Faith & Reason Honors Program

SENIOR THESIS

Name: Kaitlyn Mills

Thesis Title: Mental Illness in the Modern Age

Thesis Sub-Title: How Stigmatization Violates the Dignity of the Human Person

Thesis Director: Jeffrey Tomlinson, M.A. (Criminal Justice)

Year: 2016
Abstract

Historical misdiagnoses and a lack of understanding of personality disorders and mental illnesses clearly indicate a perpetual fear of the unknown and a clear degradation of the human person. This paper will be an in-depth analysis of past methodology in identifying and treating atypical personality traits—both correctly and incorrectly—along with a thorough investigation of current stigmatization of individuals suffering with attention-deficit/hyperactivity disorder (ADD/ADHD), anxiety, depression, bi-polar mania, schizophrenia and other psychiatric illnesses or personality disorders. With a clear understanding of past diagnoses and treatment, this paper seeks to identify errors of the past and how these mistakes have impacted current philosophy. Furthermore, it is critical to expose these practices and critique them according to the Catholic notion on dignity of the human person, along with the importance of ethical diagnoses and modern medical treatments—both medicinally and behaviorally. These points, argued in this thesis, highlight the correlation between mental illness, lack of treatment and the perpetuation of deviant social behavior in a modern society. Moreover, this thesis will scrutinize the passé use of psychotropic drug therapy over other non-medicinal options as a first line of treatment.

Keywords: mental illness, stigma, history, Catholic, treatment
The mentally challenged have faced a long history of foregone conclusions and imprisonment. Before the asylum’s creation for an initial “refuge” for the brilliant mind, society’s diagnosed “lunatic” became subject to harsh pre-modern “treatments.” Despite the millennial leap towards acceptance and scientific understanding, those suffering from mental illness are left on the outs: individuals that are misunderstood, misdiagnosed and mistreated. Without a proper understanding of where psychological treatment began, it is impossible to determine where society is now and where we must improve to achieve equality among Christ’s brothers and sisters. Without the ability to “will oneself” out of sickness, it is imperative to develop and foster the Christian humanistic approach: the importance of individual conscience (New World Encyclopedia). Before addressing the flaws within common approaches, one must logically meander through the history behind mental illness treatment, spanning from millennia before Christ to today, the year 2016. It is unarguable that medicine and an understanding of the human body have grown exponentially over the past seven thousand years, however our treatment of one another has declined. With new pills instead of potions and prisons in place of prayer, a whopping 1 in 5 adults in America struggle with ailments like depression and anxiety (AMI). While national alliances form to encourage individual treatment, society increasingly shames and stigmatizes those who deviate from social norms.

Stemming from both religion and barbarianism, some of the earliest means of dealing with mental illness trace back to 5000 B.C. Earth’s inhabitants, from the Neolithic era, left behind brutalized skull remains of the practices utilized during this period (Foerschner, 2010). According to Foerschner (2010), the most popular practice of this time was trephining. This method is defined as a surgical procedure where the skull is punctured with a drill or sharp tool
and a piece of bone is removed (Irving, 2013). Trephination, in this era, was utilized to treat modern diagnoses of epilepsy, migraines, schizophrenia and an assortment of other mental disorders (Irving, 2013). The early people of the world believed that this operation would somehow release the evil spirit or demon dwelling within the afflicted. There was no physiological understanding or humanitarian treatment available to some of the earliest individuals; rather, skull drills and stabbing tools were used to “cure someone” from the wrath of an unhappy deity (or deities) (Irving, 2013) (Foerschner, 2010).

Pseudo-religious science (practiced by so called “priest-doctors”) allowed for a shallow insight into the differences between those affected by mental disease. Other notable ancient civilizations, such as Mesopotamia, traveling Hebrews, Persians and the Ancient Egyptians attributed the seemingly “paranormal” with the “supernatural” — that is, beyond the comprehension of man-kind collectively (Irving, 2013). Speculated in Foerschner’s academic account (2010), these third and fifth century people believed that most illnesses — mental and physical—were the result of an omniscient act of affliction “as punishment for their trespasses.” Riding these same spiritual lines, the only form of relief—as practiced in Babylonia, Assyria, the Mediterranean/fertile-crescent region, along with the Middle East—involves intricate chants, prayers and exorcisms, along with purification of the human body would certainly heal any individual of the evil capsuled in his or her Earthly vessel (Irving, 2013).

A heavy emphasis, after the time of the Neolithic person through the Middle Ages, was placed on the essential “fluids of the human body” (Irving, 2013). These fluids are akin to the Grecian four humors (Osborn, 2015). These four vitalies represent specific parts of the human
body: blood, akin to air; phlegm, a representation of water; yellow bile, a choleric interpretation of fire; black bile, the melancholic humor to represent the Earth (Osborn, 2015). These fluids (or humors) were thought to be the pivotal foundation for one’s growth, metabolic processes, nutrition and digestion (Osborn, 2015). Early medical philosophes attributed a “subtle vapor”, according to Osborn, that resulted in psychological effects: capable of skewing body, mind and spirit: thus, mental illness was first attributed to physiologic imbalances. Instead of the modern medical approach of genetics and chemical imbalances of the brain, the humors look at a quantitative reality: less of one fluid and more of another encourage different emotions. Blood, the “joyful fluid” promotes happiness, affection and overall positivity—healthy blood levels with even ebb and flow allow for the well-rounding of the human person (Osborn, 2015). Phlegm, alternatively, induces sensitivity, sentimentality, over-emotional responses, lackluster moods and lethargy (Osborn, 2015). Yellow bile, unlike the others, is the most inflammatory of the fluids. Rather than a simplistic happy/sad, this humor is responsible for envy, inquisitiveness, audacity, anger and other brazen feelings. Lastly, black bile is the target of “pensive [and] melancholy” behavior (Osborn, 2015). Collectively, a balance must be achieved. Without one, the Greek diagnosis called for the “letting” of blood and purging (to produce and expel bile) and the creation of a specific diet. These early treatments were indicative of advancing knowledge and understanding. The ultimate goal, however, was to protect the “mentally healthy” and avoid any such imbalances.

In an initial attempt to protect perceptually normal, sane citizens from “[destruction of] life, limb, and property,” specialized keepers of the ill were designated. Hippocrates, a Greek physician, is often accredited with initial treatments of mental disorders—he doted them as
“diseases of disturbed physiology, rather than reflections of the displeasure of” God (or gods of the time) (PBS). Comparable to the modern paraprofessional or aid, the individual’s family was responsible for the diligent guardianship (Porter, 89) of their impaired relative. This practice, similar to modern home confinement, prevented the successful assimilation of mentally ill into the social order of the time. Such practices began four-hundred years prior to Christ’s birth on Earth and remained in effect until the mid-twentieth century in several Asian countries, like Japan and China (Porter, 90). Without proper knowledge, only the noticeably ill were confined to their residences. Individuals that possessed diseases that weren’t physically apparent, such as high-functioning autistics or schizophrenics were viewed as harmless wanderers that were simply overwhelmed by “evil spirits.” Ultimately, any individual noticeably different or deranged were treated as the dregs of society: those to be feared and exiled (Porter, 89). The middle ages grabbed the issue and sought to aggressively address the ill.

Unfortunately for the disabled, “mad members of society,” standards of treatment were just as poor in Christian Europe during the Middle Ages. Without the wave of Renaissance Christian-humanism ideas, a judgmental and condemning group of believers subsisted throughout the continent. Individuals, healthy or not, weren’t afforded the same rights, nor had access to equal opportunity or fairness. Seen as subservient and undeserving of the right to life, “lunatics… [Were often victims to] neglect, cruelty and confinement” (Porter, 90). Widespread abuse and restraint were simply the beginning: some individuals were nearly left for dead, without food, water or shelter of any kind (Porter, 92). This relinquishment of familial and personal responsibility is one “past issue” still prevalent today: the vagrant population subsists on scraps in the streets, without proper access to care or counseling.
With continual degradation, the 12th-15th centuries brought about vicious treatment on the mentally ill: the lunatic was simply an undesired anchor equipped to the familial ship structure (Foerschner, 2010). To care for these outcasts, the Christian duty of charity inspired certain change in London and later, Toledo and Barcelona. Each local gained special notoriety for their service to the community. St. Mary of Bethlehem, founded in 1247, became England’s first hospital that “handled” the mentally ill (Porter, 90) (Historic England). Noted one of the “most infamous” mental institutions (annotated later in the organization’s history), the UK’s hospital struggled under private ownership and was quickly relinquished to the City of London (Historic England). The alleged sick were hypothesized, with current medical knowledge, to have suffered from a gamut of “sicknesses” (Historic England). From individuals with learning disabilities, to those suffering from epilepsy and dementia, the dubbed “Bedlam” facility became home to poor and marginalized societal members who couldn’t be cared for by anyone else (Historic England). Unlike conventional treatment centers, Bedlam provided nothing short of torture of mind and body; with tools like chains, locks, stocks, manacles, shock therapy and corporal punishment, the patients were subjected to inhuman behavior (Historic England). It wasn’t until nearly two centuries later, in 1403, that the hospital’s nefarious practices were revealed after an apparent embezzlement and theft case were prosecuted (Historic Bethlehem). Still, the majority of mentally ill lived among the general population. No specialized, long-term institutions existed or offered any type of lifelong care for those suffering from a disease of the mind. This changed in the year 1406 in the small town of Valencia, Spain (Foerschner, 2010).
Without significant medical records, nor historical evidence, the mental hospital of Valencia remains a mystery in the field of psychiatrics (Foerschner, 2010). At this point in time, mass institutions and the phenomenon of specialized “keeping” of the mentally ill spread (Dual Diagnosis). Instead of creating an environment of treatment and compassion, “asylums” were far from their definition. These establishments offered no support, rather they were simply “reformed penal institutions where mentally ill were abandoned” by their family or caregivers, for they were too large a burden to bear (Foerschner, 2010).

Despite state influences, it was primarily religious orders and institutions that were responsible for the foundation of many asylum centers for the ill. Both Catholic and Calvinist thinkers spread notable concept treatments as far as the Netherlands (Porter, 91). Bedlam, in London, was merely a “religious priory” and did not meet any medical standards of the time (Kemp, 124). Any formal institution was merely a cage for society’s perceived “animals:” sub-humans that did not have the capacity to function at the same level.

The 1600s brought about a time of great exploration for the human race. With the seeds of American colonization planted, along with the initial shots of the Thirty Years War, the major nations of the modern age fought for freedom and equality among men (University of Houston). Unfortunately, the delegated insane were not afforded the same luxury. Only a short relief came during this century for alleged treatment: specialized hospitals with growing notoriety. Despite the spread of unique treatment centers, the care for the mentally disabled continued to decline; the “insane” were isolated, abused and often pent up with criminals, homeless, and the physically disabled (PBS). With broken brick walls and bondage as their only
accomplishes, the sick were trapped in a life of despair without true access to help. Practices from this time period focused purely on isolation and violent abuse rather than a true cure.

It wasn’t until the late 1700s that the true reformation of institution, asylums and treatment were sparked (PBS). Public concern for treatment, specifically in France, motivated a shift in public philosophy (University of Houston). The French physician Phillippe Pinel, a new owner of the Bicêtre center, instituted a permanent ban on chain and shackle punishments (PBS). Instead, Pinel insisted upon access to the outdoors for fresh air, sunshine and the ability to exercise. Despite his advancements, Pinel’s philosophies were mostly isolated to France. The next major event did not occur until the 1840s, from a prominent U.S. reformer named Dorothea Dix (PBS).

Ms. Dix, a pistol of her time, spent many years advocating for sanitary, livable conditions for the mentally ill (Dual Diagnosis). In three decades, Dix lobbied the United States government for federal funds to support the desperate need for state-based care. With her petitions, Dorothea galvanized the public, both home and abroad (History, 2009). Living her life on the fringes of society, Dix spent a short amount of time in East Cambridge, England, working in a prison. Her experience in this location, alone, sparked her desire for immediate improvement (History, 2009). Upon her return to the United States, Dix took the time to visit every accessible private and public facility that dealt with the mentally ill. As an author, as well as an adversary, Dorothea published her findings and submitted them to the legislature of Massachusetts, as well as to the public (History, 2009). Her dramatic accounts were simply one piece of the puzzle: a wave of humanitarianism spread across from Pinel’s early European work
to the United States of America (Foerschner, 2010). The new focus for treatment: “moral management.”

With advocates like Dix, and continuous medical research, advancements continued to unroll in the field of mental illness. In 1883, shortly after the beginning of significant lobbying, a German psychiatrist named Emil Kraepelin began studying the intricacies of the human mind (Dual Diagnosis). With his research, Kraepelin identified major distinctions between different mental illnesses. He “noted on the differences between manic-depressive disorder and schizophrenia,” along with observations on a true unbalanced mind versus simple sadness, fatigue and disobedience (Dual Diagnosis). Using this research as a stepping stone, well-known psychoanalysts Sigmund Freud and Carl Jung begin to treat patients with mental illnesses in the early 1900s.

Equipped with a deep understanding for the current course of dealing with the mentally “disturbed,” Jung and Freud explored a new type of treatment: psychoanalytic therapies, or “talking cures” (PBS). Just after the beginning of the twentieth century, Freud was crowned the “father of psychoanalysis” and began to explore the minds of the mentally ill, along with his students and peers (Akbar, 2010). With a profound interest of the sexual desire of the human person, Dr. Freud began to explore the inner psyche of asylum patients. As a former student under this working theory, Jung developed a devout interest in talk therapy, also (Akbar, 2010). For the sake of analysis, the importance of these scientists involve the intricacies and time-consuming practice of patient-doctor correspondence and the release of inner thoughts, feelings and innate reactions to humane stimuli. Ethical issues, certainly, were abundant with these practices. For the modern psychologist or psychiatrist, many of Freud’s discoveries have
been disproven and found entirely false by subsequent theorists (Horan, 2008). As a philosophe and analyst, Horan articulates that, though irrelevant, Freud sparked an immensely important movement for the field of psychology, along with the treatment and study of those struggling with mental and personality disorders. However, it was Freud, and later Jung, that encouraged the use of “analytic psychology” (Akbar, 2010). Along with increasing scientific study, individual writers and journalists began to express their own struggles with personal illness and how a treatment, or lack thereof, impacted their existence in society.

There are severable notable publications of that spread prior to the closing of the mid-20th century. Some notable authors include Clifford Beers, for his autobiography “A Mind that Found Itself;” Ken Kesey, for his publication of “One Flew Over the Cuckoo’s Nest,” along with an early opinion editorial, investigative journal piece written by Nellie Bly (PBS). Beers and Bly, with strictly non-fictional writing styles, debatably “shocked” the public most with their exposition of mental illness. Bly, a reporter for the New York World, utilized an undercover opportunity to unveil the hidden horrors of an asylum by falsifying a mental illness (PBS). In her time at the institution, Bly revealed that “when custodial care supersedes human treatment,” no one truly benefits” (PBS). With her exposé, Ms. Bly created an opportunity to petition improvement for those truly mentally ill; these individuals must be given the essential human dignity that everyone should receive—no person is to be treated as sub-human. Beers’ autobiography provided another brief experience in the mind of a prisoner to the mental institutions of the United States. As a patient himself, Clifford also began challenging the status quo for the treatment of the deranged (PBS). His time in a Connecticut mental institution revealed dehumanizing behavior and vilely barbaric practices of abuse and neglect that carried
onward in one of the largest countries of the world. In the year 1908, Beers’ advocacy resulted in the foundation of “the National Committee for Mental Hygiene:” a group targeting the equality in care, along with proper education on mental illness (Foerschner, 2010) (PBS). Unknowingly, Mr. Beers established one of the country’s grandest “umbrella organizations” for mental health and wellness.

Despite public outcry and the clear and convincing evidence that the 20th century still hadn’t found a proper channel to deal with the ill, drugs, electro-shock therapy and surgery continued to be used by unlicensed asylum staff (Foerschner, 2010). Throughout the 1930s, a widespread use of shock-therapy, induced-comas, and convulsions were utilized to treat the sick—specifically those with schizophrenia. This somatic therapy, like psychosurgery and psychopharmacology were based on a new, genetic model of treatment: the biological model of mental health (Foerschner, 2010). On the surface, these cutting edge tools of the time seemed to be a perfect, working cure for those suffering. Scientists identified, finally, the chemical root of mental illness—no longer would a defense of an angry deity, demonic possession or mere transgressive approach to societally-acceptable behavior be accepted as ethical diagnoses. The major issue, though, lay in the long-term (and short-term) effects of these methods. Especially with electroconvulsive therapy (ECT), the end results began to rarely justify the means. Instead of producing positive changes in the feelings and behaviors of the ill, doctors, nurses and paraprofessional staff and aids began to use ECT for penalizing, controlling and terrifying patients (Foerschner, 2010). Some patients were subjected to this “modern torture” over hundreds of times, according to Foerschner—a collective torment that could result in permanent brain damage, fracturing or even patient death. Despite a history of abuse
with this treatment, it is utilized in the 21st century with a doctor’s discretion of “a severe case” of depression or other psychosomatic symptoms.

Shortly after its developed use, ETC prompted Presidential intervention for the world of mental health. On July 3rd, 1946, former President Harry Truman signs into law the first medical act dealing primarily with mental illness. Mr. Truman insisted that substantial investigation must be done on the human mind by Mr. Beers’ flourishing organization, the National Institute of Mental Health (PBS). This group, after winning a short battle on the front of mental illness, would seek to find answers relating to the brain, conscious mind and behavior, along with their inter-relatedness. Directly because of this act, the NIMH would be formally recognized by the United States government on April 15th, 1949.

In the same year of the NIMH’s formal recognition, an Australian psychiatrist named J.F.J. Cade began conducting experimentation with the medicinal benefits of lithium in treating the severely mentally ill. Before his contribution, only bromides and barbiturates (sedative drugs) were utilized to lull a patient out of his or her psychosis to a relaxed state of mind—however, they were highly ineffective (PBS). Cade’s new contribution would make its way back to the United States just a decade later for the treatment of severe cases of manic-depression or bi-polar disorder (PBS). Lithium is simply one of many anti-psychotic drugs to become available to the free-market, developed countries of the world. With a rising production of drugs and awareness of the existence of disease, the number of known mentally ill began to skyrocket: for the first time in the history of mental illness, a fraction of individuals began to seek treatment from medical professionals or alternative sources of medicine.
During the mid-1950s, according to Foerschner and Porter, the number of hospitalized mentally ill people in America began to peak: at this time, over half a million people were committed to institutions across the country (PBS). Because of the enormous number of institutionalized people, psychology and psychiatry were forced to search for a new methodology of treatment: simple break-downs of the human condition and drugs were not enough. Dual Diagnosis speculates that this demand was one significant stimuli in the “wave of deinstitutionalization.” During this period, the public demanded for less restrictive treatment of the mentally ill. Instead of keeping individuals locked up behind gates, walls and locked doors, each person should be free from an asylum’s poor living conditions and underdeveloped caretakers. Another historic event unfolds: the life of someone dealing with mental illness need not be confined to the walls of a hospital or facility; rather, with treatment, a person could co-exist among the general public (Dual Diagnosis). With these practices, the number of institutionalized Americans decreased by over 60%, through the 60s, 70s, and 80s.

Unfortunately for the mentally ill, not all individuals were released to the care of a support system. Some struggled with maintaining consistent care and treatment for their disease, while others forewent medication or follow-up care. Alas, a modern issue that exists today rears a secondary origin: a lack of care for individuals who are co-dependent (PBS). Similar to the middle ages, those without care and housing moved to the streets — many homeless individuals suffered horrendously with mental illness, due to a lack of resources and treatment. The U.S. government responded with the passing of another bill in 1963: the Mental Retardation Facilities and Community Mental Health Centers Construction Act. After the short presidency of John F. Kennedy, Lyndon B. Johnson was forced to deal with the consequences of
this federal decision. Advocates for the deinstitutionalization that took place during and after the passing of this bill argued that the mentally ill would seek institutionalized treatment if necessary—however, this was a largely misguided conclusion (Foerschner). In fact, rather than seek treatment internally, some patients began to “self-cope” or “diagnose” possible solutions to deal with their illnesses. This act sought to aid in the humanization of those who are mentally ill; instead, it began to stigmatize individuals living together in society. Logistically, it was difficult to identify who was ill and who was not: force institutionalization was a last resort and some individuals appeared completely normal to the general public.

According to Peter Byrne in his article on advancing psychiatric treatment, stigma is defined as “a sign of disgrace or discredit which sets a person apart from others.” Mental illness is a highly profiled struggle for most individuals, where an estimated 1 in 4 sufferers exist in America, with over 450 million sufferers worldwide (NREEP) (Insel, 2000).

“Mental Illness isn’t a uniquely modern phenomenon. The genetic influences that stand behind some types of mental illnesses, along with the physical and chemical assaults that can spark illnesses in some people, have always been a part of human life. But the ways in which impacted people are treated by their peers, as well as the help ill people might get from their doctors, has undergone a significant amount of revision. In fact the ways in which modern cultures both understood and deal with mental illness have undergone a radical transformation. However much work remains to be done, if people who have mental health concerns are to reach their true potential. (Dual Diagnosis)”

With over thousands of years of experience, it is a reasonable assumption that more progress would be made with the societal acceptance of the mentally ill. Ethically, it is a disgrace that harsh treatments and actions are taken and utilized against the sick. While science has discovered that mental illness doesn’t relate to four bodily humors, the sun, moon, planetary alignment, evil spirits, demonic or witch-craft activities, it has not found a way to motivate the equal treatment and protection for those suffering with mental illness. With a
long history of imprisonment and lack of care, the ill were less than human: a practice that many believe to be a simple blemish of past history. This is a grave misconception. “Lunatics” or so-called “crazy people” are the targets, still, of ridicule, abuse, and even entertainment or amusement. To see this, an observer mustn’t look any further than the very community he or she lives in or what’s popular on television and how differences are portrayed. Bryne, in his article on the sickness of the mind highlights the “spoiled identity” of those diagnosed. Despite a late 80s and early 90s push by the American Psychiatric Association, mental illness is most certainly not something that has “overcome stigma” or become “normalized in our culture” (Bryne, 2000).

“Many people who would benefit from mental health services opt not to pursue them or fail to fully participate once they have begun. One of the reasons for this disconnect is stigma; namely, to avoid the label of mental illness and the harm it brings, people decide not to seek or fully participate in care. Stigma yields 2 kinds of harm that may impede treatment participation: It diminishes self-esteem and robs people of social opportunities” (Coorigan, 2004).

Mental illness is a very complicated issue with many aspects to consider. The issue of stigmatization is critical: society is isolating dissimilar individuals and the rippling effects of this are more detrimental than most can imagine. Additionally, individuals suffering refuse to seek treatment, thusly the stigma directly and intensely interferes with mental health care. A statistical analysis of those suffering is staggering. For a growing phenomenon, as well as one that an individual cannot simply “will oneself out of,” it is an ever growing complication—a cancer on society that continues to cause only grief.

One reasonable response to societal stigma is to react—something that often perpetuates the very stereotype or aggressive behavior directed towards the individual. The more common approach, especially regarding mental illness, involves secrecy: disallowing
anyone to know or try to understand what a person is going through (Bryne, 2000). In disguising something beyond one’s control, the mentally ill patient is truly working against him or herself. One of the most important aspects of positive, successful and long lasting treatment involves a strong support system or “social network” (Bryne, 2000). Some forms of psychology differentiate the illnesses in stages. For example, learning disabilities (dyslexia, ADD/ADHD), personality disorders (anxiety) and chronic illnesses (obsessive-compulsive disorder). A study conducted on a breadth of patient diagnoses focused on first-admission patients—that is, individuals first hospitalized as a result for their sickness. Of polled families, friends, spouses and partners, over one half reported that they had actively made “an effort to conceal the illness from others” (Bryne, 2000). The question becomes why? When did it continue to be such a shameful issue that we, as a society, must conceal and ignore symptoms? When addressing a wound, it is commonplace to clean, anoint and dress the wound. If one suffers from a headache or other body ache, it is a normal practice to take an over-the-counter pain reliever. Instead of treating this health issue like most others, sufferers are shamed discouraged from sharing or seeking help for the effects it will have on him or her, along with their loved ones.

The answer to this question is addressed clearly: negative social reaction, myths assumed to be fact, along with scapegoating (Bryne, 2000). Discrimination is nothing new to the field of mental illness—it just continues to worsen for those who suffer. While therapy and proper medicinal management are viable options, few actively seek out treatment. In low and middle class countries, an estimated 76-85% of individuals are untreated; in high income countries, up to 50% of cases are unacknowledged (NREPP). The statistics are staggering—there are pervasive reasons why individuals cannot or will not seek treatment and society is to blame.
Mental illness is diagnosable, treatable, manageable and sometimes even preventable—points that aren’t common knowledge. Conferring with the World Health Organization, the Nation Registry of Evidence-based Programs and Practices (NREPP) found that within the next four years, behavioral health disorders will bypass all physical diseases as a major cause of disability—that is mental illness will be more prevalent than any and all other well-known and accepted handicaps. Additionally, these illnesses are more common than cancer, diabetes and heart disease: all societally accepted conditions where treatment is encouraged and actively sought out (NREPP). While discrimination crosses all economic and social backgrounds, it often targets mental illness.

Byrne assess that discrimination and stigma are more than just discouragement and shame, rather it involves living conditions, mental health financial allotments, and the priority placed on informing and “normalizing” psychiatric conditions in society. Where a median delay in seeking treatment is almost ten years, it is a fair assessment that the American society is failing its ill (NREPP). If all people are in fact created equal—a founding principle of the United States—than there is no question or compromise that one’s worth can be reduced because of a mental condition.

To borrow words from holy Pope John Paull II, at the International Conference for Health Care Workers on February 11th, 1984: "It is everyone's duty to make an active response; our actions must show that mental illness does not create insurmountable distances, nor prevent relations of true Christian charity with those who are its victims. Indeed it should inspire a particularly attentive attitude..." This is precisely what the American public has failed
to do. Common misconceptions about mental illness displace legitimate causes for concern and often discourage early intervention. Rather than proving mental illness conquerable, society emphasizes the difficulties associated with the ailment and often exacerbate the circumstances by which one exists within his or her disease. Some well-versed falsities include: 1) that children do not suffer from any mental health problems, 2) individuals needing psychiatric care ought to be confined or institutionalized, 3) mental illness isn’t normal and those who suffer won’t ever be normal and lastly, 4) people that are mentally ill are crazy, dangerous and can’t be trusted (Carnegie Community Engaged University). This all create a vicious cycle of misunderstanding, ignorance and fearmongering—all preventable with understanding and knowledge.

The Carnegie Community Engaged University, involving Fort Wayne, Purdue and Indiana Universities, directly addressed each of these stereotypical assessments of those who struggle with mental disorders; an estimated six million children and young adults suffer...most are severe cases that impact their functionality at home or school. Another articulate response from the Universities addresses the general stigmas aforementioned: many people that suffer can lead productive lives with proper support, therapy and/or medication—in fact, a person can recover completely from mental illness or live while coping. Lastly, people with these illnesses are the same as anyone else—each person has their own set of strengths and weaknesses that allow him or herself to experience, work and motivate at different levels (Carnegie Community Engaged University).

What determines an individual’s functional capacity involves how severe of an imbalance or deficiency he or she endures on a day-to-day basis. Many of the most diagnosable
illnesses have chemical or biological causes, therefore the individual has no control over his or her experience with the ailment, nor the stimuli or circumstances that can exacerbate their symptoms. The Centers for Disease Control and Prevention note that only a fraction—just one quarter—feel as though peers and loved ones care for are or sympathetic towards their struggles (Holmes, 2015). Michelle Obama, current first lady of the United States, commented on this very issue:

“At the root of this dilemma is the way we view mental health... Whether an illness affects your heart, your leg or your brain, it’s still an illness, and there should be no distinction (Holmes, 2015).”

Society implies that an individual with a mental illness is at fault for their life situation. The Catechism of the Catholic Church, numbers 109 and 110, calls the human race to interpret the scripture in a way to truly affirm God and that taking into account time’s conditions and cultures. With this, society should be consistent: the word of God affirms all people, including the mentally ill. Every life is sacred and should be respected, as there is no fault to be assigned. To summate, Mrs. Obama, along with the Catechism, enforce the equality of love and respect that should be supplied equally, regardless of mental ability. Former President Bill Clinton offers another note of advice along these lines: “Mental illness is nothing to be ashamed of, but stigma and bias shame us all.” The root issue is the stigmatization itself, rather than the ailment.

Despite how widespread mental illnesses are, society still rejects the acceptance of this segment of society. Mental illness impacts life and death: the very crux of the human existence. Christians, along with other major religions, place a heavy emphasis on the importance to life. Stripped of their dignity and will to survive, individuals that suffer from mental illness often feel
trapped, unworthy of living and as if there is no escaping the horrendous cyclic nature of his or her disease—suicide claims one of this individuals every 90 seconds (NREPP). Statistically, over 90% of suicides are attributed to mental illness. Every case is preventable with proper care, acceptance and the desire to incorporate the afflicted into society as much as someone without the disability. The darkness of depression and anxiety, two disorders that are often spurred as a result of other underlying conditions capture the mind of those who suffer. Instead of logically analyzing their status, victims of these severe ailments cannot see that there is hope, or that there are adequate resources available to fight mental illness, despite its all-consuming nature (NREPP).

For the faith-based approach on this issue, the Catechism of the Catholic Church indicates that a person who commits suicide “may not be fully in [his or her] right mind,” making them not entirely blameworthy for their self-inflicted death. Viewed as a damning sin in the eyes of the church traditionally, “the sin of suicide” has changed to reflect the effect of mental illness on the human person—a child of God. In stigmatizing individuals (and in some cases, to the point of suicide), our society is violating the sacred nature of the human life. By devaluing someone to the point of nothingness, who, then, is to blame for a sick individual’s cause of death? God gives each individual precious life—“We are obliged to accept life gratefully and preserve it...” a passage from the first book of Corinthians 6:20 reads (Saunders, 2003). However, a common misconception is formed: the notion of suicide is often believed to be wholly wrong, no matter the circumstance. According to Fr. Saunders, this is not the case. While it is unarguable a mortal sin to take one’s own or another’s life knowingly and willingly, to do so under “grave psychological disturbances, anguish, or grave fear of hardship” is an
entirely different matter. These notes do not make suicide a “right action,” however, they do clarify the mortal sin and the important notion of culpability and how mental illness can severely impact this (Saunders, 2003). Catholic psychiatrist Aaron Kheriaty attributes that a vast majority of suicides are in fact associated with clinical depression or “madness” that drives someone to lose the will to live.

In his article on the Catholic Prospective on Depression and Suicide, Kheriaty asserts the scope of mental illness and how it can truly affect anyone. To support his stance, Dr. Kheriaty focuses on the recent suicide of popular comedian and actor Robin Williams—a death that rippled the American public and alarmed family, friends and fans to the severity of mental illness and improper treatment. Notable cases like this, involving famous individuals, often grab the spotlight of the public and create a captivating audience for the importance of awareness and treatment, however the public mind is far too short and fickle to commit to such a process. While his death was certainly surprising and tragic, cases of death by suicide occur every day and most times, only the close family and surrounding community are affected. Our culture has created an environment where action can and will only be taken in the most extreme circumstances: while the gun is still smoking hot, not before shots are fired. Williams, too, a child of God, a beloved “human soul of immense worth” is of equal value to a loved one or close friend or peer that suffers from illness also. They, also, should be cared for and protected from the darkness and unhealthy nature of illness, for they can also fall victim to a lack of treatment or a madness so demanding, that he or she loses the will to live their own beautiful life.
The novel *Darkness Visible*, according to its author William Styron, captivates readers by a first person account of the depression experience. He “complains that the very word ‘depression’ is a pale and inadequate” word to describe the true affliction of the disease (Kheriaty). “Pedestrian nouns,” as he refers to them, are the only true label for the suffering that the mentally sick endure. Outward appearances truly mask the deviance and chronic suffering that churns in the minds of many afflicted—not all ailments are visible. Instead, Styron describes depression with the world “melancholia,” which he enforces with imagery of dark, shadowy fog that “saps the body of all vitality.” Yet, depression is only one example of the complex illnesses that fall under the category of psychiatric care. Kheriaty asserts that the only true action to be taken against depression, and other forms of illness, are to unite medicine, psychology and theology: a holistic approach to one’s wellbeing.

Dr. Kheriaty makes compelling arguments about the true nature of depression, specifically, to generalize mental illness treatments as a whole. However, not all ailments are the same. Each illness—too many to be listed—come with different symptom sets, treatments and levels of severity...an issue with so many dynamic factors. What, then, ought to be the best solution? Perhaps this is the question society has been begging the answer to all along. Initially, each “treatment” was alleged to help or cure a person from what they suffered with, even if it meant agitating the condition or killing them in the process. Society and science learned. With each passing failure and loss, discoveries were made, advancements identified new evidence and the brain is more greatly understood today than ever before. Why hasn’t our morality caught up? The aesthetic of mental illness—the “burden” of dealing with someone who “doesn’t understand” or who “can’t motivate themselves” is too difficult for the untrained to
understand. But is it truly? Perhaps these questions do not have definitive answers. Philosophy and theology certainly leave them up for discussion and interpretation in hopes of finding a truth within the mess. Medicine, alternatively, seems to have found the ideal treatment.

The National Institute of Mental Health offers a clear and concise list of the most common sources of treatment: medication (psychopharmacology), “talk therapy” (psychotherapy) and less often, brain stimulation therapy. Within these categories, the Institute offers a breakdown of components. Specifically for mental health, it is important to evaluate the utilization of medication versus talk therapy (or the use of both) (National Institute on Mental Health). Between 2005 and 2008, anti-depressants became the third most-commonly taken medication in the United States; today, one in ten Americans over the age of twelve take anti-depressants (Dual Diagnosis). There widespread use causes two theories: first, that those suffering from mental illness are possibly seeking more treatment than in the past—a positive. Second, that individuals seeking help are simply being supplied medication to numb the pain of a deeper mental illness—a negative. While depression, along with many other mental ailments, can be treated with medication, perhaps that is not always the best “first method” of treatment.

In an attempt to “balance the brain’s natural neurotransmitters responsible for feelings of pleasure,” these medications seek to re-establish this balance that is “off” and causing the symptoms of a mental illness (Dual Diagnosis). These chemically-induced changes to the body stabilize mood, behaviors and attention spans, often relieving the patient feeling more “normal” than their ailed mind typically feels without access to medication. The American
Psychological Association notes that while prescribing different medications (like anti-depressants, anti-anxiety, stimulants, anti-psychotics and mood stabilizers) may truly assist in the coping process for a health disorder, it may not be the “most effective route for patients” (Smith, 2012). An increasing number of scientific and psychological studies have proven this to be true.

Some patients, without seeing a specialist (psychologist or psychiatrist) that holds specific and practiced knowledge about mental health and how it effects one’s mind and body, are prescribed psychopharmaceutic drugs (Smith, 2012). According to the Centers for Disease Control and Prevention, many Americans, specifically, are able to receive these types of prescriptions from their primary-care physicians (also referred to as PCPs). While PCPs maintain medical degrees just as psychologists and psychiatrists do, they often do not have the intricate knowledge of other “evidence based treatments,” like cognitive therapy (Smith, 2012). Smith’s article for the American Psychological Association features a quote from Dr. Stephen Hollon, a professor of psychology at Vanderbilt University. He offers that “…at least half the folks…treated with anti-depressants aren’t benefitting from the active pharmacological effects of the drugs themselves but from a placebo effect” (Smith, 2012). Hollon seems to argue that the perception of taking a medication is more powerful than the full-effect of the drug. The simple ignorance surrounding psychopharmacologic treatments, despite a degree of proven usefulness, leads individuals to believe that drugs are the only available option and that is not the case.
In the last decade, the use of “psychotropic drugs” leaped 22% from 2001 to 2010, with an estimated 1 in 5 adults taking (at minimum) one medication (Smith, 2012). A spending analyses in 2010 revealed that Americans specifically spent more than $16 billion on anti-psychotics, $11 billion on anti-depressants and $7 billion for drugs to treat ADD/ADHD (Smith, 2012). The switch to solely medicinal based treatment is both alarming and dangerous. Without proper psychiatric care, misdiagnoses occur more frequently—the diagnosis of various mental health disorders falls on the symptoms presented, as well as the doctor evaluating the patient. To alleviate some of the strain on doctors, a “universal screening tool” developed and routinely updated by the American Psychiatric Association named the DSM-5 (current volume) as the standard classification for all clinical settings (American Psychiatric Association, 2016). This “Diagnostic and Statistical Manual of Mental Disorders” uses three pieces to determine if a patient suffers from a specific mental health-related issue. These include: diagnostic classification, criteria sets and a descriptive text (American Psychiatric Association, 2016). Each disorder is followed by a lengthy text that includes: diagnostic features, prevalence, development and course, risk and prognostic factors, environmental/genetic/physiological and temperamental factors, course modifiers, culture and gender-related diagnostic issues, suicide risk, differential diagnosis, along with comorbidity and subtypes/specifiers for each disorder listed (American Psychiatric Association, 2016). This guide is utilized by mental health professionals and social workers alike as a manual for ethical diagnoses; however, it is perpetuating the over-labeling process in the mental health field. The DSM description holds that “it is not sufficient to simply check off the symptoms in diagnostic criteria to make a diagnosis...proper use...requires clinical training to recognize when signs and symptoms exceed
normal ranges.” There is an immediate danger in this process, especially in a wave of online information availability, the desire for “quick fixes” and a need to uniquely identify what it is a person is suffering with. In truth, many recipients of psychotropic medications do not fall under one specific disorder—many individuals struggle with an amalgamation of symptoms making one label (or more) fit correctly. To simplify, an analogy for cooking fits well: utilizing medication to treat mental illness is simply one or two ingredients within a recipe. Too much of one ingredient and a complete lack or deficiency of others weakens the end product. In the case of mental health, our result represents the overall well-being of the patient at hand. With a heavy handed prescription pad, psychiatrists and especially PCPs are perhaps over-estimating the benefits of medicine in a holistic health approach. Rather than encouraging a multi-front approach to mental illness, simple prescribing a range of medications is not an ethical practice of medicine or an efficient way of handling the growing epidemic of psychiatric diseases.

The disorders the DSM-5 uses intricate analysis to guide practitioners towards the best evaluation and treatment options for a specific patient. The diagnoses made available in the text aren’t definitions of his or her human existence, nor are anything more than emerging assessment measures to act as a piece of a multi-approach diagnosis. To expand, individuals with mental disorders cannot be labeled with one specific disorder and expect an exact, carbon-copy treatment as a secondary patient with the same symptoms. Clinical diagnosis varies drastically depending on the physician or specialist addressing your symptoms—it is truly a subjective exercise that makes effective treatment a very difficult task to achieve (The Seattle Times).
In a study conducted by Harvard University, researchers found that in one year of practice, specifically with major depression, up to 14 million (6.6%) of American adults suffer or experience symptoms. A fraction—only 1/5—were analyzed to have received adequate treatment and relief from the illness (The Seattle Times). These incorrect or incomplete diagnoses are dangerous and costly—drugs can make people sick, experience new symptoms or side-effects not present prior to diagnosis or exacerbate the existing condition. The article for Behavior Health features a specific example with the incorrect diagnosis of bipolar disorder:

“Bipolar patients need mood stabilizers...Treating them solely with antidepressants—which raise the level of serotonin in the body—could trigger manic episodes serious enough to warrant hospitalization” (The Seattle Times).

There are many debatable factors that result in frequent misdiagnoses and this is extremely perilous. In order to most safely and effectively treat patients, prior to medication distribution, a thorough cognitive behavioral therapy session should take place, along with a complete body assessment, including blood work. These safeguards will prevent the over utilization of prescription drugs, along with a more comprehensive exam of the patient seeking help. The key point is that there can be multiple effective options for treatment, including psychotherapy (The Seattle Times). The best decision a patient can make is an educated one: choosing the correct doctor and knowing all of his or her options before deciding on a medicinal treatment.

In addition to actively considering all options for oneself, adult caretakers and parents of children must be careful when choosing a proper method of treatment and physician for care. With a growing number of prescribing doctors, along with the accessibility to easily-addictive medication (like Adderall, Xanax, and other neurotransmitter-effecting drugs), the American Academy of Pediatrics has expanded its diagnosis guidelines to cover children as young as three
years old (Smith, 2012). Stimulants and mixed amphetamine salts, the standard treatment for suspect ADD/ADHD cases are generally safe, but pose an enormously higher risk for children, especially under the age of 12. Reports generated by the Academy call for an increased utilization of behavioral correction techniques and therapy before resorting to prescription medication. However, many parents opt for the medicinal route because dealing with distracted children who suffer from these ailments is extremely difficult, time consuming, and they lack the proper training to foster a comforting, yet stern environment. If all other options fail, then prescription drugs, like Ritalin and Adderall, should be provided in severe cases. This practice should be expanded throughout the field of mental health, beyond the issues of prescriptions for youth—medicine need not be the first wave of action.

Psychotherapy can be just-as or even more beneficial to a patient than anti-depressants or other medicines. Without the risks associated with potentially addictive and potent pills, talk therapy often shows signs of fewer relapse occurrences (American Psychiatric Association).

"Our impression is that patients initially need to apply the skills they learned during [cognitive therapy] treatment in a concerted fashion, but that these compensatory strategies eventually become second nature... These strategies include having patients examine their negative thought patterns and the creation of a step-by-step plan to help cope with life stresses."

Rather than addressing symptoms alone, therapy often seeks to find the root cause or stressors associated with mental illness. Simple medicinal approaches do not offer this type of coping strategy. While therapy requires more personal effort and analysis than conventional psychotropic drug therapy, it is proven to be more beneficial for patients. Inopportune, access to quality, affordable therapy is difficult. The American Psychiatric Association attributes lower psychotherapy rates with cost-specific related issues. “Lower clinician rates” of reimbursement
along with “higher out of pocket costs” are leading to a smaller percentage of Americans using therapy than ever before. Cognitive therapy (CT) is a safe and effective alternative or pair with individuals seeking assistance with mental health issues. The “cognitive model posits that” in correcting “maladaptive thinking, both acute distress and risk for subsequent symptoms” are drastically reduced (Hollon). Moreover, a combination of properly and discretionary drug use, paired with talk therapy, has proven to be the most effective treatment for mental disorders, especially depression and anxiety—the most prevalent in American society.

“Just keep in mind, if you go to see a psychiatrist, you are much more likely to get medication. Psychologists and social workers provide talk therapy ... and they can be more cost-effective if you pay out of pocket... Many insurers refuse to allow psychiatrists to do anything but prescribe drugs, except for the most severely ill patients” (Davis, 2004).

Educating oneself about all available options to ensure the best mode of treatment for each case is essential. In order to receive the full, ethical benefits of properly diagnosable mental illness, it is imperative that the patient, as well as the doctor, take their roles very seriously in determining the best possible solution.

When it comes to addressing mental illness, there are no simple solutions. With a complex history and an ever growing market of drugs and “quick fixes,” now, more than ever, a patient must be vigilant in seeking proper treatment. Despite societal stigma, it is imperative that individuals receive the treatment they need when it comes to mental health.

Individual mental health, ultimately, is the responsibility of the patients themselves. Stigma persists in society and there is much to achieve at a grassroots level, as well as on a national scope. It is important to receive an expert opinion with any medical concern, especially with a questionable issue regarding mental disorders; sometimes, multiple opinions are
necessary to find the best-tailored treatment (Smith, 2012). Without the risk of side effects, talk therapy offers significant benefits and skill-building opportunities that outlast the effects of a dose of medication.

Equally important, the United States government must act to preserve the individual identity and dignity of the mentally ill person. By maintaining clean, quality facilities with trained professionals, the federal level is actively encouraging humane treatment of the sick. Additionally, there must be affordable, equal opportunity to receive ethical, necessary treatment for the most severely ill. Without aid, society will revert to old tactics of isolation and abandonment of the lesser-abled. Proper crisis assistance must be in place to continue to aid in the removal of stigma—if labeling and discrimination is removed at the federal level, the wave of acceptance will trickle down into the states and local levels of government care, ultimately providing safe and secure treatment options for the mentally ill.

Stigma presents an unhealthy, burdensome barrier to the pathway to holistic health: a unification of mind, body and spirit and the ability to live a dignified life. Instead of chastising individuals that are “different” or who act contrary to social norms, our society must work towards understanding, rather than concealment and forcing seclusion from any possible outlets. It is the Christian mission to love all others as you would love God, regardless of circumstance. In order to be effectual in the completion of this mission, it is imperative for the increased support of research, development and acknowledgement of an ever-growing disease affecting the American public.
With increased education and awareness, America can lead a revolution in removing mental health stigma so that the afflicted will not feel shame in seeking treatment. Additionally, individuals that are suffering mustn’t be discouraged by false representations for who they are or what they are perceived to be by an ignorant society. Lastly, access to proper care is essential to achieve any type of real change in the field of mental health.

The history of mental illness has drastically shaped the current stigmatization and the inability to truly combat the existing stereotypes that linger in American society. Though patients are no longer locked in cages and subject to brutal abuse, many still lack the basic, fundamental care that any non-mental illness would receive, unquestionably. To truly chance the idea surrounding mental illness, its existence must be normalized. With the average of 20% of the American public suffering from some form of illness, it is unimaginable that more has not shaped the change of societal prejudice. Without the opportunities or motivation to seek help, a cycle of self-desecrating behavior and thought processes will continue—the mentally ill mustn’t fight alone. While many advancements and research have launched society past barbarianism and mysticism, there is plenty to be achieved in regards to the dignity of the human person. Anyone interested in seeking treatment should have the freedom and opportunity to do so without the judgement of their family, friends or peers. There is no secret behind mental illness: it is real. It is pervasive and there are solutions out there—if only our society was more encouraging to those who need it most.
References


