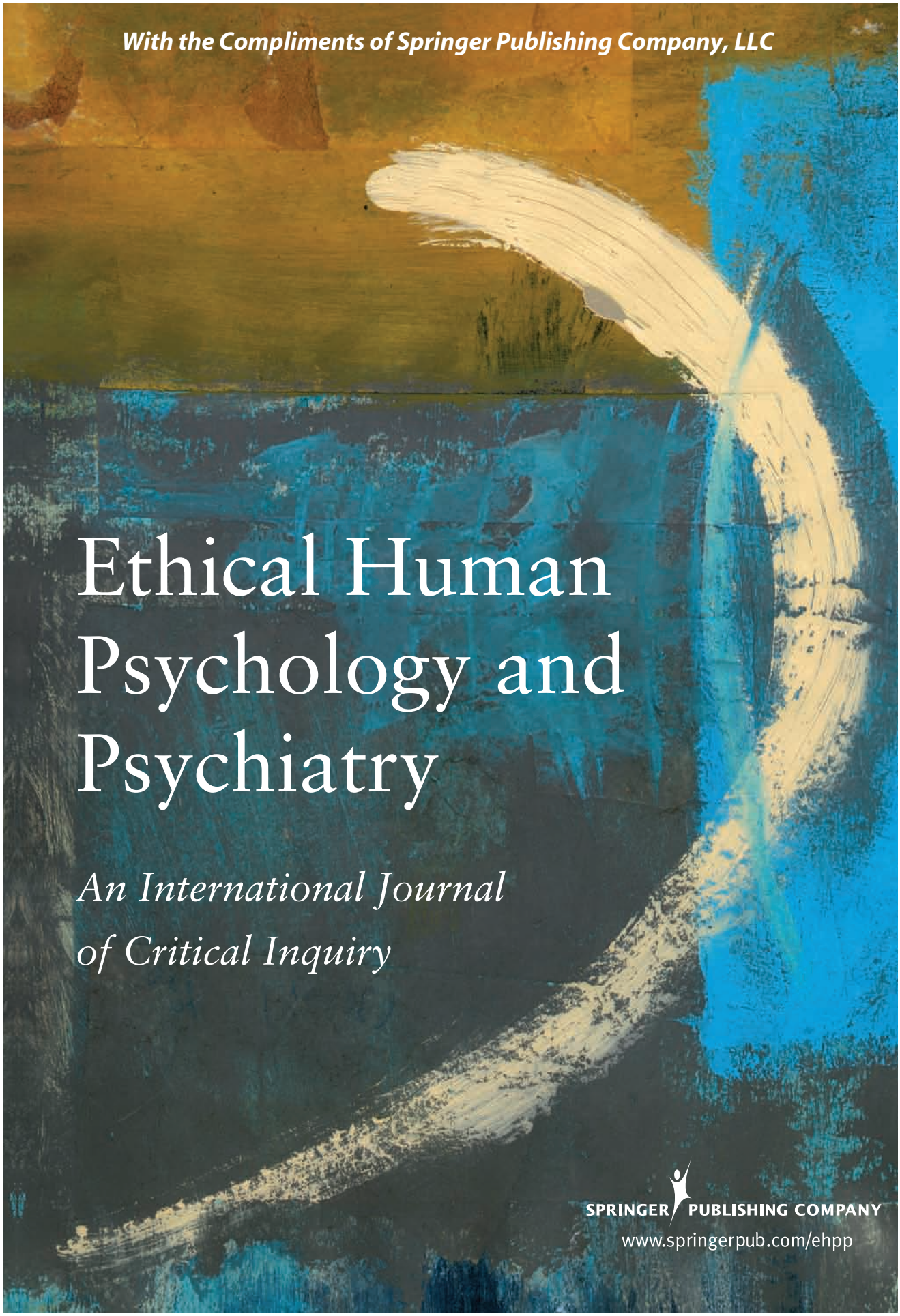

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Featured Articles

A Dialogue *About* the U.S. Dialogue on Mental Health: Exploring the Nature, Scope, and Implications of the Conversation

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With all the emphasis on having *more* conversation about mental health, remarkably little attention has been paid to *how exactly* we want to be having it. In what follows, we review five areas about which sharp differences currently exist: (a) Biology—how are physiological contributors to mental distress being framed? (b) Symptoms—how should we best work with distressing signs in the body? (c) Action steps—what needs to happen to improve mental health in the nation? (d) Barriers—what are the primary barriers that need to be overcome in improving public mental health? (e) Lifestyle—what role do lifestyle choices play in mental health? After illustrating the different positions being taken on each of these questions, we then consider the diverging implications for individuals and families facing these problems. We conclude with recommendations as to how the larger dialogue on mental health could become more inclusive and productive.

Keywords: mental health; dialogue; neuroplasticity; psychiatric medication; risk factor; stigma

News of the suicide of Robin Williams on August 11, 2014, commanded the attention of the United States. Not since the 2012 death of 20 children and 6 adults at Sandy Hook Elementary School has a public event compelled such an intensified discussion about mental health in America. In June of 2013, during the aftermath of subsequent school shootings, President Obama called for a "National Dialogue on Mental Health" in the United States. From numerous public events across the nation to online

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dialogues and the launch of a new website, mentalhealth.gov (with a tag line "Let's talk about it")—the call for more conversation has been loud and clear.

Although *more* conversation about mental health is crucial, far less attention has been paid to *what kind* of conversation we want to have and *how exactly* we want to talk about this complex subject: What are the most meaningful questions to consider? Across the many issues, where should we focus our collective attention? Whose voices should be prioritized in this conversation? And who should decide on the larger terms, assumptions, and language guiding it?

In the absence of this kind of a conversation *about* the conversation, the general public has largely adopted whatever default questions, assumptions, and frameworks have been made available to them. These are readily provided by different interest groups that promote various messages about treatment, prognosis, and the cause of mental disorder.[1] Although certain messages are often promoted as the uncontested "truth" about mental health, there are deep conflicts, contradictions, and clashes between dominant messaging and some of the less common, minority perspectives on mental health. Lost in the middle of these conflicting messages are individuals and families facing serious mental and emotional problems. As if the burden of depression, anxiety, and other problems were not enough, these people are required to make sense of ongoing debates about what exactly to do about the problem.

The purpose of this article is to contribute to a more thoughtful meta-exploration of the U.S. mental health conversation both in the professional and public spheres. Specifically, we aim to characterize patterns in the predominant conversation on mental health—juxtaposing these themes against other patterns showing up in less common conversations also happening about mental health. From a philosophical hermeneutic approach (Martin & Sugarman, 2001; Polkinghorne, 2000), these contrasting interpretive frameworks are a legitimate object of scientific study[2]—with potential benefits arising from increased awareness of the varying perspectives that exist on many of these questions.

Specifically, we explore contrasting interpretive frames for the following areas: (a) Biology—how are the physiological contributors to mental distress being framed? (b) Symptoms—how should we best work with distressing signs in the body? (c) Action steps—what needs to happen to improve mental health in the nation? (d) Barriers—what are the primary barriers that need to be overcome in improving public mental health? (e) Lifestyle—what role do lifestyle choices play in mental health?

Within each theme, contrasting interpretations are reviewed in the following text from both prevailing and minority positions. In each case, distinct stances and illustrations are drawn and referenced from several sources—including published studies, mental health advocacy organization archives, news outlets, and government reports. Relevant excerpts from our own interviewing studies are also noted, including one long-term, retrospective examination of the in-depth experience of depression treatment (Hess, 2009) and a second evaluation of the well-being of 125 youth studied years after treatment for serious emotional challenges (Draper, Bjorklund, Hess, & Preece, 2013).[3]

Throughout, we speak of mental/emotional problems generally—placing no emphasis on the meaningful distinctions between diagnostic categorizations that play an obvious role in practical determinations of a given situation. Although specificity can be important at times, for our purposes, this inclusion of a diverse array of diagnoses permits a more rich and nuanced exploration of mental health dialogue than would be possible otherwise.[4]

Overall, this article aims to make subtle interpretive patterns more accessible to public view—patterns and perceptions that might otherwise remain implicit, unconscious,

and "hidden" (Slife & Williams, 1995). By surfacing and clarifying these patterns in the broader mental health discourse, we hope our inquiry will facilitate a more thoughtful public and professional deliberation about the nature of mental health dialogue itself (Schwandt, 1996).

CONTRASTING EMPHASES IN THE U.S. CONVERSATION ON MENTAL HEALTH

Biological Contributors

When it comes to the physiological basis of mental and emotional distress, how exactly is that important aspect of the picture being framed?

Dominant Position. Mental disorder is caused by some kind of permanent, biological deficiency.

A prevailing emphasis of the current national conversation focuses on locating the primary source, origin, and basis of mental distress in some sort of deficiency in the body and brain itself. Until recently, the most common language centered on a "chemical imbalance" that underlay the painful thoughts and emotions (Deacon, 2013). When asked about their personal definition of depression, one interview participant responded, "It's that little glitch in my brain that's not producing the chemical that lets me be happy and content" (Participant 5). In reference to emotional struggles his daughter was facing, one father said, "The biochemistry just doesn't work like it's supposed to" (Participant 28f).

In light of falsifying evidence regarding the serotonin hypothesis of clinical depression (Lacasse & Leo, 2006; Valenstein, 1998), more generalized language is now commonly used—emphasizing an unspecified brain imbalance, dysfunction, or disorder. One interview participant recalled a doctor commenting that depression "was something that had to do with my brain not working the way it was supposed to work" (Participant 2). One media outlet stated the following about serious mental disorder: "This is really a disease of the brain. Not a disease of the mind" (Kroft, 2014). In a prominent mental health curriculum, a doctor is quoted as saying, "The brain is a complex organ and many things can go wrong in very small ways and make the brain go bad" (Burland, 2011, p. 4.51). The curriculum continues,

> Unhappily, things can go awry with this hugely complicated biological process—our forebears may be giving us DNA where critical genes are deleted altogether, or we get too many duplications of them, or some of the genes we get "miscode" proteins—all giving rise to genetic defects which will fundamentally compromise the neuronal integrity of the developing brain. (Burland, 2011, p. 4.32)

As reflected here, genes are also commonly emphasized as a sort of immutable blueprint that directs the unfolding of life in a fairly set and unilateral way (Marcus, 2004), a blueprint that, like the circuitry of the brain, can be fundamentally defective.

Another Position. The brain and body are surprisingly malleable.

Although the dominant conversation often frames biological contributors to mental problems as stable and enduring, elsewhere the biology is framed very differently—

especially in the wake of new research findings on the surprising fluidity of the brain and body.

Neuroplasticity, for instance, has come to be emphasized as the general malleability of brain networks or "the ability of neurons to forge new connections, to blaze new paths through the cortex, even to assume new roles . . . [signifying a] rewiring of the brain" (Schwartz & Begley, 2002, p. 15). This capacity to change reflects what one researcher calls "the adaptable brain" (Levy-Reiner, 1999). As Marcus (2004) states,

> The brain is capable of . . . impressive feats of experience-driven reorganization. . . . The structure of the brain is exquisitely sensitive to experience. Nature has been very clever indeed, endowing us with machinery not only so fantastic that it can organize itself but also so supple that it can refine and retune itself every day of our lives. (pp. 45, 148)

One psychiatric researcher elaborates,

> Contrary to the notion that the brain has fully matured by the age of eight or twelve . . . it turns out the brain is an ongoing construction site. . . . The neurons that pack our brain at the moment of birth continue to weave themselves into circuits throughout our lives . . . as mutable as a map of congressional districts in the hands of gerrymanderers. (Schwartz & Begley, 2002, pp. 128, 130, 366)

Steve Yantis, a professor of brain sciences at Johns Hopkins University further summarizes, "The bottom line is, the brain is wired to adapt. . . . There's no question that rewiring goes on all the time" (Connelly, 2010).

In contrast to the long held notion of genes-as-blueprint, groundbreaking new research reflects a remarkable picture of genetic expression manifesting differently *depending* on individual lifestyles and actions (Handel, Ebers, & Ramagopala, 2010; for more on the intimate interplay between body and environment, see "Lifestyle Contributor" section in the following text). This gene-environment responsivity is formally known as epigenetics—what Nobel laureate Barbara McClintock has called the "fluid genome" (Federoff & Botstein, 1992).

Symptoms

Symptoms are important for any serious conversation about mental and emotional challenges. How they are framed and emphasized in these conversations vary significantly. A second area of contrasting interpretations concerns the question of how best to work with various behavioral or biological symptoms of mental distress. What level of analysis should we use to understand and evaluate their meaning?

Dominant Position. Symptom identification and management is centrally important to mental health diagnosis and treatment.

A second prevailing emphasis throughout the current national conversation is a prioritization of outward symptoms in both the initial examination of those suffering and in our eventual assistance offered them. This is evident in the predominant emphasis placed on early detection and identification of particular kinds of observable, outward symptomology. In terms of basic assessment efforts, the prioritization of behavioral symptoms over other areas of assessment is striking. In our own analysis of 435 depression questionnaires, we found 98% of the surveys focused largely or exclusively on symptoms—with only 3% of the surveys addressing risk factors of the condition (Hess, Sykes, & Lacasse, n.d.).

When it comes to considering interventions, symptom management likewise often occupies center stage—prompting a focus on *some way* to manage and control these same symptoms. One doctor is quoted as saying, "The majority of patients treated for depression see improvement with their first or second mixture of medicine and therapy. . . . For some people . . . it's not easy to find the right medicine." Describing one man's experience, the article continued, "It took me five therapists and countless medication mixtures until I found the one that made me feel normal. . . . You have to push through it and not get discouraged" (Kahn, 2014).

Among the various ways to manage symptoms, use of psychiatric medication is often presented as central and essential. As one curriculum emphasizes, "Medication is an essential element of successful treatment for people with bipolar disorder. . . . Most people generally require some sort of lifelong treatment" (National Alliance on Mental Illness [NAMI], 2014a). The parent of a youth facing serious emotional struggles remarked, "I don't think there's going to be a time that she's going to be well. We're going to have to stay on it, stay on it, stay on it forever" (Participant 135f).

Most severe mental disorders are thus seen as chronic illnesses that are amenable only to careful and continuous management, rather than complete recovery or healing. Although treatment efforts can help with the management of symptoms and potentially reduce their severity or frequency, in this view, there is typically less expectation that other personal actions will elicit substantive changes in the body or mind.

For this reason, long-term symptom management via medication is often presented as an appropriate goal and even a type of recovery, as stated by one advocacy organization: "With appropriate effective medication and a wide range of services tailored to their needs, most people who live with serious mental illnesses can significantly reduce the impact of their illness and find a satisfying measure of achievement and independence" (NAMI, 2014e). For those facing serious mental and emotional problems, this kind of coping, managing, and functioning via treatment is presented as a key source of hope: "While there is no cure for bipolar disorder, it is a treatable and manageable illness" (NAMI, 2014a). Hope for deeper recovery is likewise typically presented as resting in new treatments—including "devising medications beyond the level of symptom relief" and "drugs targeting the underlying causes and not just the symptoms of disease" (Burland, 2011, p. 4.32).

As reflected here, on various levels, the presence of troubling symptoms constitute the primary focus within this conversational framework—with considerations of lifestyle patterns and underlying risk factors peripheral to the discussion. How to best decrease these symptoms becomes the primary outcome around which everything else mobilizes. Indeed, treatment, symptom relief, and recovery are often used interchangeably. In many instances, medical treatment is taken for granted as the fulcrum around which all these processes pivot.

Another Position. Symptoms of mental and emotional distress are signs of deeper patterns and concerns.

Compared to the central emphasis symptoms receive in the dominant conversation, symptoms are approached elsewhere as offering insight into deeper patterns and problems. From this vantage point, symptoms are not necessarily the primary issue; instead, they provide crucial data that point in the direction of the true problems.

In particular, the root problems driving mental health difficulties are understood to be patterns in the surrounding environment and social atmosphere. Outward symptoms become a guide to understanding these underlying problems. Like an alarm that identifies

an area of danger, symptoms alert individuals to areas in their lives that need attention. By paying attention to a particular constellation of symptoms, additional understanding may arise about what is happening in the body, the mind, or surrounding relationships. In this way, greater attention may be given to the underlying risk factors and protective mechanisms at play.

Mental disorder and associated recovery are thus meaning-laden experiences that involve learning and substantial personal effort—reflecting a belief that health trajectories may be modified over time. By making deeper adjustments on the level of risk factors, individuals can move in the direction of deepening mental and emotional wellness. As the Foundation for Excellence in Mental Health Care states, "Expect Recovery" (Nikkel, 2012). The assumption from this vantage point is that fundamental healing is possible over the long term.

Hope for any kind of deeper recovery, from this vantage point, rests in these broader kinds of changes—especially adjustments that alter root risk factors over time. This may or may not include direct symptom management itself. Rather than trying to make feelings go away directly, this encourages attention to more gentle, subtle ways of engaging painful emotional patterns that may, in turn, reduce one's biological vulnerability over time. Like other physiological patterns, of course, well-worn neural networks cannot simply be "zapped" like tumors with chemotherapy, nor do these findings imply that the solution to mental distress is spontaneously "choosing to be happy." Instead, this portrayal emphasizes the potential of the brain to be rewired and for genes to manifest differently over time depending on the cumulative actions and choices of the individual.

Recovery, in this sense, is something more than treatment alone (Hess, Lacasse, et al., 2014). From this perspective, eliminating and silencing symptoms may inadvertently cover up the clues and signs about the deeper dynamics of the problem and thus any underlying risk and protective factors. That being said, sometimes medications that aim to manage symptoms may still be crucial—depending on individual needs and experiences. Rather than being presented as an essential, first-line intervention, however, medication is presented as one option that is part of a larger treatment picture retaining sustainable, deep healing as its overriding intention and expectation.

Action Steps

As a third contrast, we turn to different perspectives on the question of what needs to happen to improve mental health in the nation and what of the many potential steps forward should be our top priority.

Dominant Position. The focus of action should be on removing barriers to treatment access.

Once symptom management is accepted as the central and crucial need, the lack of availability for this kind of management becomes the central danger. Even cursory reviews of the current national conversation catch frequent concern expressed over the lack of treatment as what is hurting people the most:

- "Each year 40 million Americans experience some form of mental illness. . . . Most of these Americans have never received the treatment of services their health needs require. Tragically,

many are doomed to move from hospital to homelessness to jails and prisons" (Burland, 2011, p. 1.15).

- "Treatment works, but only half of people living with mental illness receive treatment" (NAMI, 2017).
- "Simply put, treatment works, if you can get it. But in America today, it is clear that many people living with mental illness are not provided with the essential treatment they need" (Fitzpatrick, 2006, p. 27).
- "On any given day now in the United States, half of the people with schizophrenia and other severe mental illnesses are not being treated. . . . it's estimated that half the 7 million people in the country with schizophrenia and other forms of severe mental illness are not being treated at all" (Kroft, 2014).

In the early 1990s, a "kindling hypothesis" was proposed; wherein the untreated mental illness was compared to a conflagration spreading like wildfire over the brain without treatment (Monroe & Harkness, 2005). Since then, "untreated mental illness" has become a catchphrase in the current U.S. discussion on mental health.

One news report on the epidemic of violent shootings underscored "untreated mental illness" as an "imminent danger." The report continued,

> It's become harder and harder to ignore the fact that the majority of the people pulling the triggers have turned out to be severely mentally ill, not in control of their faculties, and not receiving treatment. In the words of one of the country's top psychiatrists, these were preventable tragedies, symptoms of a failed mental health system [and a] society that's neglected millions of seriously ill people.

This news report went on to emphasize that in many cases, if the individuals involved had been "treated," the incidences "would've been preventable." After describing the 2013 Navy Yard shooting in Washington, DC, the report asserted, "If he had been transported to a psych ward, the shootings might never have happened." One authority is quoted as saying,

> Some are getting treated. Other ones aren't getting treated. People are falling through the cracks all the time. And so to think that that won't then boil up at some point and end up in a tragedy, that's just naive. That's just naive. (Kroft, 2014)

As reflected here, the implications of being "untreated" are not left to the imagination. One advocacy website states that "approximately 40% of individuals with schizophrenia and 51% of those with bipolar are untreated in any given year" then adding, "The consequences of nontreatment are devastating." Numbers associated with homelessness, incarceration, and violence are then reviewed—in each case, linking those figures specifically to the absence of treatment:

- "*People with untreated psychiatric illnesses* [emphasis added] comprise one-third . . . of the homeless population. The quality of life for these individuals is abysmal."
- "*People with untreated serious brain disorders* [emphasis added] comprise approximately 16 percent of the total jail and prison inmate population."
- "There are approximately 1,000 homicides . . . committed each year by people with *untreated schizophrenia and bipolar disorder* [emphasis added]" (emphasis ours, "Consequences of Nontreatment," Treatment Advocacy Center).

The natural result of not getting medical attention is portrayed as being homeless, in jail, in prisons, and so forth. Financial costs are also emphasized:

- "Without treatment the consequences of mental illness for the individual and society are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives; The economic cost of untreated mental illness is more than 100 billion dollars each year in the United States" (NAMI, 2014e).
- "In the United States, the annual economic, indirect cost of mental illness is estimated to be $79 billion. . . . Individuals living with serious mental illness face an increased risk of having chronic medical conditions. . . . Suicide is the eleventh-leading cause of death. . . . More than 90 percent of those who die by suicide have a diagnosable mental disorder. . . . Over 50 percent of students with a mental disorder age 14 and older drop out of high school—the highest dropout rate of any disability group" (NAMI, 2007).

The takeaway is that treatment itself is the key action step needing to be taken to address the mental health needs in our nation. One prominent psychiatrist is quoted as saying, "About half of these mass killings are being done by people with severe mental illness, mostly schizophrenia. And if they were being treated, they would've been preventable." He continues, "We have a grand experiment: What happens when you don't treat people. But then you're going to have to accept 10 percent of homicides being [carried out] by untreated, mentally ill people. You're going to have to accept Tucson and Aurora. You're going to have to accept Cho at Virginia Tech. These are the consequences" (Kroft, 2014).

Given this kind of language, an emphasis in the mental health discourse on getting people into treatment faster, sooner, and more frequently is no surprise. The director of NIMH writes on his blog,

> "Let's talk about it"—is a good place to start, but for a 19-year-old in the grip of a psychotic episode or a 16-year-old on the path to serious mental illness, we urgently need an action plan to alter the course of their illness. . . . The majority of people with mental illness delay seeking care . . . in the United States, individuals with psychosis go untreated for, on average, 110 weeks. (Insel, 2013)

He continues, "Among other serious consequences, untreated psychosis poses an increased risk for substance use and suicide," and then states, "Our best hope of reducing mortality from serious mental disorders will come from realizing that just like other medical illnesses, we need to diagnose and preempt the illness before the symptoms become manifest" (Insel, 2013).

One prominent school-based curriculum states, "There is hope. Research has shown that early recognition, intervention, and treatment of mental disorders make a positive difference in a teen's life—potentially preventing a suicide attempt, or a death by suicide" (American Psychological Foundation, 2014). This kind of emphasis on "catching it early before more harm is done" is common:

- "Early identification and treatment is of vital importance; By ensuring access to the treatment and recovery supports that are proven effective, recovery is accelerated and the further harm related to the course of illness is minimized" (NAMI, 2014e).
- "Treat patients as early as possible—future medication might fight the rapid loss of brain tissue" (Burland, 2011, p. 4.44).

Another Position. The focus of action should be on initiating broad-based public health campaigns.

When vulnerabilities in the body are viewed as permanent deficiencies, understandable emphasis and urgency are given to getting people into treatment that will correct those deficiencies. By contrast, once biological patterns are seen as malleable in response to lifestyle shifts, a broader thrust of collective action becomes possible, namely public health campaigns drawing attention to lifestyle adjustments that may potentially shift underlying risk factors.

Reviews of the scientific literature over recent decades have confirmed multiple areas of risk factors that predispose severe mental disorders—with developmental psychopathologists documenting a multifactorial approach to mental disorder, with complex factor models of vulnerability mapping on to diverse developmental pathways (Cicchetti & Cohen, 2006; Hayward et al., 2008). In one analysis of psychiatric risk across thousands of youth, authors pointed out that "the presence of multiple risk factors . . . substantially increased risk of first incidence of all disorders examined," noting that "psychiatric disorders . . . are the product of multiple factors and these factors in turn have effects on multiple disorders" (p. 405).

As the variety of risk factors becomes better known, the range of intervention options simultaneously expands. This includes efforts to develop new treatments and educational curricula focused on addressing the underlying lifestyle risk factors of various symptoms (stressful environment, sleep/eating habits, exercise patterns, etc.; e.g., Addis & Martell, 2004; Gordon, 2008; Null, 2008). From this perspective, no single option takes all the focus. A young man expressed gratitude that his counselor "never claimed to have a cure all. . . . He didn't say 'This is the answer. You do this and you'll be fine'" (Participant 10).

Among other things, this broad-based approach accords a central and meaningful place for personal choice in directing one's lifestyle and environment in ways that eventually shape one's brain and body over time. Individuals may naturally believe they can do something to directly influence the going or coming of mental disorders.

Once again, this doesn't mean that treatment barriers are not a concern—only that they are not the overriding or primary concern from this perspective. Instead, medical treatment becomes one aspect of a whole package of integrated care.

Barriers

Closely related to action steps is fourth question: What are the primary barriers that need to be overcome in improving public mental health?

Dominant Position. The stigma of mental illness is the biggest barrier to improved mental health outcomes.

According to the dominant terms of the U.S. conversation on mental health, one of the single greatest barriers to treatment access and recovery is stigma itself.

From this vantage point, the issue is not a limitation in our knowledge or a need for more exploration; it is getting rid of the barriers people have to "getting help." If not for public stigma and fear, people would accept treatment. In this way, public stigma and fear are underscored as the biggest barrier we face.

Attention to stigma plays a large part in the ongoing conversation about mental health. Indeed, it is hard to find an article and researcher that doesn't talk about stigma of some kind:

- "First and foremost, the stigma of depression is making us sicker. . . . Eradicating the stigma of mental illness must be a public health priority" (Friedman, 2014).
- "There's also an unfortunate stigma surrounding mental health disorders that often prevents people from seeking the treatment they need. And, for those people who do want help, often they're not sure where to turn. Perhaps this tragedy [Robin William's death] will help move the nation's dialogue in a direction that focuses on raising awareness and increasing access to mental health services. If we're serious about taking steps to prevent mental health crises from occurring, it's imperative that we increase access to public education programs" (Durkin, 2014).

NAMI has made fighting stigma a central theme of their mental health campaign—fighting "inaccurate and hurtful representations of mental illness" and "break[ing] down the barriers of ignorance, prejudice, or unfair discrimination" (NAMI, 2014b). On the website, they state,

> Stigma—what is this? Stigma erodes confidence that mental disorders are real, treatable health conditions. We have allowed stigma and a now unwarranted sense of hopelessness to erect attitudinal, structural, and financial barriers to effective treatment and recovery. It is time to take these barriers down. (NAMI, 2014e)

Another Position. Cultural forces are the single biggest barrier to improved mental health outcomes.

When it comes to what prevents individuals from getting better, this position highlights the various environmental and cultural forces in modern America that can inhibit individual adjustments and changes. Speaking of their own lifestyles, two individuals commented,

- "You're not going to be able to let yourself get sleep deprived your whole life . . . you can't. You've got to kind of watch this and not think that you can go without sleep just because it feels like you could. . . . you can't do that to your brain for years on end. You can't not feed yourself. . . . You've got to take care of your body because your body takes care of your brain" (Participant 2).
- "If I go without sleep and start partying a lot and get overextended and stressed, yea, I'll hit depression. . . . I know I could bring myself another depression—I know the recipe for madness. . . . I lose my sleep; I drink too much. . . . I get involved in too many things—that's the recipe for madness for me" (Participant 12).

Within a larger context increasingly frantic and hurried, there is growing awareness of the impacts on mental health. To underscore the role of socialization, the consequences of trauma are often emphasized. For instance, a CDC study released earlier this year pointed out that just 1 year of confirmed cases of child maltreatment costs $124 billion over the lifetime of the traumatized children. The researchers based their calculations on only confirmed cases of physical, sexual, and verbal abuse and neglect, which child

maltreatment experts say is a small percentage of what actually occurs. The breakdown per child is

- $32,648 in childhood health care costs
- $10,530 in adult medical costs
- $144,360 in productivity losses
- $7,728 in child welfare costs
- $6,747 in criminal justice costs
- $7,999 in special education costs (total of $210,000/child; Fang, Brown, Florence, & Mercy, 2012)

Although the immediate symptoms of mental and emotional distress are still acknowledged as worth discussing, the primary attention here goes to life experiences that foreground and set up these patterns of symptomology. In a similar way, although stigmas against having a serious disorder are certainly acknowledged, they are not understood to be the central issue. Instead, the topic needing the most attention is how a compounded risk factor burden of current life in American culture is predisposing the brain to extreme distress.

Lifestyle Contributors

What role do various aspects of personal lifestyle, choice, and environment play in the development and amelioration of mental and emotional distress?

Dominant Position. Individual choice and environmental context are de-emphasized as causative factors in the development of mental and emotional disorder—as well as in its successful treatment.

When considering the source of mental health problems, lifestyle contributors are often framed in an interesting way. First, they are typically cast as in opposition to biological ones—reflecting the "nature versus nurture" dichotomy. Once this happens, the discussion comes to consider which is "more important."

Within this framework, environmental and lifestyle contributors may subsequently be portrayed merely as "triggers" for the true, underlying organic problem (Zuckerman, 1999). In this way, the array of potentially contributing lifestyle factors may be subtly de-emphasized and minimized. One advocacy website, for instance, states that

> genetic factors and not a shared environment account for the greatest variance in ADHD symptoms. . . . Other factors (e.g., family adversity, poverty, educational/occupational status, home environment, poor nutrition, environmental toxins, ineffective child rearing practices) do not appear to have a significant contribution to the development of ADHD symptoms. (Ellison, 2017)

Although strong evidence indicates that childhood trauma plays a significant role in later mental and emotional well-being, this has been largely ignored in the U.S. discussion until recently (Stevens, 2012).

Perhaps for this reason, the scope of trustworthy intervention options for the treatment of serious mental and emotional problems is portrayed as limited and generally focused on the body. For instance, one mental health website asserts, "There are three well-established types of treatment for major depression: Medications. Psychotherapy. Electroconvulsive therapy (ECT)" (NAMI, 2014c).

In addition, educational messages about mental health routinely discourage any degree of holding people accountable for the effect of personal choices and surrounding family relationships on mental health issues:

- "Mental illnesses are serious medical illnesses. They cannot be overcome through 'will power' and are not related to a person's 'character' or 'intelligence'" (NAMI, 2014e).
- "Mental illnesses are not the result of personal weakness, lack of character, or poor upbringing" (NAMI, 2014d).

The idea that individual effort could make a difference can even be presented as unfair and harmful:

- "One mental health curriculum cautions people against focusing on personal effort—especially, [believing] that 'if doing thus-and-so improves my mood, then I must work harder to be well.' The curriculum goes on to state, 'This misunderstanding of the illness process will mislead those involved into believing that when the mood goes down, it is a 'failure of effort,' that the depressed person 'just isn't trying hard enough'" (Burland, 2011, p. 3.20).
- "[To tell someone to] exert more mental and moral control, to have more self-discipline, to adopt a more positive attitude. . . . This is a very unfair way to treat people who are suffering from a tragic and painful illness that they cannot in fact control. To ask them to 'shape up' is like asking a person with a broken leg to run a marathon" (Burland, 2011, p. 4.36).

As reflected here, there is little by way of personal change understood to be relevant to the arrival or relief of mental distress. This same pattern is reflected in individual interviews. "This isn't your fault" another interview participant told her friend facing depression, "There is this chemical in your brain that says you can't be happy and content" (Participant 5). One woman spoke of her brother trying to help her realize that depression "didn't have anything to do" with her efforts and that recovery didn't rely on her making any changes (Participant 16). Another woman expressed gratitude for realizing that

> there was nothing I could have done to keep me from getting depression. . . . I mean, it's not like if you don't smoke you won't get lung cancer, you know? I mean, it's not that kind of a thing; you can't say, "Well it's because I ate the wrong thing, you know . . . it couldn't be helped." (Participant 5)

One woman who had faced depression said,

> I'll just never forget when I read a book that said telling someone with depression to pull themselves up by their bootstraps and "just do it" is like telling somebody who's had a heart attack to run to the top of a mountain. You know, there's really no difference. There's something physically wrong . . . with your brain and it's not working and you can't force your brain to do something it can't do any more than you can force yourself to run to the top of the mountain just after you've had a heart attack. (Participant 8)

Although there are mentions of lifestyle changes as potentially helpful, they are emphasized as not the central answer—but instead, techniques to "cope with the symptoms of mental illness" that will continue to afflict them. One exception, where personal choice is often emphasized, is in relation to compliance with treatment. After emphasizing medical

management as key to facing depression, one woman said, "The best change in my attitude was that I couldn't help that this happened," adding, "But I can control it now, you know" (Participant 5). Another individual emphasized,

> I'm responsible every single day for doing this mental inventory [of] "where am I at?" and when I notice the warning signs it's my responsibility to do whatever it is I need to do. Whether I need to get in and see the doctor, get my medication adjusted, make an appointment, etc. (Participant 13)

A sense of personal power and choice thus centers around seeking out and complying with treatment.

Another Position. Environmental context, personal accountability, and lifestyle factors are emphasized as the key to the development of mental and emotional disorder—and to its successful treatment as well.

Rounding out the discussion of where mental health problems originate, lifestyle factors can also be alternatively emphasized as seamlessly connected and intertwined with a malleable body.

From this vantage point, biology and environment are not opposing factors but instead are understood as intimately and continually interrelated. A particular mental or emotional state, then, is understood as "not composed of separate elements but a confluence of inseparable factors that depend on one another for their very definition and meaning" (Altman & Rogoff, 1984, p. 24).

As a result, both body and lifestyle are considered equally important—with complex and interpenetrating relationships wherein external and lifestyle influences can literally mold physiological processes over time as individuals respond to broader cultural and interpersonal prompts. A destructive home atmosphere, for instance, may shape brain pathways in a way that predispose youth, in turn, to seek out destructive behavior such as substance abuse (which, in turn, prompts further physiological changes). From this perspective, then, environmental and cultural forces may have a much larger, more complex role in shaping the brain. Summarizing these findings, one author concludes,

> Our physical brain alone does not shape our destiny. How can it, when the experiences we undergo, the choices we make, and the acts we undertake inscribe a diary on the living matter of our cortex? The brain continually refines its processing capacities to meet the challenges we present it, increasing the communicative power of neurons and circuits that respond to oft-received inputs or that are tapped for habitual outputs. (Schwartz & Begley, 2002, p. 373)

From this vantage point, then, "Agency is manifested in, and is not separate from, the body" (p. 137), with the body inescapably intertwined with choice, a materially structured feature of ongoing human decisions and actions and meanings. This same body may then be expected to change in one direction or another, depending on moment-by-moment actions. Citing "the brain's astonishing power to learn and unlearn, to adapt and change, to carry with it the inscriptions of our experiences." Schwartz and Begley (2002) suggest, "It is the life we lead that creates the brain we have" (p. 366). More specifically, they later explain, "The life we lead, in other words, leaves its mark in the form of enduring

changes in the complex circuitry of the brain—footprints of the experiences we have and the actions we have taken" (p. 373). Dr. Louann Brizendine (2006) reaches a similar conclusion as to the personal impact of neuroplasticity research:

> The brain is nothing if not a talented learning machine. Nothing is completely fixed. Biology powerfully affects but does not lock in our reality. We can alter that reality and use our intelligence and determination both to celebrate and, when necessary, to change the effects of [other factors] on brain structure, behavior, reality, creativity—and destiny. . . . If we acknowledge that our biology is influenced by other [environmental] factors . . . we can prevent it from creating a fixed reality by which we are ruled. (pp. 6–7)

A mounting body of literature supports the possibility of sustainable recovery among those diagnosed with severe mental disorder. This includes longitudinal quantitative studies (e.g., Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Harrow & Jobe, 2007) as well as qualitative work (e.g., Lietz, Lacasse, Hayes, & Cheung, 2014). In addition, the prevention of mental disorder through nutritional supplementation has been demonstrated (Amminger et al., 2010). Thus, rather than being fixed or permanent, a diagnosis of mental disorder carries with it the very real possibility of sustained healing.

In short, this view of a dynamic, lived, and transacting biology accompanies psychological experience, rather than underlying it. Therefore, a condition such as depression may be understood to arise not from isolated factors of body or mind alone, but from a dynamic interplay between multiple aspects unfolding over time (M. Williams, Teasdale, Segal, & Kabat-Zinn, 2007).

Without placing blame, this does raise another perspective on the role of individual choices: as ultimately mattering quite a bit for the mental health of the individual. As a result, a broad range of recovery pathways may be emphasized.

Even with such an emphasis on personal choice in the unfolding of one's health, there is no suggestion that individuals facing emotional problems are somehow morally inferior and weak. Nor is there any suggestion that individual choice and willpower are somehow absolute. Instead, actual limitations on personal freedom are freely acknowledged alongside a hope that when people make choices that *are* available, they may have a cumulative, positive effect. In turn, this may lead individuals in a direction of expanding emotional freedom over time (M. Williams et al., 2007).

In this way, rather than seeing personal freedom to be happy, to eat normally, to pay attention, and so forth as an absolute reality (or not), willpower and responsibility may thus be seen as a continuum, with a capacity to ebb and flow over time depending on current actions (R. N. Williams, 1992). As reflected earlier, this approach centers around more than simple treatment compliance. Rather, it centers on ways to shape one's habits and biology over time, moment by moment (M. Williams et al., 2007).

DISCUSSION

In June 1999, 6 weeks after the school shootings in Littleton, Colorado, another White House initiative—this time by Tipper Gore and President Clinton—called for more

attention to mental health in the nation, especially among the youth. Referring back to this event, NIMH Director Thomas Insel (2013) states,

> Fourteen years later, the conversation leaders are different, but the issues are much the same. Again we are in the wake of a school shooting; again we turn our attention to mental health in youth; and again we are discussing how to overcome negative attitudes toward those with mental disorders. But this begs the question: Why are we still having the same conversation about the same issues in mental health? How do we refocus this discussion?

Our hope in exploring different frameworks for the U.S. conversation is to accomplish precisely that. Too often in the calls for more conversation, remarkably little attention is paid to *what kind* of conversation we want to have in the first place. Instead, the focus is simply, "Let's talk!" By contrast, we encourage here more "talk about the talk" and "conversation about the conversation": *How exactly* do we want to talk, anyway? We've reviewed here two different ways of framing the mental health conversation—with different terms, emphases, and interpretations—including regarding something as seemingly basic as the biology of mental disorder.

The differences could not be more striking: Should we emphasize permanent deficiencies in the brain or potential changeability? Should we highlight in public discourse the consequences of (untreated) mental disorder or the consequences of trauma? Should we focus our public discussions on barriers keeping people away from treatment (e.g., stigma) or might we more effectively examine the kinds of precursor experiences leading people to a need for treatment in the first place?

Other questions still remain: Do these different interpretations really make a difference in actual practical experiences? Second, where are these differences in interpretation coming from anyway? Last, if these differences really do matter, why don't they come up more often in our public discussions? We briefly take up these three questions in the following text before considering some possible shifts that could enrich the larger conversation about mental health.

Diverging Impacts of Diverging Conversations

To explore potential implications of varied interpretations, it's helpful to consider a thought experiment that places the same individual (suffering and seeking relief from mental distress) into two contrasting conversations (each emphasizing different clusters of interpretations earlier). In one case, an individual is persuaded by a conversation that takes five conclusions for granted: (a) One's emotional distress arises primarily from a fundamental deficiency in the brain or body. (b) The most important priority in facing such distress is to manage and control any untoward symptoms that are arising. (c) Anything that prevents one from accessing treatment should subsequently be the primary focus of corrective action. (d) Prejudice against those facing mental illness is the most concerning barrier in that regard. (e) One's personal choices in various lifestyle domains are not central to the presence of emotional distress or whether it dissipates over time.

Now let's consider the same individual, facing the same problems, and instead imagine him or her embedded in another conversation with very different conclusions: (a) One's emotional distress arises because of life experiences that shape the brain and body in different ways over time. (b) When symptoms arise, they communicate valuable information

about underlying risk factors. (c) Although managing symptoms can be helpful, lifestyle adjustments are more likely to make a longer term difference. (d) Although barriers to treatment, including stigma, are real, more concerning is the cultural atmosphere leading increasing numbers of people to a need for this treatment in the first place. (e) One's personal choices are often quite central to the presence of significant emotional distress and whether it dissipates over time.

The clearest implications of these different conversations are evident in the diverging treatment pathways they each underscore for a person suffering. Although the first conversation predisposes distressed individuals to prioritize medications as a central and enduring fixture of recovery, the second conversation orients individuals to explore other interventions as equally central.

For many, the advent of some means of symptom control for a confirmed biological deficiency marks almost a redemptive moment that illuminates a better life ahead. One woman related,

> I remember when the doctor told me that she felt like I was bipolar. . . . I actually felt like . . . she was telling me that it this is something that was treatable—that it was an illness; that it was something that had to do with my brain not working the way it was supposed to work.

Although "not pleased with the idea that I was mentally ill," she spoke of feeling encouraged with the idea she was facing "something that was treatable" via medication to "stabilize my moods and hopefully clear up my thinking." "I was pretty scared in one way," she added, "But I was also kind of relieved in another" (Participant 8).

For others on this same treatment pathway, the feelings are more conflicted. One woman stated,

> Two really combative emotions came up when I was diagnosed—one was "God, thank you!" . . . you know, "I'm not insane—this is a real thing. It's in a book somewhere . . . we can start working on it." There was a relief that I wasn't alone, totally, anymore. And . . . it didn't feel so stuck anymore. But then . . . in a way, it made me feel more alone too, cause I was like "Oh, it's not a cold that's just going to go away or I can't take some penicillin and look back and go, 'Oh, that was crappy'"—so it . . . makes you realize that this is something that's going to be with me for [good].

She continued,

> It was so defeating, you know, "It's not going away—this is me," you know—and that's sad. You feel like you lose yourself, almost. Like a part of you dies when you're diagnosed. . . . It's almost like a grieving period realizing that the person that was faking it for so long—she wasn't real. And she kind of did die and that we had to reinvent and restructure this new being, almost. That we didn't have any information on what would make it better. . . . It was almost like we were constructing a new being, you know? Giving her the tools and the revenues, making sure she had insurance all the time, you know? I mean, it's hard. . . . [You] do feel a detachment from everything you thought you were when this becomes where you're at, because this is not who I was supposed to be.

Although many experience profound relief with biomedical treatment and diagnoses, particular distress can arise when medications stop working and/or individuals are told their problem may never go away. When asked, "Do you ever talk about 'getting fully

better' from depression?" one individual said, "I don't think that's possible. . . . I want to, but I don't think that I . . . I think, just a couple years ago I just faced it that I'm just always gonna have to have something" (Participant 8).

Although chronic prognoses have become more common, their impact on patients deserves further attention. One woman told us, "My suicidal thoughts started the day my doctor told me my depression would be lifelong." Another woman who spent years in a mental hospital before going on to full recovery said,

> When you are already feeling hopeless and in despair, to have someone tell you that what you have is a condition you're going to have to live with the rest of your life . . . it makes you feel even more hopeless, more in despair, more worthless—and like, "Why even try? Why even try? This pain is just going to last forever." (C. Penney, personal communication, October 29, 2011)

Could a mental health conversation that feels hopeless actually be dangerous for people—making something like depression feel less bearable? Dan Iosifescu, Director of the Mood and Anxiety Disorders Program at the Icahn School of Medicine at Mount Sinai Hospital states, "In the midst of profound depression, many patients start feeling that not only is their current situation unbearable, but that it will continue forever." He continues, "This seems to be the difference in why some people with depression decide to kill themselves" (Kahn, 2014).

Whether facing the dark desperation of depression, or another serious condition, the extra stress felt by individuals with a sense of hopelessness about treatment possibilities is a grave added burden. For now, maybe we should at least be careful not to insinuate permanent deficiencies in the body or lifelong diagnoses when current science suggests otherwise. Elsewhere, we explore more carefully the implications of different ways we talk about recovery (Hess, Lacasse, et al., 2014), the distressed brain (Hess, Gantt, et al., 2014), and "successful treatment" (Hess & Lacasse, 2011).

Funding Sources of Different Conversations

What accounts for the vast difference in emphases across conversations? Like many other "framing" questions in the media, it's difficult to avert attention from the influence of funding. In 2008/2009, Senator Grassley of the U.S. Senate conducted a probe of funding sources for the nation's largest mental health educational organization and found that most of their budget was coming from pharmaceutical companies (Harris, 2009). Since that time, it has become clear that this same pattern exists in other major educational and advocacy organizations. In the first quarter of 2009 alone, Eli Lilly gave $551,000 to NAMI and its local chapters, $465,000 to the National Mental Health Association, $130,000 to CHADD (an attention deficit/hyperactivity disorder [ADHD] patient-advocacy group), and $69,250 to the American Foundation for Suicide Prevention (Whitaker, 2010, p. 327).

Although funding is necessary for mental health education and does not necessarily skew that work, our own review of industry-funded educational materials uncovered significant oversights. When compared with industry-independent curricula, for instance, NAMI's own course material rarely mentions biological discoveries such as neuroplasticity and epigenetics. When "neurogenesis" does receive attention, it is described as "a still controversial hypothesis" (Burland, 2011, p. 4.33).

Mental Health Absolutism

In the earlier examination, we have considered different perspectives and approaches to mental health. Remarkably, the awareness of this diversity of views on mental health prognosis, treatment, and etiology is often still limited. Instead, there is a strong insinuation in the larger mental health conversation that basic mental health knowledge is clear and agreed on by most experts. It has become common, for instance, to hear references to "mental health literacy" (Jorm, 2000) as if mental health knowledge were as clearly delineable as the ABC's and learning to read. As one leading advocate of mental health literacy states, "Many members of the public cannot recognize specific disorders or different types of psychological distress" adding with some concern, "They differ from mental health experts in their beliefs about the causes of mental disorders and the most effective treatments" (Jorm, 2000, p. 396). From this vantage point, conversations about mental health are understood as primarily aiming to educate and raise awareness about the undisputed "realities" of mental health problems and their treatment.

As reflected earlier, a part of this literacy is ultimately aiming to "train patients to become effective health care consumers" in the words of one research team (Kelly, Scott, & Mamon, 1990). After testing people going through one mental health class, these same researchers reported "significantly improved . . . medication compliance behavior" (p. 1111).

Is this the mental health conversation we want to be having? What if we *did not* take for granted that the answers (or the problems) were agreed on? What if, instead, we fostered a larger mental health conversation where disagreements and differences were collectively acknowledged and carefully examined?

RECOMMENDATIONS

We conclude with five recommendations that we believe might enrich the ongoing U.S. conversation about mental health:

Acknowledge Current Scientific Findings in the Public Discussion

Make sure our mental health curricula promote current, updated scientific findings. Too often, as described earlier, larger educational efforts are still emphasizing the role of a deficient body while de-emphasizing the potential place of lifestyle in both the development of the problem and its amelioration. If we want to be having an "honest scientific discussion" (Whitaker, 2010, p. 359), this needs to change.

Allow Symptoms to be One Facet of a Comprehensive Picture of Risk and Protective Factors

Portraying the treatment of symptoms as the central valid indicator of a person's mental state is outdated and shortsighted, at best. At worst, it distracts from deeper issues that may move someone along to deeper, more sustainable healing. With the advances in brain science and the rapid growth of the risk factor literature, our conversations about

treatment need to acknowledge broader possibilities in a more multimodal and comprehensive picture.

Be Cautious With Proposals to Get More Aggressive With Treatment

As part of the prevailing conversation detailed earlier, there is a growing push for more aggressive efforts to get people into treatment—both children and adults (Kroft, 2014). As long as questions about various treatment approaches remain highly contested, this impulse needs to be restrained—as confirmed by the large medical literature on overdiagnosis and overtreatment (Brownlee, 2007; Moynihan & Cassels, 2005). A better approach would be to hold the tensions about various treatment approaches in awareness as a society, thus allowing a chance for more thoughtful deliberation about how to best move forward. Dan Berstein's (2014) pioneering work on mental health mediation is a good example of holding this space where diverse views are encouraged to interact in search of reconciliations and nuanced, win–win solutions.

Do Not Overdo the Stigma Focus

Perceptions of certainty can lead to reservations about those who raise questions. As one mental health curriculum states, "Lack of insight is common among people with brain disorders. Over 50% of individuals with schizophrenia and mania will not acknowledge that they are ill, nor will they accept any form of treatment. This means they are biologically stuck in denial." This curriculum goes on to conclude, "Many people experiencing mental breakdown are genuinely 'clueless,' while others are heavily into protective denial [that] they are still desperately physically ill" (Burland, 2011, p. 4.41).

Although it's clear that any of us (patients or otherwise) may be stuck in various stages of denial, statements like these can contribute to an atmosphere where concerns or questions about treatment are not taken seriously. Instead, we may automatically interpret these questions as reflecting either illness or stigma itself. Indeed, the very questions and perspectives raised in this article could be seen, from this vantage point, as a reflection of stigma.

Once again, is this the mental health conversation we want? Or might we perhaps acknowledge that thoughtful people disagree about many of these questions?

A broader conversation along these lines would acknowledge the reality of mental health discrimination and stigma. But it would not interpret critical questions as reflecting this same stigma. Instead, this kind of discussion might allow those who are hesitant about certain mental health treatments to be seen with fresh eyes. Specifically, those who resist the current mental health system might be understood as not necessarily rejecting the seriousness of mental illness, but instead, questioning some of the terms and assumptions *behind one particular paradigm of mental illness*. Would these people with concerns feel the same way about a mental health paradigm that prioritized root risk factors along the way to sustainable, deep healing?

Insist on an Authentic Mental Health Dialogue, Not a Mental Health Monologue

The four recommendations earlier could be summarized in one superordinate proposition: that mental health conversations move beyond attempts to raise awareness about undisputed facts and instead acknowledge the challenging questions still being raised

and debated by researchers and professionals alike. A dialogue, after all, is by definition a rendezvous of more than one perspective:

> Genuine dialogue must entail the bilateral, free and un-manipulated engagement of at least two persons, two unique perspectives and ultimately two distinct agendas. The moment a space becomes, in actuality, a site for unilateral, instrumental and manipulated engagement, it arguably ceases to be "dialogue." (Hess, Rynczak, Minarik, & Landrum-Brown, 2010, pp. 164–165)

As Paulo Freire (1970) said, "Dialogue cannot be reduced to the act of one person's 'depositing' ideas in another, nor can it become a simple exchange of ideas to be 'consumed' by the discussants" (p. 70).

One way to ensure this happens is to be thoughtful about who and how to facilitate a conversation. In their work with difficult conversations, Kadlec and Friedman (2007) emphasize "careful control and design" of the conversation setting—ensuring, for instance, that "no single entity with a stake in the substantive outcome of the deliberation should be the main designer or guarantor of the process" (p. 7). By ensuring diverse stakeholders and voices are heard in the larger conversation, we insure that *all* the questions are considered.

Although the dialogue can potentially involve anyone—professional, patient, or caregiver—attention needs to be brought as to how exactly that happens. Some questions comfortable for professionals may be deeply unsettling to those currently in treatment. In navigating these nuances, the guidance of dialogue professionals may be helpful.

In conclusion, we ask the following: What would an inclusive, expanded mental health dialogue in our nation look like? Rather than a mental health conversation focused on raising awareness of one perspective, what would it mean to provide a forum for the rich diversity of perspectives and opinions that exist? What would such a dialogue mean for rates of mental illness and recovery itself? And what prevents us from beginning now?

NOTES

1. For many people, the term *mental illness* insinuates biological deficiency and chronicity. For our purposes, we use more general terms such as *mental and emotional distress* or *serious mental or emotional problems*, as well as the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) term *mental disorder*. These words are used interchangeably throughout and do not imply a difference in clinical severity.
2. This approach shares meaningful links with interpretive phenomenology (Benner, 1994), constructionist revisions of grounded theory (Charmaz, 1990), and discourse analysis—especially in shifting attention beyond objective experiences (e.g., of depression or treatment) toward investigating more closely how these experiences are framed and interpreted. These interpretations, rather than a mere "subjective" overlay on our lives, are understood to be directly relevant to this same practical experience as the interpretations are "lived out" moment by moment in tangible, concrete ways (Fay, 1996, p. 178).
3. Details of these semistructured interviewing studies are available in their respective publications. Quotations tagged by a stand-alone number (Participant 9) come from the first study; if they have a combination number and letter (Participant 176f), they come from the second study [f = *father*, m = *mother*, d = *daughter*].
4. Mirroring a "maximum variation" sampling approach (Maykut & Morehouse, 2000), this permits a cross-cutting exploration without artificially truncating and limiting the discussion.

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