Alan Hu Foundation Mental Health Lecture Series

Adolescent Mental Illness, Stigma, and Families: What's Needed to Promote Thriving
Webinar by Stephen Hinshaw, PhD

Professor of Psychology at U.C. Berkeley, Professor of Psychiatry and
Behavioral Sciences at U.C. San Francisco
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[00:00:01]
CHIH-CHING HU: Hello, everyone. Welcome to Alan Hu Foundation Mental Health Lecture Series. I'm Chih-Ching Hu, Co-Founder of Alan Hu Foundation and the host for your webinar. Today, Dr. Stephen Hinshaw will present "Adolescent Mental Illness, Stigma, and Families: What's Needed to Promote Thriving."

[00:00:26]
Before moving forward, I would like to thank you all for joining us across the country and around the world. I would also like to thank Pleasanton Mayor Karla Brown and the Fremont Vice Mayor Dr. Yang Shao for joining us and supporting mental health. Let's work together to remove mental illness stigma. I would also like to thank Mental Health Association for Chinese Communities for providing simultaneous Chinese interpretation. Thank you, MHACC founder and President Elaine Peng, and thank you, Ida Shaw, for Chinese interpretation.

[00:01:10]
The Alan Hu Foundation Mental Health Lecture Series aims to make mental health knowledge common knowledge. Alan Hu Foundation's mission is to promote mental health, raise awareness, and remove stigma surrounding psychiatric disorders, and support fundamental research for cures. Please consider making a gift to Alan Hu Foundation. Your gift will be 100 percent invested into our foundation's mission to support mental health.

[00:01:42]
Today, it is my great honor and privilege to introduce Dr. Stephen Hinshaw. Dr. Hinshaw is Professor of Psychology at UC Berkeley. He's also Professor of Psychiatry and Behavioral Sciences and Vice Chair for Child and Adolescent Psychology at UC San Francisco. Dr. Hinshaw's research focuses on developmental psychopathology, clinical intervention with children and adolescents with attention deficits and hyperactivity, and both understanding and reducing mental illness stigma. He has authored over 370 articles and chapters, plus 12 books.

[00:02:30]
Dr. Hinshaw's memoir, Another Kind of Madness: A Journey Through the Stigma and Hope of Mental Illness, was awarded the Best Book in Autobiography/Memoir by the American Book Fest in 2018. His research efforts have been recognized by the Distinguished Scientist Award from the Society for Science of Clinical Psychology in 2015, the James McKeen Cattell Award from the Association for Psychological Science in 2016—it is the highest award for a lifetime of outstanding contributions to applied psychological research—and the Distinguished Scientific Contributions Award from the Society for Research in Child Development in 2017 and the Ruane Prize for Outstanding Achievement in Child and Adolescent Psychiatric Research from the Brain and Behavior Research Foundation in 2019. He is also the recipient of the American Psychological Association's Distinguished Scientific Contributions Award in 2020 and the Sarnat International Prize in Mental Health from the National Academy of Medicine in 2020. These awards reveal the breadth and the depth of his research efforts. He's the only individual ever to have been awarded all six. In addition, he was elected to the American Academy of Arts and Sciences in 2021.

[00:04:20]
In today's webinar, Dr. Hinshaw will define the concept of stigma as it pertains to individuals experiencing mental disorders and discuss severe mental illness in a family context. Following the presentation, there will be a Q&A

session. Please submit your questions using the Zoom Q&A function. The presentation is for educational purposes only and is not intended for medical diagnosis. If you have any persistent symptoms, please seek for professional help. With that, I'm going to turn it over to Dr. Hinshaw.

[00:05:04]
DR. STEPHEN HINSHAW: Thank you so much for that very warm and kind introduction, and I am able to share my screen as soon as you get yours off, I think.

[00:05:12]
CHIH-CHING HU: Okay, let me stop sharing.

[00:05:14]
DR. HINSHAW: Yeah, okay, and I will share and-

[00:05:22]
CHIH-CHING HU: Yes, I can see it.

[00:05:24]
DR. HINSHAW: Whoops. Why is it blank? Oh, we have to go back to the beginning. We'll do that very quickly. This is just to make you dizzy at the beginning– no, not really.

[00:05:37]
So, as this kind introduction just indicated, I'm going to start with a few– a bit more academic slides on what this concept of stigma really means—historically and currently—and then shift gears to a much more personal examination of my and my family's history, and then try to bring the two together to talk about when mental illness has its onset in adolescence—as it so often does—and when stigma and shame accompany the national dialogue and any family's dialogue about it, what we must do to really promote thriving and overcome such shame and stigma.

[00:06:19]
So what does this term stigma literally mean? Back in ancient Greece and Rome—and stigma has both Greek and Latin origins—it meant "a brand or mark burned into the skin of a member of a devalued group." It also literally refers to the sharp metal instruments that would be forged and then used to brand. It's a- it's a very ugly, um, horrible term.

[00:06:45]
And so, back in ancient Athens at the Agora, the marketplace, it may have been important for me to know that my fellow shoppers might have actually fought for Sparta, not Athens, and perhaps have been former slaves. Now, maybe I needed to know that to know whom to interact with or not. Well, I might not have known, except that the Athenian government had branded stigma into the skins of such people, so I'd recognize.

[00:07:16]
Now, today, most stigma is inferred psychologically. Hitler certainly branded members of many groups—Jewish individuals, gay and lesbian individuals, people with mental disorders and developmental disorders, Roma, Gypsies—with a brand of stigma: numbers on their wrists. Some countries on Earth branded HIV-positive individuals in the 1980s and early 90s, but most stigma today isn't a literal brand, it's a psychological one.

[00:07:47]
So in the middle of the slide are a number of groups that have received or currently receive a lot of this psychological stigma. You notice—and I don't have time to begin to go through all of these—"left-handedness", which

today we think is maybe an advantage, but when I was growing up in Ohio along with my little sister, our mother's mother didn't want Sally to be left-handed. That was highly stigmatized. And today, being left-handed might get you into MIT and shows you have great spatial artistic abilities, so the moral here is that as social norms change, what was formerly stigmatized may be less so.

[00:08:25]
Cancer was highly stigmatized in the '30s, '40s, '50s, and '60s of the last century. Everybody knew it was a disease you brought upon yourself because you'd essentially lost a will to live. And today it's a- it's a cause. Celebrities– Athletes are coming out with disclosures of their own cancer, many fundraising efforts– Mental health– Mental illness is essentially still where cancer was 70, 80 years ago. I think we're starting to turn the corner, but we have a long way to go. Who receives more stigma than any other groups in contemporary American society and in most countries on Earth? If you have a mental illness, if you don't have a home, if you abuse drugs: those are the bottom three—the most stigmatized attributes.

[00:09:15]
I wrote a book on this topic—now it's getting old—13, 14 years ago called The Mark of Shame—the first book in the United States to really deal with the stigma concept as applied to mental illness—and, very briefly, I chose for the cover art a painting by Hieronymus Bosch called The Extraction of the Stone of Madness. This is the middle of a triptych hanging in the Prado in Madrid, painted in 1496. So we see the surgeon, but he's wearing a wizard hat—so he's a surgeon and a wizard—with a scalpel, cutting a hole into the poor patient's scalp; the patient's looking at us, saying, "What's going on?", priest is giving a blessing. And the theory at the time in Amsterdam and Holland in the late 1400s was that mental illness was caused by a stone in your skull. So, allegedly, the surgeon is removing the stone to cure the patient's mental illness, but if you can see from the PowerPoint, you can see a couple of little V-shaped white tufts. Bosch wasn't painting that the surgeon was removing a rock or a stone, he was painting that the surgeon was removing a flower. What was the name for mental illness in Amsterdam in 1496? You were called a "tulip head"; tulip's the main source of commerce then and now in the Netherlands. So Bosch was satirically painting that maybe if you remove the tulip—the label—would that cure the patient? Or is the label and the proper diagnosis the key to treatment? Hundreds of years later, it's still a very modern and eerie painting, which is why I chose it for this book cover.

[00:10:55]
In the United States in the '50s, psychologists and sociologists thought that the cause of stigma—the cause of bigotry—was, really, child-rearing. The Authoritarian Personality was a major book written in 1950 about that. Today, social and evolutionary psychology tell us we all have the capacity to and often engage in some aspects of stigma. We're a very social species. We would have never survived unless we banded together and bonded together and cared for our young, but if we were so social, we might have been exploited by fellow humans.

[00:11:34]
So the theory goes: we all form stereotypes. We have to group other people. I wish we weren't on Zoom—we were in a meeting hall somewhere—and then I'd see who's old like me and has my ridiculous hair color, and who's young, and who wears glasses, and who has skin color like mine. Those are stereotypes.

[00:11:55]
Now, as I sometimes say, I'm a very progressive professor at UC Berkeley and UC San Francisco, and as my Berkeley ties would hold, I have never stereotyped anyone except Stanford professors and students—that's our arch-rival school, and they're a private school, and they're elite, and they wear red rather than the royal blue of the Cal Bears. Now those are all true, but they're stereotypes, and you heard my tone of voice; I don't really like those Stanford people—they're our enemies—so I'm engaging in prejudice. I've judged your Stanfordness before I've met you.

[00:12:31]
And the third in the triad is discrimination. No Stanford student will ever get admitted into my course. And of course, I'm being somewhat humorous about this example, but in the history of interactions in our world, if you stereotype and develop very strong prejudices, discrimination might mean—as it did for people with mental illness in the Middle Ages—banishment into the countryside to live like an animal, or then later living your life in a total institution where there's no humanity left, or even extermination as we know from the concentration camps that Hitler created.

[00:13:14]
So stigma has very serious consequences, and stigma really means "the sum total of stereotypes, prejudice, and discrimination," and if I stigmatize you because of the group you're in—your religious group, your racial group or ethnic group, or the group of other people with mental illness, the other "lunatics like you"—everything about you is because of that group you're in. You've lost your individuality, even your humanity. So this is the literal meaning of the term, and the– today's meaning, it shows how deep the concept goes.

[00:13:52]
So I'm going to last just a few seconds on this slide because there's too much, uh, text on it. We know from hundreds of studies that are now accumulated around the world that people, when confronted with either the diagnostic label of or the behaviors consistent with many people with forms of mental illness, want to keep away from such people—don't want to be near them. We call that social distance.

[00:14:16]
This is even more true when we get at less conscious attitudes. Beyond research, in the United States today, in half of the states, if you admit to having a mental illness, what happens? Pretty quickly, you cannot renew your driver's license, you can't vote or serve on the jury or run for office, and you pretty much automatically lose custody of your children. That's discrimination.

[00:14:43]
As you'll learn in a few minutes, my depressions—my family's very serious mental disorder history—means that, well, I could never run for office. As I wrote in The Mark of Shame, it's a good thing that law wasn't on the books federally in 1860—Lincoln could have never been a candidate for presidency of the US: clear depressions throughout his life, potential hypomanic episodes as well. And in addition to these laws and policies, media portrayals, even though they're more sensitive in many ways, still predominate with violence and incompetence, and maybe the stereotype of mental illness in today's American climate is a picture of a violent, deranged-looking young man in his 20s who's a psychotic school shooter. So we've got a lot of avenues through which we must overcome stigma.

[00:15:39]
Two more kind of academic chalk talk slides. If society stigmatizes you because of the group you're in, well, you know what those stereotypes are. And back in earlier times in history, you knew from campfire stories. And today, we know from social media and tweets and what's posted online. It's likely– it's not inevitable, but if society stigmatizes my group, I may well come to internalize that; I'll show self-stigma. I want– I don't want to, but I feel kind of compelled to take on the attributes that everybody says my group has. What happens in mental health is- is that if you or your family show high levels of self-stigma or internalized stigma, it's a good predictor of treatment dropout—if you're in treatment—or never getting engaged in treatment in the first place: another reason to fight stigma.

[00:16:44]
And our second concept on this second slide is courtesy stigma. What- what on Earth could this mean? This was a term used by Erving Goffman, the famed sociologist who ended his career at UC Berkeley. He had passed away

before I came up to Berkeley, and in his book called Stigma, he said, tongue in cheek, if society stigmatizes a certain group, well, it's only common courtesy for society to stigmatize anyone close with or associated with those group members, like, for example, family members. So in mental health, until just the last few decades, American and European psychiatry were pretty clear that parents caused mental illness in their kids through their bad parenting. So not only were parents and family members victims of courtesy stigma, they were also held blameworthy for having caused the condition in their offspring.

[00:17:44]
Who else is close to people with mental or neurodevelopmental conditions? Scientists, psychologists like me, clinicians, doctors: we work with or research or treat "crazy people": people of very low social status who have a defective form of mental illness. So it's little surprise that, in major surveys done not so long ago, adults with severe mental illness characterized among the top three sources of stigma in their lives, the attitudes and, kind of, respect or lack of respect they got from the people treating them. So courtesy stigma casts a long shadow.

[00:18:38]
We know in the United States—and this is true around the world—much more as a society about mental illness, factually, than we did 50, 60, 70 years ago. There are better websites; there are better news stories. However, despite this greater knowledge, stigma has not budged. In fact, three times more people today in the US, if they hear the term "mental illness," believe that the person "responsible" for their own mental illness, or their family, are likely to be violent than in 1955. So we've either made no progress, or we've gone backwards. Of course, we've closed most of the major snake pit mental hospitals from back then, so many people's confrontation with mental illness is seeing tent encampments out here in California, homeless individuals and families living under freeway overpasses– We have not provided the level of care and funding for community treatment that we've needed to, so we may be inadvertently increasing stigma rather than decreasing it.

[00:19:55]
So that's our first few slides on this very ugly topic of stigma, so let's shift gears. Why would there be stigma against teenagers—adolescents, like Alan Hu, for whom the foundation is named? Well, most forms of what we consider to be adult mental disorder—depression, schizophrenia, bipolar disorder, post-traumatic stress disorder—actually appear, or have major risk for, during the teen years, if not before. Many such youth show inconsistency in their behavior; ADHD is a classic example—attention deficit hyperactivity disorder—where the student may be doing well in algebra class and not so well in history or English, and people wonder, "Well, why are you so inconsistent? You must not be trying. You must be able to control your moods and show better emotion dysregulation." So adolescence can be a time of much stress for teens and families, but on top of that, if emotionally dysregulated behavior is leading to cycles of despair and atypical behavior, many people will say, "Well, that kid– that teen should be able to control herself or himself." And again, the stereotypes. For example, bipolar disorder: Dr. Jekyll/Mr. Hyde—you're all good, you're all bad; you're elated or you're despairing. And the reality is, it's much different from that.

[00:21:31]
If you are fortunate enough to get evidence-based treatment—good psychotherapy or family therapy, and for the conditions that require it, you get medications—so many people say, "Well, why would you ever medicate a child or a teenager for a mental illness? That's mind control. Meds are poisons." There are so many myths and there's so much disinformation that we need to overcome, which is another piece of the puzzle of decreasing stigma. And of course, many teens, if they get on appropriate medication for their mental or neurodevelopmental disorder, are ambivalent about taking them because they don't want to be teased or thought different by their peers. So we have the stigma against taking medication, and we have the stigma of taking medication, which is a big issue for- for teenagers.

[00:22:24]

So let's get personal and go to the second part of my talk, and, uh, mentioned in the introduction was my book Another Kind of Madness that came out four years ago. Uh, that's my father, a philosophy professor, on the left, and me at age 18, uh, different color hair, mustache—we could talk about that later—in the backyard of our house in Columbus, Ohio, where my father was a professor of philosophy at Ohio State. This is just two months after my first spring break from college back east, returning to Ohio, when my dad had pulled me into his home library and said, "Perhaps, son, you should learn about my life," which had been totally hidden from me and my sister for that past 18 years and 17 years of my sister's life because of stigma that I'll mention.

[00:23:18]
"Another Kind of Madness" is a passage from a book by James Baldwin, Giovanni's Room, where he talked about the madness of people who remember and the madness of people who forget, and "Another Kind of Madness" is in one of those long beautiful sentences. And my book editor and I, a few months before the book was gonna get ready to be published, said, "'another kind of madness'—that's stigma." It's one thing to have a severe form of mental disorder that requires treatment, but it's another thing entirely if you can't even mention it, or you're too ashamed to mention it. So "another kind of madness," borrowing from Baldwin's quote, refers to stigma, which I still contend is worse than any form of mental illness. We can treat most forms of mental illness quite successfully—many of them these days—but if there's shame and stigma and lack of hope, that's the kind of madness that we just– we cannot endure.

[00:24:19]
All right. Thanks for the sip of water. So I'm going to read a passage from the introduction to this book to give you a sense of what I learned that day, back in the early '70s, just a couple of months before this picture was taken in my dad's study.

[00:24:38]
"In the late summer of 1936, scalding winds scoured the Southern California region. As the calendar reached September, the 16-year-old known as Junior [that's my dad, Virgil Hinshaw Jr.] couldn't shut off the voices now shouting inside his head. Preoccupied with the growing Nazi threat in Europe, day and night he roamed the sidewalks of Pasadena [his hometown], the same ones that had carried him to grade school on his metal roller skates a decade before. Begging him to save the free world, the voices grew in intensity each day.

[00:25:17]
"[…] As his thoughts gathered speed [wandering the sidewalks night after night] another insight emerged [in Junior's mind]. Alone among humankind, he had attained [he believed] the power of flight. His arms, in fact, had become wings. Like Icarus, if he lifted them toward the sky, he'd be aloft. Once he soared toward the clouds, the free world's leaders would witness this magnificent signal and [conquer to pledge or] pledge to conquer the Fascists."

[00:25:53]
When you're developing an episode of bipolar disorder in your teen years, which is often the time they develop, and it gets severe, the same kinds of disordered thinking and delusions and hallucinations that appear in schizophrenia are part of the picture. So my dad's belief within a few days of not sleeping went from "Let's stop Hitler and the Fascists" to "I can now fly, and if the world's leaders can see my flight, they will pledge to stop Hitler."

[00:26:29]
"The Nazi threat is real [the voices shouted inside his head]! Black-and-white newsreels looped before his eyes: Brownshirts marching, Hitler's speeches before massive crowds. […] Possessed by his new mission, he understood that if he dared not step forward, who would?

[00:26:46]

“But how? If not for him, the Fascists might prevail.

[00:26:51]
“As the early-morning hours of September 6 inched toward dawn, the winds [finally] abated. […] Enthralled by his energy and [insights, he] reached his block on North Oakland Avenue, moving furtively past a few yards to find his own home […] Breathing in, he crossed the lawn with muted footsteps. […] All was silent in the early daylight.

[00:27:16]
“There was no turning back. The time was now.

[00:27:18]
“But how to ascend? Thinking fast, he nimbly scrambled up the trellis, steadying himself […] A final thrust and he was on the roof above the small front porch, the walkway 12 feet below. The sky loomed majestically before him, the air already torrid. The voices inside his mind reached a crescendo […] Save the free world!

[00:27:41]
“Glory would be his.

[00:27:43]
“Approaching the edge, he shed his clothes and heaved them over, shoes, pants, and shirt floating to the ground beneath. Suddenly cooler, he held his breath. Calf muscles straining, arms outflung, he pushed off [for his flight] and propelled himself forward. For a second, there was only the feel of the air against his skin.

[00:28:02]
“The ground rushed toward him before everything turned black.”

[00:28:08]
So this was Dad’s first severely psychotic episode of bipolar disorder at age 16-and-a-half. He survived his flight when he crashed to the pavement below, had a concussion and a broken wrist; his older brothers—there were three older and two younger half-brothers in the home, parents were away—got him into the hospital, and he was finally shipped from LA County Hospital to Norwalk County Hospital in the San Gabriel Valley with a diagnosis of chronic schizophrenia. Bipolar disorder was not really diagnosed in the United States between about 1915 and about 1970.

[00:28:50]
He spent six months at the hospital in adult unit—no school. Several months into his stay, he thought the Fascists were still at work in the United States, poisoning the food supply. So he stopped eating; he only drank water. And he went from a football player, shot putter, 180-some-pounds, to 117 pounds and nearly died of starvation. His grandfather was called in to witness the last rites one evening at the hospital facility.

[00:29:22]
Somehow, winter turned into spring, and the voices cleared, and he got back to kind of more normal functioning, and the staff released him. He had straight A’s at Pasadena High School. The family didn’t want to talk—after six months of his being hospitalized—with him about this bizarre episode. They thought it would be very shameful, and they didn’t want to jinx his recovery. So no one discussed it, and he started 12th grade after the weekend following his release, where he suddenly earned all A’s for both fall and spring semester: seemingly back to normal.

[00:30:06]

My dad's life of manic highs and horrible lows and the combination often—what we call mixed episodes, where both are present at the same time—had begun at ages 16 and 17.

[00:30:23]
So Dad was Virgil Hinshaw Jr. He was born outside of Chicago—La Grange, Illinois—fourth of four boys; his father, my grandfather, Virgil Hinshaw Sr., was a Prohibition leader in the United States and a Quaker. His mother was a missionary; she'd done missionary work in South America. But his mother died when he was three—operated on for cancer at Chicago General Hospital. So here's one risk factor: Dad with– the older boys were five up to 13. When you lose a parent between three and four, that's a significant risk for developing depression or bipolar disorder later in your life. So Dad had one risk factor already.

[00:31:08]
In fact—just to get a little more personal with photos—in the spring of 1923, in an international Prohibition newsletter, this picture was published, called "The Motherless Hinshaw Boys," and to the right of the wagon's my uncle, Harold, 12 going on 13. Then in the wagon's my uncle Randall and then my uncle Robert, five, and then little Virgil Jr., three. No social smile for him; he looks puzzled. Just a couple of weeks before this, as he later told me, he had his first memory—well, he– the event occurred that led to his first memory. He was taken into the living room of their house in La Grange, and there was a big box, and his gran– his father, my grandfather, said, "Your mother is in that box. It's called a coffin. You will never see her again in this lifetime." So, quite a first memory to see your mother's body in a coffin.

[00:32:08]
My grandfather decided to move to California, remarried another missionary a couple years later, two more half-brothers joined the family. All the family was scholarly and athletic and religious; they endured the Great Depression. And then, as I just read you the passage about, when Dad was 16, in 1936, he had his first very florid episode and nearly lost his life from the bipolar delusion that he could save the world from the Fascists.

[00:32:39]
Then recovered, did very well at high school and Pasadena Junior College—as they called it then—uh, was accepted at Berkeley, made a very incredible decision to go to Stanford on a scholarship instead, and then, because he couldn't go overseas to fight in World War II, because the family were conscientious objectors but also because he'd been six months in a mental hospital—in a "loony bin", a lunatic asylum—he was 4-F, he decided to keep up his studies of philosophy. Got a master's degree at Iowa, went to Princeton for his PhD, where he worked for a year with the Visiting Professor Bertrand Russell in a one-on-one tutorial and got to know Albert Einstein across the street at the Institute for Advanced Study—and got to know Einstein well enough to write a book– book chapter in a volume on Einstein: "On Einstein's Social and Moral Philosophy."

[00:33:38]
So Dad had very good educational experiences, and yet, at age 16– and then, just as he was finishing his dissertation at Princeton in 1944, he thought he could predict the end of World War II by telepathy and became quite manic and delusional again and was hospitalized this time at Byberry State Hospital— Philadelphia State Hospital, which I later learned was the worst mental hospital in the United States.

[00:34:09]
There were 7000 men in room for 1400 in the men's dorm. Conscientious objectors took photographs there the year Dad was there and thereafter and showed the shallow graves and the starvation and mass beating. Dad had the delusion while there that he was being held in a concentration camp. His older brother Randall visited him and thought– and told me later, much later, how psychotic your dad must have been to believe he was in a concentration camp, and I plead with him to know that he was in Philadelphia. So Dad did have a psychotic delusion, but at another level, Byberry, which many visitors confirmed was the closest thing the United States had

to a concentration camp at the time. So at a metaphorical level, the plight of people with severe mental illness because of stigma has been not so different from the plight of many concentration camp survivors and victims who perished.

[00:35:12]
Here's my dad after his hospitalization at Norwalk but before grad school at Princeton as valedictorian at Pasadena High School.

[00:35:23]
When my dad got out, six months later, of Byberry, he applied for university positions. His dissertation had been accepted, he published papers, and he got a job at Ohio State University in Columbus. Became kind of the go-to professor there—the youngest member of the department—and he met my mother, who was a grad student in history, on a blind date, and they fell in love and became engaged. And what did Dad tell Mom during their courtship about his past? "Honey, I had a few problems in an– at high school and then at Princeton." Not a word about being misdiagnosed with schizophrenia or the torturous hospitalizations. You would never tell your fiancé that you had such a mental illness, or you would not have been marriage material.

[00:36:17]
When did Mom learn? When she became pregnant with me and my sister in the '50s, both of those pregnancies spurred huge episodes for Dad. He wasn't around for my birth. He wasn't around for my sister's birth. When we were young and he would get well and come back home, he asked his lead psychiatrist at Ohio State, "What should I tell my darling little children about my episodes of schizophrenia—as they thought it was—and my hospitalization?" And the doctor looked him in the eye and said, "Professor Hinshaw, if your children learn, ever, about your mental illness, they'll be permanently destroyed. You and your wife are forbidden from ever mentioning the topic." That's stigma.

[00:37:05]
I wrote a passage in Another Kind of Madness where I said, "What if an oncologist today told a Mom or Dad with cancer, 'if your children ever learn of your cancer, they will be permanently destroyed. You're forbidden from ever mentioning the topic.'" Well, we'd sue the doctor for malpractice. But that was the practice a generation or two ago in the United States. Mental illness was so off-limit, so shameful, that if your children knew that a parent had it, they would never get over it, and their lives would be destroyed. This is the stigma and shame that we need to overcome, and it's part of my family legacy.

[00:37:41]
So we need to wrap up so we can get to some questions. Um, finally—there's just too many words on this slide—after Dad talked to me when I had returned home from college, I was now 18. I wasn't a child anymore. He felt he was free to tell me about his past. So I went back to Harvard, my undergraduate college, and changed my major to psychology. I wanted to become a psychologist and understand mental illness. So, many of us in the field have such a motivation. But I was also terrified because I didn't tell my professors; I'd never be– get a recommendation for grad school with such a family, or girlfriends or roommates. I thought, any night I couldn't sleep and I might lose control of my mind, I would end up in a mental hospital just like that. It took a long time for me to learn that opening up is the key.

[00:38:36]
I went to grad school at UCLA after I directed summer camps. Bruce Baker, my mentor there, helped me learn a ton. I was supervised by Kay Redfield Jamison at the UCLA Neuropsychiatric Institute before her own disclosure in An Unquiet Mind about her own bipolar disorder.

[00:38:56]

Here's the six boys in the Hinshaw family during a family reunion in the late '40s. My uncle Harold, he was the tall one by the wagon in that early picture who developed alcoholism and died of alcohol poisoning. My uncle Randall, an economist, who was so nice to my dad during hospitalizations—very anxious, but escaped major mental illness.

[00:39:20]
My uncle Bob in the plaid shirt, about two years older than Dad, was the first one out of the house in 1936. Seeing his younger brother splayed on the sidewalk below, he pledged at that moment to become a psychiatrist and a psychologist, and he did. He got an MD and a PhD, helped treat my dad; Dad was the fourth patient to receive Thorazine in the United States in the '50s, '60s, and '70s. But Bob had migraines, like all the boys in this picture, and like I do; all the men in the family– And with his medical license, to overcome the pain, he could prescr- prescribe himself painkillers, got addicted, lost a leg to gangrene, and died of substance abuse.

[00:40:04]
There's my dad, fourth from the left, in his T-shirt. He's robust; he's regained all the weight. And then the two half-brothers from my grandfather and step-grandmother—they're both in their 20s; the older guys are in their 30s. They both have male pattern baldness, they're both a little shorter, both have lighter hair. Harvey in the sweater vest's son—Harvey was a famed musician and pianist—developed schizoaffective disorder and shot himself when he was 31 because it was hard to live outside a mental hospital. And Paul, still alive in Southern California at 94—his oldest son Marshall couldn't finish his first quarter at Berkeley, back when Berkeley was on the quarter system in the late '60s, and has had schizophrenia for 53 consecutive years, and I visit him to bring my cousin Marshall food every weekend at his horrific little apartment in downtown Berkeley.

[00:40:59]
So in the Hinshaw family, there's some great attainment and very serious mental illness, and my goal is to, through my work as a researcher and a speaker and an advocate and an author, get us through the stigma so that we can do the work we need to do.

[00:41:18]
So—no more text slides—I got my PhD. Dad and Mom were out for a visit in Southern California—Dad's in his mid 60s, so am I—but why is his hair dark? And, well, not everything's genetic. Little punch from the lithium– He finally got diagnosed because I diagnosed him correctly and got good treatment for him in his latter years.

[00:41:40]
But just six years later, now, up at Stinson Beach in Northern California, Dad, as you can tell, has lost 30 pounds. He developed a Parkinson-like illness in his latter years; all the misguided Thorazine and Mellarill—the schizophrenia meds he didn't need—all the electroconvulsive shock therapies, which can be very effective treatments for people with severe depression but not for someone with bipolar disorder if they had been on lithium, had he ever been diagnosed accurately.

[00:42:12]
Dad's latter years were a slow fade. He told me not long after this photo was taken that he wished he had cancer much of his life, and I thought Dad was having another episode. I said, "What could you mean?" He said, "Think what mental illness means to a philosopher; It means the illness is mental. I probably imagined it. If I'd only had cancer, son, I might have had a real illness and maybe could have forgiven myself." So Dad knew he had this biologically-, genetically-mediated illness called bipolar disorder in half of his mind, and in the other half of his mind, he was a 16-and-a-half-year-old on the back ward, mistaken and given up for dead and hard to integrate when you're not treated well as an adolescent.

[00:43:02]

Dad was a great dad when he was around. He wasn't around a lot when I was a kid because he was in hospitals a lot. Good sense of humor, he was smart– He had a university job with tenure; he would have been fired from any other job. My mom, the unsung hero of the story, covered for him—was not allowed to talk ever about what was going on until she opened up in her latter years and said, "Our family will never be silent again."

[00:43:30]
Dad had a genetic loading. Dad lost his mom when he was three, his stepmother abused him—the only one of the four original boys that she physically abused when he was growing up—to teach religion into him– So Dad had a number of risk factors, and we know that for many forms of serious mental illness, it's both genes and life experience like trauma that can sum together—not always, but- but many times.

[00:43:59]
I just told you that Dad in his latter years wished he had cancer, and when I finally discovered why, I finally got it. All the teaching I tried to give him about this biological- biologically real bipolar disorder only went in halfway.

[00:44:17]
What couldn't our family have said? Bill Beardslee is a professor at Harvard—Harvard Medical School. He's developed a form of family therapy for those families in which one or both parents has either depression or bipolar disorder, and the family therapy is based on talking about what the kids know is going on. The parents need therapy; the parents often need medication, but this is a family therapy that has now actually been branded. It's called Family Talk. If you receive Family Talk as a kid or a teen when your parents have severe depression or bipolar disorder, not only do you do better four months into the therapy, but four years later, your own risk of developing a mood disorder is cut by 30 to 40 percent. Yes, genes and biology matter, but one of the great anti-stigma truths we know of and treatments we have is to talk about it.

[00:45:27]
So we need to get to questions. I want to thank the Alan Hu Foundation that's been very inspirational when I first met the family a few months back; my colleagues at UC Berkeley, UCSF; Oxford Press, publishing some of my books; St. Martin's Press, the publisher of Another Kind of Madness; and thank you everyone for tuning in this evening. And let me stop sharing—not information, but stop sharing my slides—and let's go into questions.

[00:45:59]
CHIH-CHING HU: Thank you so much, Dr. Hinshaw, for sharing your family stories and a wonderful presentation. Okay, now we are open to Q&A. Uh, we have some pre-submitted questions; there's some recurring questions. Um, the first question is, uh: How do parents tell if their teens need professional help?

[00:46:22]
DR. HINSHAW: Well, this is a huge question which we could talk about for the next hour of our seminar. The teenage years are erratic at best for many teens, but what you look for is: you don't try to make a diagnosis—that's what a professional can help you do. Is your kid just not motivated the way they were before? Has there been not just a daily change or a bummed out mood after a failed exam or a breakup, but a consistent pattern of low motivation, tearfulness sad mood, erratic behavior—which could be the first signs of a psychotic illness or the first signs of substance abuse, which many teens engage in to kind of damp down the pain of a mental illness- a growing mental illness?

[00:47:11]
And part of– The hidden part of the question is: How do I talk to my kid about this? My teenager doesn't want to talk to me. And evolution: Why- why are there teenagers? Why is there adolescence? To get kids out of the home so they can individuate and procreate. That's sort of the way it's gone through human history. At the same time, while your teenager or preteen says, "I don't want to talk about it. I'm independent. Don't baby me," look

for opportunities. Your kid, when you least expect it, is dying for you to be attuned, and they will come to you if you don't judge. It's hard to keep a curious attitude as a parent because a lot of teens do things that parents don't like so much. "Why are you doing that? I'm sorry you feel that way. Uh, we'll wake up tomorrow and get on to the next." But your curiosity and your active interest—and it's happened with our three boys in our family who are– one's a teenager, and two are- are quite a bit older—when you least expect it, you will get that opening; you'll get that invitation more times than not, and then you can try to get professional help as needed.

[00:48:28]
CHIH-CHING HU: Right, um, the next question related, um: How do parents persuade their teens or young adult children to get help if they refuse to do so?

[00:48:38]
DR. HINSHAW: Yeah, this is a huge issue. Let me get a little water first.

[00:48:45]
Once you're 18 in this country– in many countries, you're an independent adult. It's very hard even if an 18- or 19- or 20-year-old is developing a very serious form of mental illness. Some of those forms of mental illness include psychotic delusional thinking, where you believe everyone else is out to get you, but you don't have a problem. How do you convince someone in that state that they need help? They think that you're part of the devil or part of someone trying to control their mind. It's really, really hard, because in the effort to enforce human rights and not have people locked into mental hospitals permanently, as my dad was many times, it takes extreme suicidality or extreme homicidality or an extreme lack of ability to care for oneself, where you can even get three days involuntarily committed to a mental hospital. And after that, it's really hard to get anything more than that, unless a judge might extend it for another a couple of weeks or maybe 30 days at most.

[00:49:54]
Try to get your kid—that you believe and are seeing with your own eyes is struggling—peer groups, counselors at school. Kids will often talk to other kids way before they'll admit shamefully to a parent about their cut marks or burn m-marks, if they're self-injuring, or how
awful they feel about themselves. As I just said in the answer to the first question a moment ago, keep yourself open, try not to be judgmental, and your kid may well come to you when you least expect it with a little bit of an opening. And then that can allow you to voice your concern and your love, and that may help the kid get propelled into opening up more to other people. But it is the hardest issue in young adult mental health that I know of, which is how to convince—and even for older adults, of course—how to convince someone they need help when they're convinced, because of a severe mental illness, that it's everyone else's fault and not theirs.

[00:50:58]
So let's go to other questions because I know there's probably a lot.

[00:51:01]
CHIH-CHING HU: Yes. Yeah, there are a lot of questions coming in already. Um, the next question is, uh: Where should we go, when we first suspect a psychological illness, for getting an accurate diagnosis and treatment?

[00:51:16]
DR. HINSHAW: So there are a lot of ways to go. We have, in the United States, this totally inequitable health care system where we're loaded—in the San Francisco Bay Area, in LA, in Seattle, in New York and Chicago—with tons of professionals, but especially through the pandemic, their waiting lists are 18 to 24 months long. And then you go out to more rural areas, where there's hardly a doctor or psychologist within miles. And so, where do you go first? Go to support groups for parents. There are websites galore: the Mental Health America Association, NAMI—the National Alliance on Mental Illness, the Depression and Bipolar Support Alliance– There are

many websites; I'm compiling a list of them for this latest book I'm writing, just now, on girls with ADHD.

[00:52:12]
Talk with relatives, talk with friends, voice your worry, get some feedback about whether you're over worried or- or not. And then the pediatrician that your kid sees should be a good source of information about whether—and very few pediatricians have specialty training in mental health—where's the local clinic, where's the guidance center, uh, where's the collaboration office between psychiatrists, social workers, and psychologists in your community. Get dialogue going, and if your concern gets to a certain point, you're not going to do yourself or your offspring many favors by waiting month after month, year after year.

[00:52:53]
The sad fact is that the average length of time in the United States for someone—a young adult, a teen, or their family member—to recognize symptoms of mental illness and getting help– The average is 10 years, which is inexcusable. We need better parity. We need better health insurance. We need to enforce the Americans with Disabilities Act, but we also need to have mental health struggles—not a sign of weakness to talk about; we get our cars tuned up, we get our bodies tuned up– Everybody needs a mind tune-up. If we can change the nature of dialogue to "It's a sign of strength to reach out for help" rather than "weakness," we'll be somewhere down that road.

[00:53:34]
CHIH-CHING HU: Okay, next question is: Is there a difference in the stigma of different diagnoses, especially borderline personality disorder?

[00:53:46]
DR. HINSHAW: Right, so there's kind of two answers to this question. Number one, any form of mental disorder, or someone seems off or threatening or off-kilter—in every culture we've ever studied—receive stigma. Yes, the East does better than the West for some things, but stigma against mental illness is universal, and pretty much anybody who gets labeled receive stigma.

[00:54:15]
However, part two of the answer is: in many respects, the most severe form—schizophrenia; bipolar disorder, where you're having delusions, as my dad did; severe depression; suicidality—scares the pants off of most people in the public. More severe conditions get stigmatized; HIV gets more stigma than the flu, right? Et cetera, et cetera. However, it's not as simple as that. ADHD, that I do a lot of work on and my lab does—which seems milder, although it can lead to many different impairments later on—is marked by consistent inconsistency. So disorders like high-functioning autism or ADHD, where the kid seems kind of fine but then weird and they're not trying, actually receive very high amounts of stigma because everybody believes they should be able to keep it under control.

[00:55:14]
So the more we learn about stigma, we know that all forms of mental disorder and neurodevelopmental disorder—autism, learning disorders—are prone to receive stigma. More severe forms are somewhat more likely to, but inconsistency in behavior is another trigger for stigma– trigger for it.

[00:55:33]
So let's keep going because I know we're going to run out of time before too long.

[00:55:37]
CHIH-CHING HU: Yes, um, so next question: So what– Should we see a psychologist instead of a psychiatrist or vice versa?

[00:55:46]
DR. HINSHAW: So psychiatrists are medical doctors, and then they specialize and do a residency in– for four years in psychiatry—mental illnesses. And then child and adolescent psychiatrists are a subspecialty of psychiatry, where you do an additional couple years of training in disorders for kids and adolescents and young adults. Psychiatrists prescribe medications. Psychologists don't; now there's a state where you can—in some regions, in rural parts, where you can. A psychiatrist– psychiatrists are trained today to be experts in psychopharmacology and the proper use of medications; some psychiatrists are great therapists, too, but their training makes them more biologically-oriented. Psychologists may have a lot of knowledge of biology, but their training, by and large, is in cognitive behavior therapy or dialectical behavior therapy or family therapy.

[00:56:43]
The best is to get a psychologist working with a psychiatrist or a pediatrician called a developmental/behavioral pediatrician—these are pediatricians with specialty mental health training—so you can get the most of the psycho– best of the psychotherapy and family therapy worlds and the best of medication if needed.

[00:57:04]
CHIH-CHING HU: All right. So, um, with a question regarding the stigma: What can high school mental health clubs do to help school community to remove stigma?

[00:57:15]
DR. HINSHAW: So I've been involved for 10 years with a very slow starting movement—and now the movement has become bigger and the pandemic has slowed things, but we're in a new strategic phase of planning—to work with, and some people are working as young as the elementary age, middle school age– Our work with Bring Change to Mind, a non-profit here in San Francisco founded by Glenn Close, focuses on high school clubs that are not mental health knowledge clubs. We don't have lessons on schizophrenia and depression and PTSD. The clubs are designed for the kids—along with their advisor and with their support team from Bring Change to Mind Central and following our guidebook—to develop their own unique curriculum to fight stigma.

[00:58:08]
We're in a number of states now, we want to ramp up, we've shown– we've done research showing that these clubs are helpful for kids who join them, and we'd like to get more research going to see if we can start to track the spread of influence to other kids in the schools and school administrators and families. Our model is: young people are social activists, and they're empathic, and in today's world, we know that social media giveth and taketh away, but they're a lot more authentic than the other white or gray hairs of my generation. Many young people don't believe in stigma; they've heard differences talked about all the time. So if we can only—kind of like the good kind of wildfire—get these clubs spreading, in 10 or 20 years, these are going to become our national leaders, and we may have a different national model of how we view mental illness, and we may finally show a big dent in the stigma that's persisted for 70, 80 years.

[00:59:14]
CHIH-CHING HU: Okay, um, next question: What are simple steps schools, family, and the individual can do to reduce or remove stigma?

[00:59:24]
DR. HINSHAW: So there's a couple of ways to think about this. One is "What can schools, individuals, and families do to reduce stress?" I mean, it's almost a badge of courage today among teens to see who's more than– college students—who's more stressed than everybody else. We need to have breaks. I think we should not have every course graded in high school. I would have never made it to grad school if I didn't take a quarter of my classes in college pass/fail. That's why I took physics and Dostoyevsky and other fun courses. There's so much

stress all the time; we need to reduce it. Meditation apps, exercise—all these are important.

[01:00:02]
To reduce stigma, again, it's going to take big policy: enforce the ADA—the Americans with Disabilities Act, make sure that Congress enforces parity so that your mental health condition gets the same level of coverage as your broken arm. But for all of us, it's maybe confronting the person who ridicules someone with a mental disorder the way people used to do for blindness and deafness; it doesn't happen as much anymore. Or maybe it's encouraging someone in your family to speak up when they don't really feel like it. You- you want to push hard but not too hard, and it's all of us modeling ourselves, unlike what we see on Instagram all the time, where everybody's perfect. It's okay to admit coping and struggle and weakness because that helps us get stronger.

[01:00:55]
CHIH-CHING HU: Uh, Dr. Hinshaw, I think we passed 7:30 now. I think that should probably be the last question.

[01:01:01]
DR. HINSHAW: So depending on how you want to work it, I'm here if you want to go for a few more because I-I've seen some flash on chat, but I couldn't read them because they were off–

[01:01:10]
CHIH-CHING HU: Yeah, they keep coming in, and it's just a lot of questions, yeah. Um, I think maybe we can pick up one last one.

[01:01:19]
DR. HINSHAW: Okay, good.

[01:01:20]
CHIH-CHING HU: Go, yeah, um, let me see. Um, how do we determine what psychiatrist is best able to work with different diagnoses?

[01:01:37]
DR. HINSHAW: Yeah, so, go in– Parents need to get educated. This is true if you want school accommodations for your kid with a learning or mental emotional disability. You've got to demand getting a 504 plan or an IEP, and you've got to get educated. So if your doctor says, "Here's a psychiatrist, but I don't know– I just know that that psychiatrist is in town," ask where the psychiatrist got their degree. Ask what their experience is in treating depression or PTSD or ADHD. Um, support groups for a– kids– families or kids with ADHD or learning disabilities or depression—there's many different support groups in- in most large towns and even in smaller ones; you can go online.

[01:02:26]
Ask other parents who live near you, "Who really does a good assessment? Who doesn't do a 10 minute quick Q&A?" and "Who really gets it?" and "Who really doesn't rely just on medications or just on psychotherapy, but maybe the combination?" Ask around, sharpen your skills, go to the good websites, and inform yourself, and I think that will help you make good decisions.

[01:02:50]
CHIH-CHING HU: All right, thank you so much, Dr. Hinshaw. Um, I think we are going to close this event. Um, I learned a lot, um, from you tonight, and I-I learned that, um, removing a mental illness stigma by knowledge itself—it's not enough.

[01:03:09]

DR. HINSHAW: Knowledge is good; we don't want to have an ignorant society-

[01:03:12]
CHIH-CHING HU: Yes.

[01:03:13]
DR. HINSHAW:-but if it's just the facts, sometimes the facts are just promoting the stereotypes. We need to humanize. We need to– This is what happened with breast cancer in women; this is what's happening with prostate cancer in men. Everyday stories of strength and coping—not just celebrities, not just athletes; that's good, that's important—the more we talk about it, Congress can't ignore it, the mental health system can't ignore it, and everyone will be beyond the point of thinking that admitting to a struggle mentally is a sign of weakness. No, it's just the opposite.

[01:03:48]
CHIH-CHING HU: Yeah, we need to create an environment of, uh, psychological safety to cultivate-

[01:03:53]
DR. HINSHAW: That's exactly right.

[01:03:54]
CHIH-CHING HU:-humanity.

[01:03:55]
DR. HINSHAW: Yeah.

[01:03:56]
CHIH-CHING HU: Kindness, compassion, and empathy.

[01:04:00]
DR. HINSHAW: So I just want to thank you and everybody for listening in. I wish we had another hour, and, um, the Alan Hu Foundation and so many other groups—locally and nationally, internationally—are doing the work we need to do to bring that compassion to bear, so thank you.

[01:04:18]
CHIH-CHING HU: Thank you. Thank you, Dr. Hinshaw. So with that, I'm closing the event right now. Thank you everyone for joining the webinar. Goodbye, stay safe, and stay healthy.

[01:04:32]
DR. HINSHAW: Thanks.

[01:04:33]
CHIH-CHING HU: Thanks.