialization, which is flippantly talking about serious things in a silly and inaccurate way. One recent study (Robinson, Turk, Jilka, & Cella, 2019) found that mental illnesses were more stigmatized and trivialized than physical health issues on Twitter. Interestingly, the study found that mental illnesses that were stigmatized were less trivialized, and vice versa. For example, 32 tweets stigmatized depression, but 70 tweets trivialized it. In this study, the gap was worse for schizophrenia, in that 410 tweets stigmatized, while 135 trivialized (see chart, above). This may indicate that the less stigmatized a condition becomes, the more it feels acceptable to trivialize it—however, trivialization makes it harder for people to accurately recognize serious symptoms and can marginalize the feelings and triumphs of those who actually have the illness in question.

What is the impact of stigma?

Stigmatized individuals often feel isolated and may not perceive the availability of social support. Further, stigma can cause a sense of shame or guilt, as if they have intentionally caused their “problem” and are personally responsible for it. As a result, a serious consequence of stigma is its effect on help-seeking: those living with mental health problems are less likely to seek help if they feel their condition is stigmatized (Yap, Reavley, & Jorm, 2013). Additionally, stigma has been shown to increase suicidality, symptom relapse, and hospital admissions (Eagles, Carson, Begg, & Naji, 2003; Penn, Kohlmaier, & Corrigan, 2000).

Unfortunately, researchers have found that fighting internalized stigma, or “self-stigma” is quite difficult and that “these internalized perceptions may be more difficult to deal with than the illness or disability itself” (Stuenkel & Wong, 2009, p. 64). However, a good first step is open, accurate, and sensitive communication about stigmatized conditions like mental illness. A 2012 study determined that in countries where the general public felt more comfortable talking to people with mental illness, those living with mental illness had lower rates of self-stigma, perceived lower rates of discrimination, and felt more empowered (Evans-Lacko, Brohan, Mojtabai & Thornicroft, 2012).

Though we now believe that mental health issues are not an individual’s “fault”, but are caused by genetic and environmental factors similar to physical illnesses, this attitude can be unintentionally disempowering or infantilizing to these patients if exhibited in the wrong way. In their “[Why Social Science](#)” blog, Burnette and Desmarais explained a study regarding problematic substance abuse (Oct. 22, 2019). Participants—all of whom had a history of problematic substance use—were asked to read one of two passages about substance misuse: one in which it was framed as a disease, and one that explained the various factors that combine to create a substance abuse situation. Those who read about addiction as a disease reported weaker beliefs in their potential to change their own substance-related behavior and were less confident in their ability to stop misusing alcohol and drugs.

A 2019 study of 167 adults with SMI who were receiving treatment found similar results. In participants with higher education levels (some college or more), actual stigmatizing experiences led to greater engagement in their own treatment, but self-stigma was associated with poorer treatment engagement (Hack et al., 2019). Why is this? The researchers suspect that people with more education may be better able to critically analyze and resist stigmatizing messages from others, but may also base more of their self-worth on financial or occupational achievement, so when they internalize stigmatizing messages—i.e. that mental illness diminishes one’s ability to achieve what you want—they become demotivated, lose hope, and become less engaged in their treatment.

In summary, even if an individual can ward off the effects of public stigma, self-stigma can have real consequences on his or her mental health outcomes.

» MENTAL HEALTH IN THE MAINSTREAM MEDIA

What is framing, and what impact does it have on our conversation about mental health?

“Framing” is the communicative process of highlighting and focusing on certain aspects of reality (Birkland & Lawrence, 2009). Public discourse—and thereby public attitudes—can be changed when certain people make certain claims about a common issue’s causes and solutions. By using certain words or phrases, linking issues together, or talking about issues in specific places or specific times, we can change an audience’s perception about those issues. Framing is most obvious when the topic at hand is controversial: for instance, mass shootings in America are framed in different ways by various political parties and figures in order to drum up support for their proposed solutions.

In the context of mental health, mainstream media has a big impact on how our society talks and thinks about mental illness. Research suggests that positive reports and social media posts about schizophrenia, psychosis, bipolar disorder, or general mental illness can lower stigmatizing attitudes, while negative reports and posts are likely to increase stigmatizing attitudes (Ross, Morgan, Jorm & Reavley, 2019).

Tying mental health together with other issues can frame it in a certain light. In one study, researchers asked 293 college students to read five short, fictitious news articles regarding a mass shooting incident, then answer questions about attitudes toward people with mental health issues (Wilson, Ballman, & Buczek, 2016). Students reading stories that highlighted the fictitious shooter’s history of mental health issues were more likely to perceive mental illness as dangerous and were less likely to believe that recovery from mental illness is possible, versus those reading stories that did not mention mental health at all.

Another study (Hecht, Kloss, Bartsch, & Oliver, 2019) asked participants to view videos about either schizophrenia or autism; some participants viewed videos that were framed as fact, while others viewed videos framed as fiction. Further, some videos used emotionally moving background music, while others used neutral music. Videos with emotionally moving music lead to higher ratings of empathy than did videos with neutral music, and empathy increased more for viewers watching the video framed as fact. (It has been suggested that higher levels of empathy can reduce mental health stigma; Bartsch et al., 2016; Batson et al., 1997; 2002; Oliver et al., 2012).

Whether positive or negative, intentional or subconscious, it’s clear that a story’s framing can significantly impact its effect on an audience. Words have power, and we need to be responsible in using them.

How does the media link mental health to catastrophic events or tragedies?

Mass shootings, while unacceptably frequent in America, are always tragic. The confusion, sadness, and anger that these incidents elicit often spurs renewed interest in mental health treatment. The often-random nature of such events, which often take place in public or seemingly “safe” places, tend to feed the public’s longstanding fear that individuals living with mental health conditions are unstable and dangerous (Angermeyer & Dietrich, 2006). This, unfortunately, bolsters public concerns about a link between mental illness and mass violence (Wilson, Ballman, & Buczek, 2016).

Sometimes, the connection between mental illness and mass violence is expressly communicated. For example, in November of 2017, when 26 people were shot to death in a Texas church, President Trump said in a press conference, “I think that mental health is your problem here. ...This isn’t a “guns” situation” (Baker, 2017).

Other times, the supposed connection is expressed more covertly. Mass tragedies like the Virginia Tech or Newtown shooting often spur national conversations to increase funding for mental health initiatives. But while the intentions may be good, the timing may unintentionally deepen the incorrect assumption that mental illness leads to violence (Fox & DeLateur, 2014). In an April 8, 2013, speech in Hartford, Connecticut, which came on the heels of the Sandy Hook school shooting, then-President Barack Obama urged Congress to prevent similar tragedies in the future: “We need to help people struggling with mental health problems get the treatment they need before it is too late.” When framed in this manner, Obama’s statement could be interpreted as implying that mental health consumers will all, eventually, lash out violently. Further, statements like this imply that the only reason we should fund mental healthcare is to prevent mass tragedy, not because we care about people. As Swanson (2008) suggests, “We should endeavor to help the mentally ill out of concern for their well-being, not just because we are worried about the well-being of those they might kill.”

Reporting sometimes distorts reality

Researchers have found no clear relationship between psychiatric diagnoses and mass murder (see Busch & Cavanaugh, 1986; Dietz, 1986; Taylor & Gunn, 1999), and many studies have shown that individuals living with mental health conditions, on average, are not violent (Choe, Teplin, & Abram, 2008); research shows that only 4% of violent crimes are committed by individuals with mental health issues (Fazel & Grann, 2006). As a matter of fact, research shows that individuals with mental illness are more likely to be the victims of violence than the perpetrators of violence (Choe et al., 2008). While it is true that individuals with mental illness do perpetrate more violence than the general population (7% of persons with mental illness versus 2% of the general public commit violent crimes), the increase in aggression associated with psychological difficulties is small and is thought to be caused by factors such as substance abuse or medication non-compliance, rather than the actual mental illness (Fazel, Gulati, Linsell, Geddes, & Grann, 2009; Swartz et al., 1998). On Jan. 9, 2020, medical professionals and professors from Texas testified during a four-hour hearing of the Texas House of Representatives committee on Mass Violence Prevention and Community Safety, saying that hate and domestic violence are more common, reliable indicators of violence than mental health issues (KVIA.com, Jan. 9, 2020).

But that's often hard to tell, based on how these stories are reported. A 2016 analysis (McGinty et al., 2016) of 400 new stories regarding mental illness published in various types of media between 1995 and 2014 found that 55% of them mentioned violence, while only 14% described successful treatment and recovery from a mental illness—and only 7% profiled a person in successful recovery. Though the proportion of news stories mentioning both mental illness and violence did not increase over those two decades, these stories were more likely to appear on the front page in the second decade studied. In other words, we're still incorrectly tying mental health issues to violence, and we're doing so in a more prominent way.

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When people talk about mental illness, a lot of time that's tied in with homelessness, or violent behavior. If I think I want to go get help [for mental illness], but all I see is that the people who need help are those who are shooting up the country, I'm not going to get help. We need more [communication] on the positive side of mental health, the preventive side, quite frankly.

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—Dr. Courtney Aklin, Chief of Staff, National Institute on Minority Health and Health Disparities

In an analysis of 433 news reports on mass shootings published between 2013 and 2015 (Duxbury, Frizzell, & Lindsay, 2018), researchers determined that race is a “strong determinant” of whether journalists frame the shootings as caused by mental illness. News stories were 19 times more likely to present mental illness as a cause for mass shootings when the gunman was White (and 12 times more likely to do so when the gunman is Latino) than when the gunman is Black. In the case of a Black gunman, stories tend to present environmental factors (such as childhood abuse or living in an economically disadvantage neighborhood) as causes of violence. This type of framing takes blame off of White shooters—and onto mental illness—while focusing on the criminality of shooters of color. Not only does this perpetuate racial stereotypes, it propagates the idea that mental illness cannot be controlled and causes people to be dangerous.

Subtle word choices and the tone of a media story can have a big impact on its overall effect. For example, a series of randomized experiments exploring news media's coverage of poverty (Iyengar, 1990) found that event-focused news coverage emphasizing specific individuals or events can lead to readers blaming poor individuals for their own poverty. On the contrary, thematic news coverage of poverty—stories that described poverty in large, general terms—led respondents to more frequently attribute responsibility for poverty to societal factors. With this in mind, one research team (McGinty et al., 2014) found that during the years of 2007, 2011, and 2012—the years of the Virginia Tech shooting, the Tuscon, Arizona shooting and the Newtown, Connecticut shooting, respectively—the prevalence of news stories that linked serious mental illness and gun violence spiked, and 69% of those stories were event-focused which, as noted above, tends to encourage readers to blame individuals for large social issues. Overall, less than 10% of those news stories mentioned key facts about serious mental illness, like “most people with SMI are not violent” and “predicting violence among persons with SMI is difficult.”

“It's hard to not conjecture and infer, and sometimes in media, we talk in finite terms: ‘This is why you're violent.’ And we need to avoid that,” says Nichole Cross, Ph.D., and news anchor for Spectrum News in Austin and San Antonio. “The challenge is not to speak for someone else, but to simply communicate the facts that have been shared: ‘This person said this.’”

How does the media report suicide (policies, language used, best practices)?

According to the National Association of Mental Illness (NAMI, 2020), a wealth of research has proven that news coverage of suicides has the potential to encourage suicide in vulnerable others—specifically, stories that explicitly describe the suicide method or employ graphic headlines or images, and continuous/repeated coverage of one suicide can glamorize the death and ultimately spark *suicide contagion*. If someone is already struggling with mental health challenges, news stories that describe someone’s method of suicide not only normalize suicide, but also teach them what methods “work.” Further, when news coverage about a person’s suicide document mourning friends and family members or describe memorial services or ceremonies, it can make suicide seem preferable to a reader’s current level of pain, isolation, or perceived rejection.

To combat suicide contagion and present a more honest view of suicide, journalists have developed a set of guidelines for reporting such deaths. In many newsrooms around the country, it is standard practice to not create a news story around a death via suicide unless there is something newsworthy about the person—in other words, suicide is not the story, it is often a detail that does not need mentioning. Commonly, suicide will not be mentioned in obituaries; the reason for death is either not mentioned or listed as “died suddenly” or “died unexpectedly.”

Additionally, word choice matters when reporting on suicide. For example, “completed suicide” is preferable over “committed suicide” or calling it a “successful suicide attempt,” because the term “committed” implies a crime, and “successful” frames suicide as an achievement, or something to strive for. For more details on how journalists are trained to report suicide, see the Resources section.

How does the media normalize therapy, support-seeking and other mental health treatments?

In recent years, high-profile actors, musicians, and other celebrities have come forward with details of their mental health, including personal stories of mental illness. Athletes like Michael Phelps, Oscar De La Hoya, and Terry Bradshaw have gone public about their mental health challenges, while actors such as Dwayne “The Rock” Johnson and Ryan Reynolds have openly talked about their experience with depression and anxiety disorder, respectively. Additionally, Mariah Carey revealed she has bipolar disorder, and Prince Harry stated that he has sought counseling to deal with grief and anger. By talking about their mental health challenges, these celebrities help normalize the idea that mental health should be taken seriously and that mental health struggles are not shameful. NAMI now has a team of “Influencer Ambassadors and Supporters” who promote open, honest dialogue about mental health.

Similarly, direct-to-consumer advertisements for prescription medications— which became prolific in the late 1990s, after the FDA released broader guidelines for broadcast ads—have been shown to reduce public stigma toward advertised illnesses (Ventola, 2011). Such ads generally use communication techniques that encourage perspective-taking and personalize symptoms in a manner that disconfirms stereotypes (Ball, Liang & Lee, 2014). In this vein, when celebrities share their own stories of mental health struggles in a personal, yet educational, manner, it may help alleviate shame and negativity around mental illness. However, such stories must be told with caution, as they may disparately impact various audiences: a 2014 study asked 272 individuals – about 40% of whom self-identified as having a mental health issue – to watch ads for Cymbalta, an antidepressant medication (Corrigan et al., 2014). Among those who acknowledged struggling with mental health, the ads seemed to reduce blame for mental illness, reduce participants’ desire to avoid those with mental illness, and increased their willingness to help such individuals. However, participants without a history of mental illness were less likely to offer help and endorse recovery for people with mental illness after watching the ads.

Not only is the audience important in such messaging, the topic makes a difference, too. For example, a 2019 study found that narrative messages emphasizing external factors, while also acknowledging personal responsibility, can reduce stigma and encourages audiences to attribute responsibility to something other than the individual—for certain conditions (Heley et al., 2019). This study tested narrative messages around obesity, opioid misuse, and cigarette smoking, but the narrative messages only reduced stigma for prescription opioid addiction, not the other two issues.

What do we need to consider when changing how stories are framed?

As noted above, we must use caution when attempting to reverse negative framing of mental illness, as messages are interpreted differently by various audiences, and can backfire. In one recent study, (Vyncke & van Gorp, 2018), participants were given brief background information about mental illness and were asked to read a short opinion piece regarding the struggles of people who have a mental illness: some opinion pieces were created in a deframing light, which refuted elements of the original “mental illness leads to violence” frame to undermine its narrative (i.e. the piece noted that “it is wrong to assume that mentally ill people have a permanent higher risk to get addicted or to commit suicide”). Other opinion pieces were structured in a reframing voice, or introducing a new way of thinking about the issue without referencing the original stigma (such as saying, “Mentally ill people are very great citizens”). For those with no personal history of mental illness, the deframing vignette significantly reduced public stigma. However, for participants with a personal history of mental illness, reframing increased the perceptions of stigma. Researchers posited that the reframing stimulus may have offered an overly optimistic representation, which triggered a desire in the stigmatized participants to remind others that they are still stigmatized against.

There is also something called the “backfire effect”, in which people without personal experience with mental illness actually lower their perceived stigma after viewing a stigmatizing message. Political researchers suggest that audiences may perceive overtly stigmatizing or stereotyping messages as “weak,” which therefore bolsters their belief that the more accurate, non-stigmatizing viewpoint is more accurate (Chong & Druckman, 2007).

How are journalists trained to report on these issues?

Though American society is becoming more comfortable talking about mental health and mental illness, there are still few formal training programs or classes that teach journalists (and aspiring journalists) how to appropriately, sensitively and accurately report on these topics.

“[Mental health issues] cut across social status, age, geography, all sorts of factors,” says Uche Onyebadi, Ph.D., Associate Professor and Department Chairman at TCU. “Yet, it’s not being emphasized as much as it should. A lot has been done, but we’d still need to do more— much more.”

Some college journalism programs discuss mental health within existing courses on other topics. Students at the Missouri School of Journalism at the University of Missouri are required to take a cross-cultural reporting class, in which they think critically about (and report on) underrepresented populations, including people with mental health diagnoses. “Whether that’s in a public relations or journalistic context, they get a semester of trying to be inclusive of all stakeholders, and not assume that there is one spokesperson or representative of any group,” says Lynda Kraxberger, Associate Dean for Undergraduate Studies. At the Moody College of Communication at The University of Texas at Austin, journalism students may discuss mental illness within various required classes, but there is no specific course or required outside opportunities to learn how to accurately and sensitively report about mental health issues.

Similarly, at Baylor University, mental health-related communication lessons are integrated throughout the required journalism-major courses, according to Mia Moody-Ramirez, Ph.D., chairwoman of the Department of Journalism, Public Relations and New Media. Journalism students at the Bob Schieffer College of Communication at Texas Christian University (TCU) are required to take a course called Diversity in the Media, which touches upon proper verbiage and framing when reporting about certain marginalized populations, such as people with physical disabilities and those living with mental health conditions.

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Students struggle with the language and science background of [mental health issues], to be able to report it intelligently. They’re taking it from expert voices in the medical field, and not hearing real-life voices. They don’t have a curiosity to report on it, because it’s not their world. Because they don’t see it reported enough, it’s not in their world.

—Jamie Loke, Ph.D. and Associate Professor, Bob Schieffer College of Communication at Texas Christian University

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Do training programs work, anyway?

A 2019 meta-analysis by Ross, Morgan, Jorm, and Reavley, examined published studies of media training programs around mental illness stigma (including schizophrenia, psychosis, bipolar disorder, or mental illness in general). Three of the interventions they reviewed were specifically focused on current or future journalists; they varied in length from 2-3 hours and utilized education or direct contact with people who have are living with mental health diagnoses. All three were found to significantly improve journalists' attitudes towards mental illness [40], increase their awareness of mental illness stigma, and increase both negative and positive reports on mental health and schizophrenia.

However, the long-term effects of those interventions were mixed: following one intervention, analysis of newspaper reports showed a 33% increase in the number of positive mental health news reports and a 25% increase in their length following the intervention. Unfortunately, the analysis also showed that negative news reports about mental illness also increased (25%), with the length increasing about 100%, and the number of stigmatizing reports about schizophrenia increasing by nearly 50%³.

In analyzing the efficacy of three other training programs by NAMI, Wong et al. (2015) concluded that the In Our Own Voice, Parents and Teachers as Allies, and Provider Education Program all yielded significant short-term attitude improvements about mental illness. Among other benefits, these programs reduced participants' desire for social distance from individuals experiencing mental health issues and higher confidence in their ability to be supportive. (See Resources for details on accessing these programs.)

» PROVIDER COMMUNICATION ABOUT MENTAL HEALTH

While healthcare providers spend years learning to recognize, diagnose and treat physical and mental issues, not as much attention is paid to learning how to effectively communicate with patients. Providers often have a hard time starting conversations around mental health and may not be comfortable when patients want to discuss mental health challenges. The following are problems that can occur during patient-provider interactions that can dissuade patients from talking openly and honestly about mental health, which can ultimately hinder the provider's ability to provide quality care.

What are common issues with how providers talk about mental health?

Poor Listening Skills/Communication

Patient-provider communication can be fraught with challenges for all patients, and this important relationship has been studied for decades (e.g. Hawkins & Mitchell, 2018). Ineffective provider communication has even been shown to directly impact patient outcomes in chronic illnesses such as diabetes (Linetzky, Jiang, Funnell, Curtis & Polonsky, 2017). Older adults with clinically significant depressive symptoms reported poorer scores on their providers' ability to listen carefully, show respect for what they had to say, and ability to explain things that was easy to understand (Nelson & Purtle, 2019).

Provider stigma

Personal stigma held by providers can cause issues with mental illness treatment. Specifically, for people living with borderline-personality disorder, healthcare provider stigma has been shown to lead to different treatment because of their diagnosis (e.g. Aguirre, 2016; Sulzer, 2015). This latent provider stigma (again, specifically around borderline personality disorder) has been suggested to cause negative outcomes such as difficulty empathizing, a lack of belief in recovery, perceptions of patients as dangerous and manipulative, and rationalization of treatment failures (Aviam, Brodsky & Stanley, 2006; Markham & Trower, 2003; Sansone & Sansone, 2013).

Lack of physician knowledge and confidence

A survey of 283 pharmacists in the Toronto area (Phokeo, Sproule, & Raman-Wilms, 2004) found that despite generally positive attitudes about patients who use psychiatric medications, pharmacists reported feeling more uncomfortable consulting about symptoms and medications with patients experiencing mental health issues than with patients needing cardiovascular medications. One barrier to mental health-related medication counseling was inadequate training (as well as a lack of privacy for such consultations).

³ It should be noted that none of the three interventions studied used control groups (instead opting for pre- and post-tests), and they all employed small samples of convenience.

Similarly, a 2018 meta-analysis of qualitative research (Brunero et al., 2018) found that general health practitioners feel that they do not know enough about mental illness to screen, recognize, or identify such patients, and that their lack of knowledge around this topic created a lack of confidence in their skills, which prevented them from starting such conversations with patients. In a study of rural nurses, participants admitted to feeling unsure of what to say or how to ask questions sensitively when attending to someone who may have mental health concerns. Their anxiety stemmed from a fear of misusing psychiatric terms like “anti-depressants” or “depression,” with participants admitting that they didn’t want to say the wrong thing and “make them worse.” (Reed & Fitzgerald, 2005).

Interestingly, context matters: behaviors that are seen as diagnostic cues in mental health settings—such as wandering, talking loudly or being rude to others—are not seen as symptoms in a generalist setting, but rather are indications of a safety risk (Brunero et al., 2018).

Poor cultural understanding

Lack of cultural understanding by healthcare providers can cause them to underdiagnose, misdiagnose, or inappropriately adjust their communication and care. Though suicide rates for Asian-American women are 30% higher than for White women (U.S. Health and Human Services, 2016), discussing mental health concerns is taboo in many Asian cultures. Many young Asian-Americans seek support from friends or other network members, rather than professionals; Asian-Americans are three times less likely to seek mental health services than people from other racial groups (Spencer et al., 2010). Misunderstanding cultural



artwork by Anjola Coker, Courtesy of UT Institute for Excellence in Mental Health

terminology or a culture’s unspoken communication norms can also create harmful distance between patients and providers. In a study of ethno-cultural variations in mental health beliefs, (Carpenter-Song et al., 2010), researchers determined that European Americans often seek care from mental health professionals and espouse beliefs about mental illness that align with the biomedical perspective on disease, while African-American and Latino individuals are more likely to embrace non-biomedical interpretations of their symptoms, such as “demons were around me” (p. 238) or “*ataque de nervios*” (“attack of nerves”; p. 237). In order to engage patients in care and offer the most appropriate, most acceptable care possible, providers need to recognize that different cultural groups describe and attribute symptoms differently, as well as understand how various cultures stigmatize mental illness, or what various groups consider “appropriate” recovery goals or outcomes.

Lack of interaction with those living with mental illness during med school and residency

A small qualitative study of graduating medical students found that students are frustrated by a lack of direct contact with patients experiencing mental illness (Iezzoni et al., 2006). The study participants noted that residents often avoided having students observe patients with mental illness during non-psychiatry rounds, or residents were observed handing such patients off to psychiatry units as soon as a major mental illness was noticed in order to avoid treating the patient by himself or herself. In this manner, mental illness is stigmatized as frightening, unnecessarily time-consuming, or “beneath” treatment by a non-psychiatry provider. Students in this study mostly had no personal experience with mental illness and described their perceptions of it in emotional or empathetic terms, rather than medical diagnoses and definitions (as they would for other illnesses). Even during psychiatric rounds, students said they were often not offered direct patient contact, which hindered their ability to interact with and learn from such patients.

Differing views of “collaboration”

Though studies have determined that collaboration between providers and mental health consumers—as evidenced by consensus-building and shared decision-making—is productive and preferred by consumers, the two populations often have different ideas of what those concepts look like. In one qualitative study of mental health consumers who also received health promotion guidance from providers (to address issues such as weight loss, healthier eating, or better overall lifestyle choices), consumers said that providers often have a narrow view of health and push a “one-size-fits-all” model, which discouraged negotiation and shared decision-making (Pals & Hempler, 2018). Participants expressed a wish for providers to be more curious and exploratory about the consumer’s preferences and experiences, and to trust individuals more to be aware of their own needs.

Hierarchy between Provider and Patient

Talking about mental health can be uncomfortable, as it is an intimate and often personal part of one's life. Providers who are nervous to ask about a patient's mental health miss a chance to build trust and solicit more honest, helpful information about a patient's mental health status. Studies have shown that patients crave a personal connection with their providers (Pals & Hempler, 2018), which can be as easy as sharing a sentence or two about the provider's own experience with mental illness (perhaps a family member who was diagnosed or simply an admission that the provider sometimes feels overly stressed, anxious, or depressed).

How are providers currently trained to talk about mental health concerns with patients?

Much like with journalism students, medical students are usually not given extensive, dedicated training on how to speak with patients about mental health. Though communication lessons are often interwoven into classes on other topics or practiced during clinical experiences, few medical schools have semester-long courses specializing in patient-provider communication on any topic. Many primary care physicians report a significant lack of behavioral health training during residency (Williams et al., 2004), and brief lectures on how to engage in psychosocial discussions with patients have not been shown to be effective in skill acquisition (Brown, Riley, & Wissow, 2007). Even when schools do teach about mental health and mental illness, traditional lecture-style learning is not very effective in changing stereotypes or reducing stigma (Bell, Johns, & Chen, 2006).

"In most medical schools, there's very little psychiatric education to the traditional medical student at large," says Dr. Charles Nemeroff, Ph.D. and M.D., acting chair and professor of the Department of Psychiatry at Dell Medical School, at the University of Texas at Austin. "You get Behavioral Science in the first year or two, some lectures about depression and anxiety, and the average range of time for psychiatric clerkship is 3-6 weeks, with most schools erring toward the lower number. Think about Obstetrics and Gynecology: for one-third of the women in the U.S., their gynecologist is their only doctor, and if that person can't recognize depression, then that's a real problem."

Around Texas, medical schools and pre-med programs are focusing on helping medical students understand and communicate more effectively about mental health issues. A few noteworthy examples include:

- In The Graduate Portfolio in Integrated Behavioral Health at Dell Medical School at The University of Texas at Austin, graduate students from any discipline can join the program, which offers courses from a variety of behavioral health disciplines around topics such as social determinants of health, evidence-based strategies, organizational dynamics, and interprofessional clinical practice.
- Students in the PharmD program at The University of Texas at Austin College of Pharmacy go through the Teaching Patient Counseling and Pharmacy Communication classes, which teach students how to start difficult conversations and reduce stigma through careful language usage. Further, students are required to take six hours of mental health first aid training, which explains warning signs of mental health and addiction concerns, presents strategies for how to help someone experiencing a mental health crisis, and offers more resources for further help. The goal is to familiarize students with the signs of mental health issues and make them more comfortable discussing and addressing mental health, both personally and professionally.
- Students at the The Baylor School of Medicine takes a behavioral science course that touches upon mental health issues, as well as learn how to record someone's life history (including biopsychosocial aspects). They also take a course on Determinants, Disparities, and Social/Population Health that teaches them about structural components of health, and participate in a two-week service learning program that introduces the concept of narrative medicine (in which patients are encouraged to share their life story with providers, not just a list of symptoms). Baylor has made student mental health a priority by clearly identifying and sharing mental health resources aimed at students and faculty.

Elsewhere, innovative programs are helping future healthcare providers recognize and attend to their own mental health issues and beliefs. For example, in Canada, Dr. Kathy Fitch, M.D., created a workshop based on dialectical behavior therapy (DBT) to help healthcare providers and community leaders improve their own attitudes and behavioral intentions toward people living with borderline personality disorder (BPD). Preliminary results indicate the program—which included educational aspects and social contact

elements—was successful in improving healthcare provider attitudes towards persons with BPD and, to a lesser extent, toward individuals with general mental illness (Knaak et al., 2015).

Another program offered third- and fourth-year pharmacy students in three Canadian undergraduate programs direct contact with mental health consumers, in an attempt to reduce student stigma. Students attended small-group sessions with young adults diagnosed with bipolar disorder or schizophrenia; speakers told their personal stories (provided testimonies) and answered students' questions. Of the students who participated in the discussion sessions, more than 65% improved their scores on a stigma measurement tool, compared with students who simply listened to lectures about mental health (Patten, Remillard, & Phillips, 2012).

Recommendations

05

Recommendations

Simply spreading more accurate information about mental illness may not be enough to change the way Americans think about mental health issues. Few studies have shown a connection between greater scientific understanding of mental illness and reduced prejudice (Pescosolido, 2013). For example, a 2016 study determined that factual articles about mass shootings do not impact attitudes about discrimination against people experiencing mental illness (Wilson, Ballman, & Buczek, 2016). Efforts to change the national conversation about mental health must go beyond education lectures: tactics must be evidence-based, engaging, strategic, and systemic. As Link and Stuart (2017, p.13) wrote in their review of the history of stigma:

“It is not just ignorance or bad messaging, but rather people believe things for reasons, and even if those reasons make little sense or are unfair, if we fail to address such reasons, we can expect attitudes to change only in the short term and to be very difficult to alter at the population level.”

While it is simplistic to believe that any two or three actions can completely change the way an entire society talks and thinks about mental health, we believe that key actions—taken by key people—can have a large impact on making mental illness a less taboo and misunderstood topic. Therefore, we present the following recommendations for both journalism and medical students. Journalists and healthcare providers play very different roles in society and face different barriers to effective mental health-related communication. However, judging from current research, we believe that there are several ways that both groups can reduce their mental illness stigma, improve their communication skills, and help change the national conversation around mental health. These are discussed below.

» 1. Increase opportunities for direct, personal contact with mental health consumers.

There is a call to provide better models for training medical students about communicating with patients who are experiencing major mental illness (Iezzoni et al., 2006), and for future journalists to better understand the populations they report about. The most effective way to understand the reality of mental health challenges is direct contact with people experiencing them.

Social contact with individuals living with mental health conditions has been shown to reduce students' desire to distance themselves from such individuals more than other, more traditional education methods, such as lectures or assigned readings (Corrigan et al., 2002; Couture & Penn, 2003; Rusch et al., 2008). In one study, filmed contact was shown to reduce the desire for social distancing and negative emotions towards people with serious mental illness better than an immersive simulation of auditory hallucinations, such as patients with schizophrenia may experience (Brown et al., 2018). Such personal connections only challenge one's stereotypes or stigma about mental illness, but can foster “a lot more humanity [and] compassion” (Happell et al., 2015, p. 22) and move students beyond their personal fears. By getting a firsthand look at the lived experience of mental health issues, such as obsessive-compulsive disorder or general anxiety, and serious mental illness, such as schizophrenia, people can form more empathetic, richer, more nuanced perspectives.

Intergroup contact, or meeting someone who is perceived to belong to a group different from your own, has been shown to reduce stigma when conducted under the right conditions. Foundational work on intergroup contact has indicated—and prior work has supported—that people from different social groups (such as “patient” vs. “healthcare provider”) can develop mutual understanding and reframe expectations of each other under the right conditions, specifically if: 1) there is equal status amongst groups during the interaction; 2) contact is supported by authorities; 3) the groups are pursuing the same goal; and 4) the groups are asked to cooperate (Allport, 1954).

But what does this look like in practice? Interpersonal contact could involve: (a) inviting people who have experienced mental health issues into the classroom for frank conversations; (b) hosting speaker panels that include mental health consumers, their family members, and community members involved with providing support for such individuals, and/or; (c) leading student visits to local mental health clinics or support spaces. Care should be taken to introduce students to individuals who live with a mental illness but are in recovery. Such patients may have stronger communication skills and perspective to clearly explain their experiences, as well as the ability to accurately explain the different stages they went through to get to recovery. Further, patients brought in as “subject matter experts” must be empathetic to students’ questions, which may be misinformed or unintentionally triggering.

Some notes of caution

Interpersonal contact with mental health consumers should be coordinated carefully to ensure successful outcomes for both the students and the consumer. Previous attempts to bring this type of learning into classrooms has mainly been through guest lecturers, who have limited or no ability to control curriculum, which can leave speakers feeling vulnerable or patronized. Further, inviting a mental health consumer into a classroom as merely a speaker (rather than an individual with an important story to share) and not allowing for student questions or interactions can inadvertently create a power balance (professor/provider versus speaker/patient), which can actually reinforce, rather than address, existing power imbalances in the real world (Happell et al., 2015). Positioning the mental health consumer as an expert and/or someone with unique knowledge can help combat an often-felt power differential between medical professionals (including students) and patients.

The temptation to substitute role-play scenarios for real-life contact with mental health consumers should be avoided, though working with inter-disciplinary experts may admittedly present logistic challenges. A 2014 meta-analysis of stigma-reduction literature (Stubbs, 2014) found that role-play was ineffective in fighting mental illness stigma, and that having students role-play as mental health consumers may actually

reinforce stereotypes without providing an opportunity to address those stereotypes’ (in)accuracy. Films relating to mental illness may offer an affordable, realistic solution. Several studies (e.g. Clement et al., 2012; Nguyen, Chen, & O’Reilly, 2011) have found a similar level of stigma reduction between filmed contact and personal contact.

Regardless of how the intergroup contact is made, “it’s important that it doesn’t seem fake or cheesy, because that will give the students the wrong impression,” says Samantha Vogel, PharmD, BCPP, pharmacist in UT Health Austin’s Integrated Behavioral Health Center and instructor at The University of Texas at Austin College of Pharmacy. “Something fake or overly dramatic can actually do more harm than good. It’s important that these seem genuine, to offer a more real experience to the students.”

Journalism and journalism curriculum is very good about saying, “don’t do this!” and raising awareness about a problem, but is not very good about offering practical, concrete solutions. For example, when we’re on deadline, what is the best way to let someone with a mental illness represent themselves, rather than going to a spokesperson for a group?”

—Lynda Kraxenberg, Associate Dean for Undergraduate Studies, Missouri School of Journalism

» 2. Encourage students to understand their own mental health, and how mental health issues touch their friends and family.

Importantly, students can and should also get in touch with their own mental health. A 2018 study of full-time college students in eight countries found that 35% of them screened positive for common mental health conditions (World Health Organization, 2018), yet only about 1 in 10 American students seek college-provided mental health assistance (Associated Press, Nov. 25, 2019). Further, about 35%

of physicians do not seek regular, preventive health care for themselves (Gross et al., 2000) — in one study, 50% of female physicians did not seek help, though they exhibited symptoms of a mental illness (Gold et al., 2016). If medical students and physicians are unwilling to seek their own mental health assistance, they will be less likely to talk about it with patients; if journalists do not have a personal understanding of what mental health means to them, they will not accurately be able to represent mental health challenges in others.

Students should also be encouraged to check in with friends and family members about mental health; considering how common depression and general anxiety disorders are, it's likely that everyone knows at least one person living with these or similar issues. When we realize that mental health challenges are all around us—and that people we know and love are living with such diagnoses in a way that goes against negative stereotypes—we begin to chip away at our own stigma. There are numerous evidence-based guides available for people wanting to talk with loved ones about mental health, including resources from:

(a) NAMI (nami.org/Your-Journey)

(b) Mental Health America (mhanational.org/time-talk-tips-talking-about-your-mental-health)

(c) U.S. Department of Health and Human Services (mentalhealth.gov/talk/friends-family-members).

» 3. Teach about mental illness in a clear, medical way, and talk about it using person-centered language.

We know that words matter, and language can make a big difference, especially when attempting to accurately diagnose, treat, or describe mental health issues. In one study (Iezzoni, 2006), medical students described their perceptions of mental illness in emotional or empathetic terms, rather than medical diagnoses and definitions (as they would for other illnesses), and did not seem to have a strong grasp of medical treatments or tactics to improve patient outcomes. Students should understand the medical nature of mental health conditions, (such as depression, general anxiety disorder, and post-traumatic stress disorder) and serious mental illnesses (like schizophrenia and bipolar disorder), including the biological components and physical ramifications. Using medical terms to describe mental health issues and potential treatments—just as we describe physical ailments—support the legitimacy of mental illness and help fight the outdated stigma that “it’s all in your head” or that “you can control this if you really want to.” Framing mental health conditions in the same way we frame physical conditions supports accurate clinical knowledge, which leads to better care for patients (King, 2014). For example, an Australian study of emergency care providers (16 nurses and 20 doctors) found that a main factor related to triage inaccuracy of people experiencing mental health crises was a lack of understanding of mental health problems, including symptoms and how to handle them (Gerdts et al., 2012).

Which is not to say that medical language is perfect. In some Asian countries, there is an official push to drop the term “schizophrenia” for the diagnosis of “integration dysregulation syndrome,” which emphasizes that the disorder is treatable and recovery is possible (Sato, 2006). Researchers developed and tested four new sub-groups and terms for patients experiencing schizophrenia, including anxiety psychosis and stress sensitivity psychosis (Kingdon et al., 2008); when these terms were tested among medical students from seven countries, both “psychosis” labels elicited more favorable attitudes about achievement of a full recovery than the label of “schizophrenia” (Rathod et al, 2018). (*Related: For a well-argued perspective on inadvertently stigmatizing language around substance misuse, see Broyles et al., 2018.*)

Learn the technical aspects, but communicate in personal terms

That being said, there are individuals and groups for whom any medicalization of mental health issues is problematic. Framing depression, anxiety, PTSD and other mental health issues as illnesses can feel disempowering, and can imply that medication is the only reasonable “cure” — or that those individuals desire a “cure” in the first place. Those viewpoints should be recognized and respected.

Mental health conditions are but one part of a whole person, and we should be careful to use language that promotes that viewpoint. Beyond simply avoiding outdated and offensive terms like “crazy,” “freaking out” or “psycho,” person-first language literally and figuratively puts the human before his or her condition: “a person diagnosed with schizophrenia” versus “a schizophrenic.” And person-first language can have a real impact on our attitudes around important health topics: in one study of clinicians, the term “substance

abuser” elicited stronger feelings of personal culpability and more desire for punitive measures than the term “a person who has a substance use disorder” (Kelly & Westerhoff, 2010). Healthcare providers and journalists (both current and in-training) should make a point to understand the clinical side of mental health, yet communicate about mental health challenges in a respectful, person-centered, empowering way. This is not an easy balance, but it is worth striving for. “Everyone can agree to come from a place of ‘People First,’” says Katherine Jones, director of strategy and mission for Dell Medical School’s Design Institute for Health. “When thinking about language or design, if we all start at the basis of helping people, it’s easier to ground the debate and come to agreement.”

» 4. Create a “safe” place for students to discuss perceptions, fears, and biases of mental health.

In the 2012 study of healthcare providers in emergency room settings, referenced above, another major barrier to properly triaging emergency room patients exhibiting symptoms of mental illness was the nurses’ personal attitudes toward mental illness (Gerdtz et al., 2012). Nurses, in particular, admitted that social stigma around mental illness resulted in them underestimating the urgency of such patients’ needs. The triage nurses indicated they were very cautious when attributing behavioral signs and symptoms to mental illness, rather than physical illness. In other words, nurses tried so hard to avoid negative aspects of stigma that they were less likely to diagnose mental conditions—even though that’s what they were trying to avoid.

“Familiarity and trust is important, as a Latina woman, so when a doctor talks to me with familiarity and trust (maybe tells me a little bit about themselves, or show me pictures of their kids, or talk about going to the university), makes it easier for me to talk about my kids, and my family. If they’ve had experiences with mental health issues, or they have a family member, it normalizes it: “Sometimes, I see patients with RA who are impacted by depression, is that happening to you?” I feel like I’m meeting with someone who is meeting me halfway.”

—Deborah, patient, about what she wants from a doctor

Similarly, the Iezzoni et al. (2006) study mentioned earlier, in which medical school students talked about their training around mental health, also noted that students want a safe space to discuss real fears and thoughts about mental illness and mental health. The authors encourage professors to build a judgement-free space for students to discuss conflicting feelings about mental illness and consider which fears may be legitimate (i.e. fears relating to physician safety or personal hygiene) and which may prevent them from delivering compassionate, effective care.

Stigma around mental illness often prevents honest, open discussion, and without an opportunity to ask questions and be challenged, people lack the chance to learn and grow. And students do have questions and concerns about mental health-related communication. Sharon Rush, R.Ph. at the University of Texas at Austin College of Pharmacy, says that first-year students

are asked to complete a survey on their personal experience with mental health issues. “In the qualitative comments, many note that they’re not sure how to act in those situations, concerned about their own safety, and have a fear of effectively communicating without offending anybody,” Rush says. “Students have a lot of interest in learning about mental illness.”

By giving future physicians, journalists, and other professionals a place to safely express their concerns, ask questions without judgement, and face their implicit biases against mental illness before they go out into the world and begin communicating about mental health on a large scale, we can provide accurate information and positive messaging, which will empower individuals to change their own stigma. When we address our personal biases, stereotypes, and misconceptions, we begin to understand what is true—and what is holding us back from the truth.

» 5. Help students understand the structural, cultural, and psycho-social determinants of, and factors around, mental health.

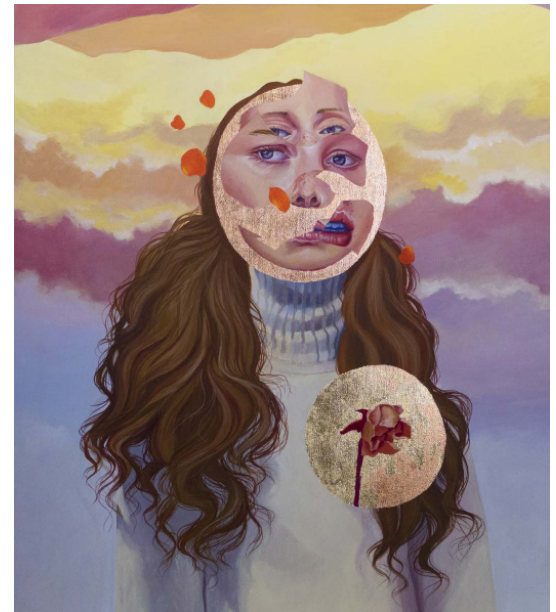
Mental health groups were on the forefront of the cultural competency movement: in the 1980’s, mental health agencies began requiring that clinicians demonstrate “cultural and linguistic competence” to meet the unique and diverse needs of mental health consumers (Cross et al., 1989). Twenty years later, the U.S. Department of Health and Human Services created a set of standards around culturally-appropriate care for all medical patients.

But beyond simply understanding the role that culture plays in one's overall health, structural competency is a more critical framework that acknowledges that there are policies, norms, and procedures that actively create health inequities between various populations. Structural competency is an understanding of how matters of race, ability, sexual orientation, economic status, and other social determinants shape interactions between patients and healthcare providers (Petty, Metzl, & Keeys, 2017). By learning how economic and political conditions produce health inequalities between populations, students of all disciplines will develop a more holistic view of mental health and understand (a) the societal and environmental factors that contribute to mental illness; (b) why some people do not or cannot seek traditional "treatment" for a mental health issue; and (c) why and how some individuals must work harder to achieve recovery than others.

Some may argue that such training is not necessary, and that simply having empathy for or sharing a common lived experience with patients or story subjects will be enough to understand their realities. However, numerous studies have suggested that without a structurally-informed perspective, even the best-intentioned providers may be more likely to miss opportunities to address health disparities in their delivery of care or even accidentally exacerbate structural barriers (e.g. Waitzkin, 2000; Wear & Aultman, 2005).

Structural competency is now being taught in some medical and nursing programs and aligns with sections of the Medical College Admission Test (MCAT), in which students are expected to explain the influences of culture and community on health behaviors and outcomes. A small 2015 study of medical residents (N = 12) found that as little as one three-hour training session had a positive impact on their relationships with patients and helped them "build a partnership" (Neff et al., 2016, p. 432).

"Health communication in America is very vertical, and full of assumptions: We assume that you understand the system, that you're going to use that system to promote health, that you want to take prescriptions, and that you have access to healthy food," says Ruben Parra-Cardona, Associate Director for Research at the University of Texas at Austin's Latino Research Institute. "For example, as a physician, you want to talk about my high blood pressure, but you haven't even asked me how things are going with my job, or my family. Eat more vegetables, sure, but my coffee and my Mac Trio keep me going because I only get five hours of sleep at night, and that food is cheap. If we engage with these populations without understanding their maltreatment and without asking their narrative, we will miss something."



artwork by Margo Lunsford,
Courtesy of the UT Institute for Excellence in Mental Health

A note of caution

Lessons around structural competency should include resources and strategies for students to address structural inequalities in the clinical setting and beyond. In the Neff et al., (2016) study, participants noted "feeling overwhelmed by their increased recognition of structural influences on health" (p. 432) and requested practical ways they could address such inequalities in their own practice.

Recommendations Summary

- (1.) Increase opportunities for direct contact with mental health consumers.
- (2.) Encourage students to understand their own mental health, and how mental health issues touch their friends and family.
- (3.) Teach about mental illness in a clear, medical way, and talk about it using person-centered language.
- (4.) Create a "safe" place for students to discuss perceptions, fears, and biases of mental health.
- (5.) Help students understand the structural, cultural, and psycho-social determinants of, and factors around, mental health.

Conclusion

06

Conclusion

As we compiled research around mental illness prevalence and treatment rates, stigma, patient-provider interactions, and media effects, we realized that there are no “right” answers, nor any “easy wins” when it comes to communicating more accurately, sensitively, and productively about mental health. Messages designed to reduce stigma can sometimes backfire; conversations intended to make people feel comfortable can, instead, create an awkward environment that makes people less inclined to talk in the future. Terms, words, and phrases that some people find acceptable and descriptive make others cringe.

It can be disheartening.

But the more we learn about how communication impacts society’s attitudes around mental health (and vice versa), the more effectively we can fight the negative stereotypes and stigmas around mental illness. Changing the national conversation – especially by helping providers communicate more clearly with patients and showing journalists how to responsibly frame their stories – is not easy, but its worthwhile work.

We believe that this whitepaper is, above all, a hopeful document, and that the research it summarizes paints an optimistic roadmap for the future. Our evidence-based recommendations can help “move the dial” on changing the way we all speak and think about mental health issues—to that end, we have also begun creating curriculum modules for the medical field and journalism, directly aligned with our research-supported recommendations.

A heartfelt thanks goes out to the researchers who have conducted studies cited within this document, and similar studies that we did not include here. Only by conducting vigorous scientific research can we understand the best ways to change the national conversation around mental health and mental illness. This is important work, and we are grateful to those who spend their lives finding answers to such important questions. Additionally, we thank you, the reader, for engaging with this research and thinking critically about your own role in this mission. We encourage you to seek creative and productive ways to put the information you absorbed here into practice, both professionally and personally.

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