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Inspiring Woman: Dr. Shari E. Miles-Cohen

by Emily Follin

When Dr. Shari E. Miles-Cohen was about five or six years old, her aunt died of pancreatic cancer. She and her sisters were forbidden to attend her funeral. They were told that they were not "emotionally equipped" to handle the event (2). However, her younger brother was allowed to go to the funeral without any implications of his lack of emotional fitness. Miles saw this as incredibly unfair, and this sense of injustice has stayed with her and has fueled all of her work as a feminist (2). Today, Dr. Miles-Cohen plays a major role in a great many organizations dedicated to women's issues and the psychological health of women.

Miles-Cohen was born in 1964, but beyond that, not much is published about her early life. She attended the University of Colorado at Boulder where she received her bachelor's degree upon graduation (3). Initially, she was a pre-med student, but that changed after taking a class in rape crisis counseling. At this point, she wasn't sure if she wanted to be a rape counselor, but she did know that she no longer wanted to be a medical doctor (2).

She went on to Harvard to get her master's degree and doctorate, and it was there that she decided that clinical work was not for her. At Harvard, she took a class in clinical psychology, and she found that she didn't enjoy it at all. During a summer job at the Library of Congress, a book fell from the shelf and opened to an article by Kenneth Clark scolding psychologists for ignoring social issues and not playing a more active role in them. This inspired her to switch her focus to policy-making (2).

Miles-Cohen sees her race and her sex as being equally important issues and she is just as devoted to black activism as she is to feminism. She often finds that it is easier for her to be a black feminist in a predominantly white environment than in one that is predominantly black because when she is surrounded by other black women, she feels pressured to choose one over the other rather than fighting for both issues together. In white society, she doesn't feel she has to choose one over the other, but simply defend herself from both sides (2).

Currently, Dr. Miles-Cohen works as Senior Director of the Women's Programs Office (WPO) at the American Psychological Association (APA) and as the Staff Liaison to the Leadership Institute for Women in Psychology (3). WPO is a part of the APA that serves as an information and referral resource on women's issues. It also releases pamphlets, reports, and other materials on topics that affect women's lives. These topics include disabilities, abortion, depression, the sexualization of young girls, poverty, and violence (1).

Before becoming the Senior Director of WPO, she was the Executive Director for the Society for the Psychological Study of Social Issues. She also acted as the director of the Union Institute Center for Women, the African American Women's Institute at Harvard University, and the Women's Research and Education Institute (WREI). She served as the WREI Congressional Fellow for Representative Ronald Dellums, acting as his representative on women's issues, healthcare, and education. She even serves as an advisor to the mayor of Washington D.C. as a member of the D.C. Commission for Women (3).

In addition to her primary responsibilities working with various professional organizations, she also finds time to mentor young women from the inner-city and encourage them to get into the sciences. She has tried teaching, but has found that she does not enjoy it because she finds it difficult to work with students who are very privileged or entitled. Somehow, even with all that, she finds time to raise her young son (2).

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Image Courtesy of *Feminist Voices*, http://www.feministvoices.com/shari-miles-cohen/

Understanding Self-Harm
by Brianna Vear

Self-harm, also referred to as self mutilation or self injury, is complex. It has no universal definition and plays out differently in different people. The broadest and simplest definition is the deliberate behavior of causing oneself pain or injury. To an individual, however, it is much more than inflicting pain. In most cases it is either a coping mechanism, a way to survive, a way to feel, and/or a cry for help (1).

Self-harm was a quiet epidemic until 1996 when Princess Diana, during a television interview, explained how she often cut her arms and legs in order to cope with what had been occurring in her life. She said, "You have so much pain on the inside you hurt yourself on the outside because you want help" (2). Self-injurious behavior includes, but is not limited to: cutting, burning, branding, hair pulling, picking, and intentionally causing bruises or broken bones. At times eating disorders, risk taking behavior, and drug and alcohol abuse may also be termed as self-harm but for the purpose of this article, I will be focusing primarily on direct self-injury (1).

Most commonly self-harm is a coping mechanism to environmental stressors. Common stressors include bereavement, bullying, financial crisis, and past or current physical, emotional or sexual abuse. A person who self injures may have low self-esteem or poor body image and may use self harm to "punish" the body. People we term as "overachievers" or "perfectionists" fall into the high risk category as well. Their perfectionist behavior works as a coping mechanism in and of itself. They remain busy in order to avoid facing their problems. This then leads to high stress as well as emotional buildup. It is when the levels of stress and emotion reach a peak that they may turn to self-harm. A person who self-harms, most often does not know any other way to deal with their pain or stress. They were not taught any other type of coping mechanism, which leads them to feel that self harm is their only option (3).

Due to the very nature of the act, self-harm is accompanied by many myths and stereotypes. The most common myth is that a self inflicted injury is in fact a failed suicide attempt. Another similar myth is that a person engaging in the act wishes to die. Although suicide has an element of self-harm, not every person who intentionally injures themselves wishes to die. More often than not, a person partaking in this behavior is interested in living. As mentioned above, most commonly it is a coping mechanism. People who self-harm often describe either extreme emotional pain, or a sense of numbness. Self-harm allows an individual who is in extreme emotional pain to gain temporary relief by causing him/herself physical pain. A person who feels "numb" uses the physical pain to feel alive again, to merely feel *something* (1).

Another common myth about self-harm is that

Image courtesy of www.recveryourlife.com

people who do it are seeking attention or trying to manipulate someone else through their self injurious behavior. This, however, is far from the truth. Studies show that two-thirds of people who cut do not tell anyone about the behavior and go to great lengths to cover it up (wearing long sleeves, injuring areas that are not commonly visible, etc.). People who self-injure often have difficulty expressing emotions in a verbal way, or feel they do not have one person that they trust enough to discuss their problems with. Self harm then becomes a way to relieve, escape or control feelings of anger, sadness, or self-loathing when the feelings become too intense (4).

Did you know that it is only emotional teenage girls who self harm and it is usually caused by a break up? This is, of course, yet another myth, but it would seem that the media wishes us to believe this. In reality, a number of studies show that girls and boys self-harm equally. The problem is that girls are more likely to seek help for their problems (6). I would argue this is due to the nonsense of socially constructed gender norms: girls are allowed to cry, hurt, and seek help but boys must be strong, independent, stoic and never show emotion or appear vulnerable.

The truth is that age, race, religion, gender, socioeconomic status and sexual orientation are all irrelevant in determining who self harms. It is the stressors in a person's life and whether they have learned coping mechanisms that affect their chances of partaking in self-injurious behavior (6).

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Depression, Anxiety, and Women
by Alex Nichipor

Depression and anxiety are a pervasive problem in this society. According to the National Institute of Mental Health, about 21 million adults have a depression disorder, and about 40 million more have an anxiety disorder.

Generalized anxiety disorder is defined in the Diagnostic and Statistical Manual of Mental Illnesses (DSM IV) as having the following characteristics: it lasts for more than six months; it is uncontrollable and distressing to the patient; the patient is tense, fatigued, and has difficulty concentrating and sleeping; and lastly, these symptoms are not due to substance abuse or to another physical or mental disorder (1). Major depression is defined in the DSM as including these characteristics: depressed mood; diminished interest in activities; fatigue; diminished ability to concentrate; thoughts of death. Again, these symptoms cannot be due to substance abuse or another physical or mental disorder.

As you may have noticed, there is a lot of overlap between the symptoms of these disorders. Though clinical anxiety and depression are two different mental illnesses, they are often related. Moreover, anxiety and depression as mental illnesses should be distinguished from anxiety and depression as mental *states*; if you are anxious about your upcoming exam or depressed that your cat is dying, you probably don't have a mental illness – you're just going through a hard time. However, if you get painfully nervous about every assignment, or you can't even function because you miss your cat so much, you may have clinical anxiety or depression. Please see a counselor; you don't have to suffer alone.

Gender differences in the experience of anxiety and depression are also very marked. Women experience anxiety and depression at twice the rate of men (2, 3). (However, many experts believe that anxiety and depression are under-diagnosed in men, since men are often socialized to repress emotion, or to express despair and terror as rage.)

Image courtesy of http://www.mylasiciliana.com/

Why is depression so common in women? Some neuroscientists argue that women's brains process stress hormones less efficiently than men's brains. Researchers have found that the brains of female rats are more sensitive to the effects of corticotropin-releasing factor (CRF), a hormone that organizes stress responses in mammals (4). However, in highly social and intelligent creatures such as humans, neurochemistry is probably only one root cause among many. It is significant that not every woman with neurochemical or genetic predispositions to depression ends up developing it. It would seem that the social environment is another major factor in the development of depression and anxiety.

Indeed, there are many reasons for women to be depressed. Women still endure high rates of domestic violence and sexual assault – indeed, post-traumatic stress disorder, an illness characterized by anxiety, depression, and flashbacks of a traumatic event is twice as common in women as it is in men (5). Significantly, women report that rape and sexual assault are the most common causes of their illness. Sadly, PTSD is one of the least studied anxiety disorders, but cognitive behavioral therapy, social support, and medication can help people with PTSD manage their illness (5).

Post-partum depression is a depression disorder that is found mostly in women (there are a few documented cases of fathers developing PPD), and it manifests as a severe bout of depression following childbirth. Some studies have indicated that PPD is caused by hormone imbalances before and after pregnancy, but there seems to be a social element as well. Poverty, racism, sexism, and homophobia all worsen PPD, and about 44% of women with PPD make below $19,000 a year (6). Though awareness of PPD has increased in recent years, the illness is still not well understood.

The experience of being seen as a sexual object (something that many women endure) also creates anxiety and depression. Moreover, a very narrow beauty ideal leads women to constantly think about how their bodies appear to the outside world, and this leads to anxiety and depression extreme enough to actually impair cognitive functioning. One Yale study compared the performance of two groups of young women on a math test; the only significant difference between the two groups was that the women in one group were wearing sweaters, and the women in the other were wearing bathing suits. The women wearing bathing suits performed poorly, because they were too anxious about their appearance to focus on the test. In extreme cases, the anxiety and depression caused by poor body image can lead to anorexia and bulimia.

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PsychoMedia: Stereotypes of Mental Illness in the Media

by Skyla Seamans

Stereotypes of mental illness are all too prevalent in the media. Whether it is in the news, on television, or in the movies, the media renders images of mental illness in a negative way and does nothing to discourage viewers from believing in these myths. PsychoMedia is the result of combining mental illness exploitation in movies and television with biased reporting in the news to create an image of all mentally ill people as disturbed and aggressive or simply mindless human beings, even though this is far from the truth. However, there are ways to stop the negative portrayal of mentally ill people in the media, but first these images must be recognized as detrimental misrepresentations in order to educate the public (1).

The most common myth portrayed is that all mentally ill people are violent. However, research shows that mentally ill people are more likely to be victims rather than perpetrators of violence. Cheryl K. Olson, co-director of the Center for Mental Health and Media at Massachusetts General Hospital Department of Psychiatry, found that mental illness alone does not predict violent behavior. Other variables like substance abuse, history of violence, stressors, and demographic variables also play a role (2). Another popular stereotype is that mentally ill people are unpredictable. Contrary to this belief, the majority of people with mental illnesses are ordinary individuals who go to work and try to enjoy their lives like everyone else. They won't "go berserk" and attack a person for no reason, even though this seems to be a common theme in the media. Another view is that mental illness is incurable, even if positively portrayed. For example, the lead character in *Monk*, who has an obsessive compulsive disorder, regularly attends therapy but shows no improvement. However, the success rate for treatment of mental illnesses ranges from 60 to 80 percent, according to the Mental Health Association of Tarrant County. This media misrepresentation gives viewers the idea that treatment is unproductive, even though treatment is available and can often be successful.

Other common myths regard depression as a chemical imbalance in the brain. Many people believe mental illness treatment is simple and requires a specific drug to fix the imbalance, although it is much more complicated than this. Some people suffering with depression are never able to find a drug to help with their illness. Teens with mental illness are seen as simply going through a phase. Movies like "Heathers," "Thirteen," and the "American Pie" series show alcohol, substance abuse, sexual promiscuity, eating disorders, self-injury, depression, and impulsivity as normal teen behavior, but the media glamorizes these behaviors. Movies also rarely make distinctions among mental health professionals. This confuses viewers about how each practitioner can actually help patients (2).

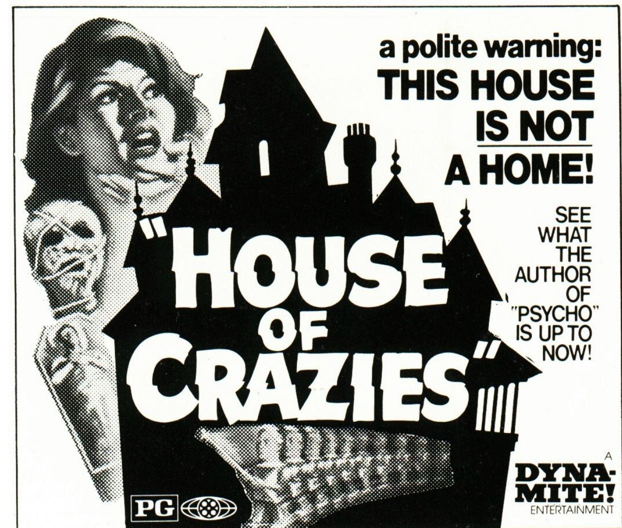

Image courtesy of Psychomedia.com

Since the 1900s, the movie industry has been portraying psychiatry in a subjective way and has been providing the public with inaccurate and frightening views of mental health professionals, which can be classified into three portrayal types: Dr. Evil, Dr. Dippy, and Dr. Wonderful (3). Dr. Evil is described as "the Dr. Frankenstein of the mind," who is disturbed and uses dangerous treatment on patients. This doctor is most commonly seen in horror movies, but is also revealed in shows like "Criminal Minds" and "Law and Order: Special Victims Unit," where a recent episode showed an egotistical psychiatrist who exploited his patients and turned out to be the killer. Dr. Dippy is seen as more erratic than his patients and his treatments can range from strange to impossible. Although this doctor rarely harms his patients, he may believe he is supernaturally skilled or can read minds. Robin Williams' character in "Good Will Hunting" illustrates this. Finally there is Dr. Wonderful, who breaches ethical boundaries and violates confidentiality to discuss patients to whomever he pleases. This doctor lacks boundaries between personal and professional relationships. These three stereotypes are the most commonly found in media portrayals of psychiatrists (3).

The latest Batman film, "The Dark Knight," is a prime example of the false stereotyping of schizophrenia. The Joker is given split personalities and is seen as a violent, murderous villain in the film. There is even a scene where Batman describes the Joker as a schizophrenic clown, which gives viewers the idea that other people suffering from schizophrenia may act in the same violent manner. Doctor Byrne, psychiatrist at Newham University Hospital in London, wrote a report on this film for the Time to Change Campaign. He said that the humor and violence in this film are based entirely on the common misunderstanding of mental illness.

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Women Veterans and Mental Health
by Corinne Blake

The official policy of the U.S. Military is that women soldiers are prohibited from serving in ground combat units. This policy may cause some to wonder, if this is true, why would a woman come back from the Middle East with any mental health issues if she has not had to face any combat? Consider this: the war in Iraq has no front lines, no safe zones, and no way to hide from car and roadside bombs and in-flying mortars. Non-combat units can become combat at any time. Many women are coming back in the same condition as the men: some with physical injuries and some with less prominent, but still serious, mental health issues (1). Any veteran returning from war may be at risk of many mental health issues. These risks include anxiety disorders, mood disorders, depression, and post traumatic stress disorder. A veteran may even suffer from a mental health issue that results from a war among their fellow Americans: military sexual trauma (2).

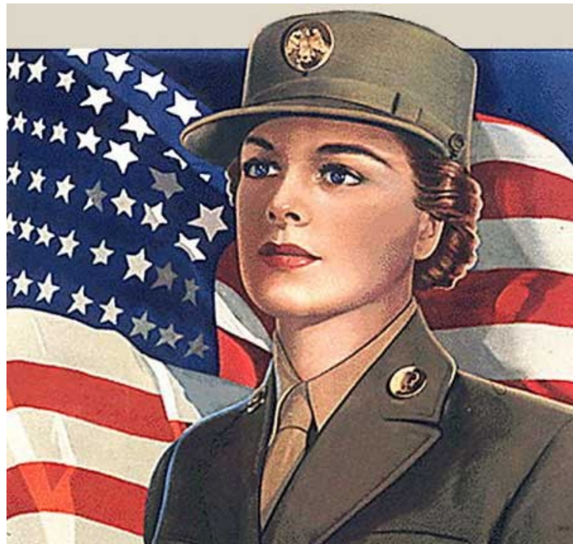

Image courtesy of War-veterans.org.

Women are the fastest growing group of veterans. In 2008, eleven percent of veterans from Iraq and Afghanistan were women. Twenty percent of these women veterans have been diagnosed with post traumatic stress disorder (3). PTSD can be caused by any sort of traumatic event a person may experience. It is important to note that not all women who come back from war, and not all women who experience a traumatic event, suffer from post-traumatic stress disorder but women *are* more likely than men to develop PTSD. Women may be more likely to develop PTSD if they have a past mental health problem, were sexually assaulted, were injured during the event, had a severe reaction at the time of the event, experienced other stressful events afterwards, and/or do not have good social support (2). PTSD shows itself in many forms; one form of traumatic stress is military sexual trauma.

Military sexual trauma is a form of trauma that many women (and some men) experience during their military service. MST is defined by the Department of Veteran Affairs as "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training (4)." In other words, it is trauma that results from sexual harassment or sexual assault experienced while you are in the military. This can include put-downs because of your gender, unwelcomed flirting, unwanted touching or grabbing or forced sex, among other things. Unfortunately sexual harassment or sexual assault happens in the military more than some would like to admit. According to VA statistics, approximately 1 in 5 women and 1 in 100 men admit to having MST, and this is probably only a fraction of the people who are actually assaulted (4). Some women take to carrying weapons (such as knives) with them at all times and some are afraid to walk around at night (1).

Symptoms of MST and PTSD are similar. Symptoms for PTSD include reliving the event that led to the trauma, avoiding situations that may remind you of the trauma, feeling numb, and/or hyperarousal (5). Difficulties associated with MST include strong emotions, numbness, trouble sleeping, trouble concentrating, reliving trauma, and also some physical health issues (4). Both forms of trauma can lead to relationship problems, and/or drinking or other drug problems (4, 5). Both forms of trauma may benefit from counseling as a form of treatment and the VA provides counselors for both issues. Unfortunately, sufferers of MST and PTSD often have a feeling of hopelessness and keep things bottled up inside and do not seek treatment at all.

One piece of good news concerning mental health issues and military service concerns the recent abolition of "Don't Ask, Don't Tell" (DADT). As an official government policy, DADT required gays and lesbians in the armed forces to keep their sexual orientation secret. The termination of this policy means that a major source of potential stress has been eliminated because gays and lesbians now have the option of being open about their sexual orientation.

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Eating Disorders: The Silent Epidemic
by Emily Burke

Women are bombarded with pressure to lose weight every day. From magazine ads, to weight loss programs, and everything in between, women are getting sent a clear message: only one body type is acceptable. Although our bodies naturally fall into different categories, many women will attempt to alter their bodies to fit the societal ideal. When one becomes so preoccupied with food and weight that it affects every day functioning, it may manifest as an eating disorder (1).

Eating disorders are common. An estimated 10 million females and 1 million males in the United States are suffering from eating disorders such as anorexia nervosa and bulimia, and an estimated 25 million more are suffering from binge eating disorder (2). One study found that up to 20 percent of college students reported that they had suffered from an eating disorder at one time (3).

Despite the prevalence of eating disorders, they do not receive as much attention as they deserve. Eating disorders have the highest mortality rate of any mental illness (4), so why don't we pay more attention to them? One answer is that we don't adequately value women's health. We need to start valuing women's bodies no matter what form they take. Eating disorders are rarely spoken about because society wants women to be as thin as possible by any means necessary. Eradicating eating disorders is a threat to the status quo. To end eating disorders, we must stop viewing women as objects and start viewing them as people.

It's common in our culture to congratulate somebody when we notice they have lost weight. While this may seem like an innocent act, it reinforces the idea that one body type is better than another, and it may reinforce some unhealthy means of achieving weight loss. Little comments can contribute to a dangerous, unhealthy mentality about weight and food. Saying "I'm so bad for eating that cake" is really like saying "women's moral worth is contingent on the food they eat". Saying "she is too fat to wear that outfit" is like saying "fat women shouldn't be allowed out in public in anything that I don't deem acceptable for their bodies". Language really does matter. You may say these things every day and think nothing of them, but they stick with people for a long time and can contribute to an unhealthy relationship with food.

When the media does talk about eating disorders, they often show the same type of person suffering: a white, thin female usually between the ages of 16 and 25. However, all different types of people have eating disorders. Seventy-four percent of American Indian girls have reported purging and using diet pills to lose weight (4). Although purging and using diet pills do not necessarily indicate a clinical eating disorder, studies have shown eating disorders affect women of all racial and ethnic backgrounds at similar rates, but there hasn't been much research done on women of color and eating disorders because this misconception about white women and eating disorders still exists (5).

Additionally, ten percent of people seeking help for an eating disorder are male (6). Transgendered individuals may be at high risk for eating disorders, lesbians are at higher risk for binge eating disorder than heterosexual women, and 10-42% of the men suffering from eating disorders identify as homosexual (7). When talking about eating disorders, it is important to consider diversity. Many people will not be treated for very serious eating disorders they may have because they do not fit the stereotype of a sufferer.

Eating disorders may coexist with other mental health issues such as mood disorders, obsessive compulsive disorder, and self-harm (9). When treating an eating disorder, other existing conditions will also have to be treated as well. Recovery from eating disorders is possible through seeking professional help, individual therapy, other coping strategies, and challenging negative self-image thoughts (10). If you are suffering from an eating disorder, you can take steps toward recovery by seeking help. If you are not currently suffering from an eating disorder, you can also help end eating disorders. Refrain from using language in a way that reaffirms the unhealthy societal ideals about women's bodies. Start to love your own body. Lastly, be supportive of others around you in their journey towards self-love.

Image courtesy of www.ifood.tv

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Women's Studies Minor

Spring 2012 Course Offerings

ANTH 365	Sex Roles and Society	Birns
CCSS 268	Culture and the Body	Colligan
ENGL 397	Women and Film	Lambert
PHIL 385/WMST 395	Women and Philosophy	Silliman
SOWK 375	Family Violence	Birns
SOWK 443	Casework w/Couples & Fams	Ethier
SOCI 395/WMST 395	Latinas in American Society	Castro
WMST 395	Women as Global Leaders	Hejnova

Understanding Self-Harm, continued

People who do not understand self harm may think that because the person is choosing to do it, that stopping is easy. This is often not the case. Most often the need to self-harm is described as a strong urge or pull toward the action. Those trying to stop claim that it is hard to think of anything else. Your head may burn, you may get antsy, and like alcohol and drug addictions you need a 'fix.'" It is like any form of addiction, few are able to just stop at will. It takes time, and one may "fall off the wagon." With support and understanding, as opposed to ostracism and judgment, a person can stop self-harming (5).

A person also must *want* to stop. While it may seem like the obvious thing to do for those who do not self harm, there is a great fear of stopping. It is often seen as a security blanket. You must face the fears and emotions that you have kept inside and avoided for so long; continuing to self-harm seems to be the "easy way out." That is not to say however, that one should not try to stop, but merely that it is not easy to do (5).

Self harm is a growing epidemic in our country as well as world wide. It is estimated that three percent of the population self harms and this number is on the rise. If you or someone you know self harms, don't be afraid to talk. If you are ready to talk find a friend, a counselor, or a therapist. Work on finding safer coping mechanisms such as journaling, going for a walk or simply leaving the situation that is giving you the urge. Just remember that you are not alone. People love you, need you and will be there for you.

Resources:

- National Hopeline Network (U.S.A.)
  www.hopeline.com - 1-800-SUICIDE
- S.A.F.E. - www.selfinjury.com – "S.A.F.E. ALTERNATIVES is a nationally recognized treatment approach, professional network, and educational resource base, which is committed to helping achieve an end to self-injurious behavior."
- Self Mutilators Anonymous:
  www.selfmutilatorsanonymous.org - "Self Mutilators Anonymous is a fellowship of men and women who share their experience, strength and hope with each other, that they may solve their common problem and help others to recover from physical self-mutilation."
- To Write Love On Her Arms- twloha.com : A non-profit movement dedicated to presenting hope and finding help for people struggling with depression, addiction, self-injury and suicide. TWLOHA encourages, informs, inspires and also invests directly into treatment and recovery.

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Images courtesy of First Signs.org

Depression, Anxiety and Women, continued

Anxiety and depression are serious problems for college students. One study indicates that between 34 and 41 percent of college students have moderate to severe anxiety. If you think you might be one of them, I suggest you to contact Counseling Services on campus (Ex. 5331). Anxiety and depression are real illnesses, and there is no quick cure, but there is no reason to live with despair and fear.

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Image courtesy of gotosee.co.uk.

Eating Disorders: The Silent Epidemic, continued

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PsychoMedia: Mental Illness Stereotypes, continued

At the end of the movie, the second hero (Harvey Dent) also embraces evil by becoming the character "Two-Faced," which furthers the stereotype of schizophrenia. The misleading stereotype in this film, and so many others, is that people who are schizophrenics have multiple personalities and the second personality is always evil (4).

The media also shows bias in the news regarding mental illness. On November 16, 1999 an innocent young woman was violently struck on the head with a brick by an unknown attacker. Although no one knew who the attacker was and no suspects had been arrested, assumptions were made. All of the local papers said the perpetrator had to be a mentally ill homeless person. The New York Daily News front-page headline read: "Get the Violent Crazies off Our Streets," which included a two-page editorial titled "Hospitalize the Deranged." Although this is just one example, it is echoed throughout the news in many different publications and creates hysteria and discrimination against mentally ill people in the eyes of public (5).

In order to stop PsychoMedia from taking over our society's media and piercing the public's views, stigma must be documented whenever possible. The public should send letters, make phone calls, or e-mail the people who are fostering these stigmas. Supporting efforts to expose stigma in the media and asking local, regional, and national leaders to take a stand can make a difference. Ignoring these images is not enough; the public must educate themselves about these issues in order to fight to eliminate mental illness stigma. People must avoid using generic hurtful labels such as "retarded," "crazy," or "lunatic." Abilities instead of limitations should be emphasized when talking about someone who has a mental illness. It also must be made clear to directors and producers that it is possible to break box office records without these negative images. Viewers who see positive representations in books and the media should reward publishers, editors, authors, directors, and actors who are educating people about the false representation of mentally ill people. It is crucial to become a critical consumer (6).

People with mental illness are not oblivious to these media portrayals. The media teaches its viewers to fear, undervalue, and distrust people with mental illness. People who are mentally ill need understanding, but are faced with rejection and isolation, as well as discrimination in housing and employment. They may become hesitant to seek treatment because they do not want the prejudices in the media applied to them. In fact, more than 20 percent of the U.S. population (44 million people) experience a mental disorder in any given year, but almost half of these individuals do not seek treatment. One in five teens develops some form of mental illness and suicide is the third leading cause of teen deaths, according to the American Psychological Association. In the end, people may internalize the stigma associated with mental illness and suffer even more from the misrepresentations in the media (7).

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