SPEAKER NOTES

Progress in Mental Health: Fighting Stigma, New Models, and the Need for Communication

Summarized by Thomas T. Thomas

Our educational speaker meeting on September 24 featured **Stephen Hinshaw, PhD,** Distinguished Professor of Psychology at UC Berkeley. He spoke on changes in the mental health field over the last several decades—neurodiversity, blending biology and context, and more equality in doctor/patient communication, among other topics.

To recount Dr. Hinshaw's biography would take multiple paragraphs. In short, at UC Berkeley he was Department Chair from 2004 to 2011, Director of Clinical Training, and Professor in Residence at the Department of Psychiatry and Behavioral sciences at UC San Francisco/UCSF Weil Institute for Neurosciences. He also wrote *Another Kind of Madness: A Journey Through the Stigma and Hope of Mental Illness*, about his father's experience with bipolar disorder, which was a Best Book winner as an Autobiography/Memoir in the American Book Fest.

Dr. Hinshaw now runs programs for children with neurodevelopmental disorders, attention deficit/hyperactivity disorder (ADHD), and bipolar disorder. "You can learn more," he noted, "by collecting the right measures before, during, and after treatment."

There has been a lot of progress in mental health, he said, but for several reasons including bureaucratic programs and old training, it can take a long time—seventeen years on average—for new findings and methods to be disseminated and implemented. At the beginning of the twentieth century, psychology was all about Freudian psychoanalysis, and in 1960 the head of every psychology department was both a male and a psychoanalyst. Now, with developments in the study of genetics and environmental influences, the department heads—quite as often female these days—are more trained in the biology of mental illness.

"As far as we know," Dr. Hinshaw said, "the brain is the most complex entity in the universe." About six or seven weeks after conception, the embryo forms the neural tube that is the beginning of the brain. And for seven and a half months after that, the brain forms 8,000 neurons *every second*. At birth, a baby as twice the number of neurons that it will need in life, and so begins a process of pruning. The nucleus of each neuron forms the "gray matter" on the surface of the brain. From the nucleus extends an axon, covered in a white coating of myelin, and they collectively form the "white matter" inside the brain. There the neurons make connections with each other, called synapses. The extension of these axons and their connections depends on the experiences the individual has during development. The developed brain has about 90 billion neurons and trillions of synapses—and some neuroscientists think this is underestimated, and that there are more connections than particles in the universe.

"With all of this complexity," he said, "it's little wonder that some brains don't develop optimally."

Psychology has progressed from psychoanalysis to the study of genetics and environment, where genes explain a large part of major mental illnesses and lead to more practical therapies. However, even though the genes stay with you through your lifetime, they are expressed differently at different times, which we have learned through the study of epigenetics. So, individuals with the same genes may have different outcomes. Scientists used to look for one gene that caused schizophrenia or bipolar disorder, but they now know that these conditions are caused by many genes working together.

"The more we know about genetics," he said, "the more complicated it is."

Going back to the Nixon administration, we've had a "war on cancer," Dr. Hinshaw said. Cancer was once thought to be psychosomatic: that as people got older and became depressed, their bodies shut down, and certain cells started multiplying. Now we know that cancer is genetic. There is no mental attitude, and so no blame and shame attached to cancer. But mental health issues—which affect more people than cancer—still get blamed on emotional development and personal outlook.

Dr. Hinshaw wrote *The Mark of Shame: Stigma of Mental Illness and an Agenda for Change* in 2009, but he said it would probably need to be updated today.

Stigma reflects something about a group that is discredited. It's the brand or mark of an outgroup. In ancient Greece, a person whom citizens thought could not be trusted in the marketplace—such as former slave—would be branded on the shoulder as an identifying mark. We wouldn't be a single human species if we could not cooperate, but we also are alert to signs that not everyone can be trusted.

Lefthanded people used to be stigmatized because they were different and the Latin for "left" was *sinister*. Today, we know that lefthanded people, who are right-brain dominant, often have excellent creative, imaginative, and spatial capabilities. But stigma, while no longer an obvious physical brand, is often inferred from psychological conditions like schizophrenia and bipolar disorder. In fact, the major outgroups today are the severely mentally ill, drug abusers, and the homeless. And people in the lower classes get stigmatized more often than those among the wealthy and secure.

We used to think that people were raised to stigmatize others, but stigma has older cultural significance. It starts with stereotyping, which is cognitive: looking for signs of difference in others. That leads to prejudice, which is affective: feeling averse to the otherness. And that leads to discrimination, which is behavioral: treating the others badly. Sometimes it is not far from discrimination to exclusion, dehumanization, and even extermination, as practiced by the Nazis in the 1930s among others.

People with mental illness threaten our ideas of stability, of whether a person is in control of their actions or out of control. With our modern understanding of genetics, this reduces a person to the product of their lousy genes. But some genetic variations are useful in different environments. For example, people who were restless with the genes that develop into ADHD helped hunter-gatherers in Asia move across the Bering land bridge to North America during the last Ice Age, and today the genes for ADHD are more prevalent in indigenous populations in the Americas.

But those same genes make it more difficult for people with the condition to sit still and focus in modern schoolrooms and on the assembly line.

Media also plays a role in our current wave of stigma, creating depictions of violence and incompetence. Videogame and movie villains, like the Joker, are both evil and psychotic.

People with mental illness also tend to self-stigmatize. They internalize the popular conceptions and may come to believe they are not fully human. This—along with anosognosia, the belief that they are not really ill—prevents them from getting treatment. There is also a tendency for the public to extend "courtesy stigma" to people related to mental illness, like families and mental health practitioners. In the medical community, psychologists are held in lower esteem, somewhere just above dermatologists.

"We know more about mental health than we did in the '40s and '50s," Dr. Hinshaw said, "but the course of stigma remains flat." Since the deinstitutionalization of the mentally ill that took place in the last fifty years, with more severely ill people out on the streets, today if you hear about "mental illness," you are inclined to think more about violence. The first sign of change is that now people think more kindly about those with anxiety and depression, but they still stigmatize schizophrenia, psychosis, and drug abuse.

Dr. Hinshaw then described his father's experience with mental illness, as told in *Another Kind of Madness*. His father was the third of four sons of a national leader in the Prohibition movement. When the boy as three years old his mother died, and that is the age when such a loss is most traumatic. When the boy's father remarried, his stepmother abused him physically and sexually. And, as it turned out, he had a genetic risk for bipolar disorder.

During the 1930s, as a teenager, Dr. Hinshaw's father was concerned about rising fascism, believed he had the power of flight, and tried to draw the attention of world leaders by leaping off a tower. He was diagnosed at the time as schizophrenic, put in a mental hospital, and went on a hunger strike. When the delusions lifted, he was sent home with no medications and no course of psychotherapy. Out of shame, the family wouldn't talk about his condition.

The father went on to school, got straight A's and a scholarship, and went to Stanford and Princeton to study philosophy. As he was working on his doctoral dissertation, he had another manic episode. He was sent to a Philadelphia institution with a terrible reputation for abuse, where he was treated with insulin coma therapy.

When he got out, the father went to Ohio State as a professor and got married without discussing his condition with his new wife. But when she went into pregnancy and labor with Dr. Hinshaw and his sister, their father had another episode and was treated with electroconvulsive therapy and with a new medication in the 1950s, Thorazine. And the doctors later changed his diagnosis from schizophrenia to bipolar disorder.

The psychiatrist treating the father forbade Dr. Hinshaw's mother from discussing his illness with the children; so, all they knew was that their father was "resting in another state." And Dr. Hinshaw as a young man would internalize the situation: "I thought I was the reason Dad would leave."

This was why Dr. Hinshaw went into psychology. Today he believes in science, diagnosis, and evidence-based treatment. He believes that we need to talk more about mental illness, not the code of silence he grew up with, but also that labels can be dehumanizing.

His model for communicating mental illness is based on coronary artery disease. Just over half of heart disease is attributable to genetics, and less than half to lifestyle choices about eating and exercise. Serious mental illness is still more genetics than personal experience, and yet it gets more stigma than heart disease. But even if the tendency toward mental illness is in your genes, you can make changes in your life. You can accept your differences, access treatment, manage your recovery, and thrive.

The advances today combine medication and psychotherapy for better treatment. Targeted deep-brain stimulation has been shown to work for depression. Doctors need to become more humble about the way they treat the mentally ill—and patients need to become more assertive in their treatment. It's an equal relationship. And we need to think more broadly about conditions like neurodivergence, because many people who are high functioning have excellent analytical skills and good concentration for jobs like software coding.

The person with mental illness needs to learn how, when, where, and with whom to disclose their condition.

And the people around them need to understand that most mental illnesses are on a spectrum of severity, especially ADHD, schizophrenia, bipolar disorder, and neurodivergence. You need to draw the line between acceptable behaviors and unacceptable actions like violence and self-harm.