Article

Gender Disparity in the Wake of the Pandemic: Examining the Increased Mental Health Risks of Substance Use Disorder and Interpersonal Violence for Women

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Abstract: The global COVID-19 pandemic has profoundly impacted women compared to men in the workplace, creating gender disparity associated with mental health. In occupational fields where women comprise nearly three quarters of the workforce, outcomes of increased depression and psychological distress have resulted, creating even greater gender disparity in terms of mental health risks. These include an exponential increase in substance use associated with mental health issues for which continued stigma and negative perceptions of mental health conditions and substance use have prevented the pursuit of treatment. Further, the increased occurrence of interpersonal violence experienced by women during COVID-19 also presents considerable comorbidity with mental health issues. Research also shows a significant relationship for women between severe intimate partner violence and substance use. It is imperative that gender disparity associated with mental health risks be addressed within the current crisis and that we better prepare for the future to ensure inclusive and accessible resources within workplaces and improved behavioral health outcomes.

Keywords: mental health; substance use disorder; risk factors; intimate partner violence; women; gender differences; female; self-concept clarity; COVID-19; inclusive leadership

1. Introduction

Fifty years ago, in 1972, feminist icon Phyllis Chesler published Women and Madness, a definitive work on women's psychology that addressed critical questions around women's mental health. Chesler's foundational work cited studies highlighting a predominantly male psychiatric population, or 90% male compared to 10% female counterparts, who had been diagnosing, hospitalizing, and researching a predominantly female population of patients [1]. Furthermore, Chesler argued that research at that time showed that female clinicians, having studied under male teachers and professionals, were echoing the professional biases of their male colleagues when diagnosing women with mental health issues [1].

During the 1990s and early 2000s, Chesler (2005) pointed out that gender-biased diagnosis within psychiatry persisted, with many textbooks failing to include mention of sex or gender bias or the feminist critique [2]. In 1999, Brady and Randall's summary of research on mental health issues such as substance use disorder (SUD) highlighted gender differences related to psychological and biological factors, indicating that men had a statistically higher rate of dependence on, and use of substances compared to women [3]. However, it is critical to note that research focused on addiction during the 1980s and 1990s particularly about alcohol use disorder (Blume, 1986) and treatment (Weisner and Schmidt, 1992), shows that women were almost entirely excluded [4]. Certainly, we must consider the significance gender biases have had on diagnoses, treatment, and research related to SUD, which have contributed in part to associated gender disparity. Brady and Randall (1999) proposed that

the increase in women entering traditionally male dominated professions and workplaces might also impact these gender differences through changes in the drinking culture and societal influence that would potentially increase women's participation in drinking and drug use in the future [3].

Despite Chesler signaling the urgent need for gender discrimination to be addressed in the field of mental health, over the decade's most mental health and addiction research continued to be skewed in terms of gender. Within the United States, however, female psychologists in education, as well as females in professional roles in the field of psychology and within the American Psychiatric Association are currently experiencing greater representation compared to males [5]. This has undoubtedly created the potential for increased focus on gender differences in diagnosis and treatment related to mental health. However, despite these advances, for the past two decades there have still been broad inequities in salary, training, and job opportunities related to gender in the field of psychiatry. According to Clay (2017), there are even greater disparities for women with disabilities as well as women of color [5].

Notwithstanding, there are examples that have provided valuable insights regarding the relationship between gender differences and mental health disorders. For instance, a longitudinal study of more than three decades (Fillmore et al., 1979) found that predictors for future alcohol dependencies were significantly differentiated by gender [6]. Furthermore, Jones' (1968, 1971) research showed that coping difficulties and reduced self-concept clarity serve as predictors for future alcohol dependencies. Additionally, Walitzer and Sher (1996) found that sense of self played a more significant role in the etiology of alcohol use disorder in women than it does in men [7]. Also, a 1997 study of more than 1000 women found that those with sexual experiences before age 18, specifically sexual abuse, were at risk for later substance use, as they reported significantly more symptoms associated with alcohol dependence and misuse of drugs [6]. We are, therefore, seeing the prior gender gap associated with mental health illnesses like SUD narrowing worldwide. This is especially true given the rise of prescription drug abuse, which is creating gender parity among adolescents engaged in misuse [8]. In 2013, the CDC reported a 400% increase in prescription opioid overdoses in women compared to the 265% in men [8]. Efforts by the National Institutes of Health (2015) requiring that sex be considered as a biological variable within research has helped to advance understanding regarding how gender plays a role in disease processes and to inform development of interventions [9]. However, there is still more progress needed, particularly in terms of intersectional identities. In 2022, the National Institutes of Health reported that intentional prescription drug overdose deaths occur more consistently among women than men with an even greater increase among non-Hispanic Black women [10]. Furthermore, recent research on gender convergence for prevalence of substance use suggests an increase in vulnerability to alcohol and prescription drugs due to the biological and social challenges women face at different stages in life, including changes in mobility, menopause, osteoporosis, empty nest, and career [6].

Given these inequities, there is a long way to go in terms of female-gendered power and status that can impact institutions, governance, and organizations in terms of addressing gender-differentiated mental health needs. Now, three years into a global pandemic, the need to focus on mental health issues and experiences of women as well as gender-diverse individuals in workplaces across all industries and sectors around the world is inescapable. The prevalence of COVID-19 and its global impact seems to have subsided with the elimination of restrictions like mandatory masking, quarantining and social distancing in most public and communal spaces. However, while the collective perception may be that the pandemic has ended, Shmerling (2022) points out that we are merely shifting from the panic we experienced in the pandemic to "endemic acceptance" [11]. This is extraordinarily true as there is still a significant number of deaths and daily cases being recorded worldwide.

2. The COVID-19 Pandemic Exacerbated Mental Health Issues for Women

The global pandemic has had a profound impact on women compared to men in the workplace, and principally negative impacts include increased workload and mental health issues. Women were more likely to be exposed to the virus as frontline healthcare workers where they represented more than 70% of the workforce, increasing the severity of occupationally associated depression and anxiety [12,13]. Research during the pandemic found that healthcare workers, especially women, experienced a greater risk of developing mental health symptoms such as depression, insomnia, and psychological distress [12]. Huang et al.'s (2020) survey of medical staff in a tertiary infectious disease hospital in China found that female medical staff working on the frontlines of the pandemic early in the outbreak experienced a higher incidence of symptoms associated with anxiety and post-traumatic stress disorder comparative to their male counterparts [14].

The worsening mental health effects for women related to the COVID-19 pandemic were not limited to the frontlines of healthcare. For example, women in academic STEM fields experienced burnout or chronic workplace stress, extreme disruptions to work-life boundaries, and the exacerbation of existing gender-based inequalities in role advancement and workload compared to male counterparts [15]. Borrescio-Higa & Valenzuela (2021) found that across sectors with higher female employment, the pandemic profoundly affected gender inequality [16]. Women experienced disconcerting rates of mental health problems and an increase in health-related socioeconomic vulnerabilities such as interpersonal and intimate partner violence and increase in substance use [17,18]. The relationship of health-related socioeconomic risk factors and mental health disorders must be considered concomitant risk factors for developing substance use disorder, shifting to an increase or relapse if already recovered, especially given the high comorbidity of SUD and other psychiatric illnesses [14,18,19]. Furthermore, women have been found to have "a significantly higher prevalence of comorbid psychiatric disorders, such as depression and anxiety than men, which typically predate the onset of substance-abuse problems" [16] (p. 249). Women are also more likely to report the existence of trauma prior to the onset of SUD as well as more frequent use of substances to manage associated negative effects [8]. Lindau et al. (2021) found in their U.S. based cross-sectional study of 3200 women aged 18–90, those with pre-existing mental health symptoms and health-related socioeconomic risk factors were subject to two- and three-times greater risk for worsening circumstances during the pandemic, many of which are addressable with mitigation strategies [18].

2.1. Substance Use Disorder (SUD)

The COVID-19 pandemic profoundly disrupted humanity. No one has been immune to some level of stress induced by the myriad of economic and societal effects. Moreover, it has elicited a global mental health crisis; individuals with pre-existing mental disorders are experiencing a worsening of their conditions, and new mental health issues are surfacing as well [12,17]. Amid the pandemic, there was an exponential rise in substance use associated with mental health issues. In the first year of the pandemic, alcohol sales rose nationally in the U.S. by 262% compared to the prior year [20]. In 2020, the American Medical Association (AMA) reported that nearly 75,000 deaths were caused by drug-related overdoses, with increased concerns for individuals with mental health issues and SUD across 40 U.S. states [21]. Despite these alarming statistics, the pandemic overburdened both health care and social services, such that in many cases addressing the economic impact included diversion of resources for SUD-related resources [22]. The combination of reduced support and resources and the stigma and discrimination experienced by people with mental health challenges created serious implications at a time when interventions for SUD were needed most. Pfeffer and Williams' (2020) study of more than 36,000 respondents found that 81% of those with SUD did not receive treatment due to the continued stigma and negative perceptions of mental health conditions and substance abuse. More recent data found that nearly 110,000 drug overdose deaths occurred in 2021,

with the AMA urging action for increased "access to evidence-based care for substance use disorders" [23]. Women in treatment for SUD consistently report increased barriers associated with perceived stigma and greater negative outcomes associated with employment, social, family, medical, and psychiatric functioning, which may be related to the disproportionate percentage of women who seek treatment [8].

Stigmatizing views of people with SUD are commonly associated with perceptions of questionable personal responsibility and an inaccurate belief that addiction is a moral failing rather than a persistent treatable disease. Descriptive terminology often associated with such discriminatory beliefs about addiction and substance use has included user, junkie, drug abuser, addict, drunk, and substance abuser. Our earliest understanding of the word addiction is the Latin compound, addicere from the 5th to mid-3rd century BCE, a verb that translated as 'to speak to', assent or agree, whereas the noun addictio described someone indebted or enslaved by a judge or creditor [24]. In the first century BCE, the use of the verb addicere transitioned from a legal or technical term into a term to represent self-destructive behavior, particularly in descriptions of women who gave themselves to their ruinous desires, whereas in contrast it was often perceived as positive or honorable when applied to a male [24]. In the 16th and 17th centuries, the word addict represented attachment, commitment, or devotion to king, religion, or God. Many Protestant Evangelical reformers (e.g., Calvinists, Anglicans and Catholics) utilized the term to describe attachments to objects of sin [24]. In this context, the word was depicted positively if the attachment was considered appropriate, and negatively if it was connected to something identified as sinful. Rosenthal and Faris (2019) point out that throughout the historical evolution of addiction terminology there is "tension between the active and passive meanings, suggesting that both obligation/compulsion and active choice may be built into the original meaning of the word" [24] (p. 14).

Notably, advances in both the clinical and psychiatric study of addiction have helped to reduce attitudes of blame that foster discrimination and the misconception of choice in relation to compulsion which has aided in providing deeper understanding of its characteristics as a disease. Discernment of various facets of substance use disorder—"reinforcement and reward, tolerance, withdrawal, negative affect, craving, and stress sensitization"—have expanded our knowledge [25] (p. 1015). Prior criteria and classifications associated with substance use disorder found in the DSM-IV defined substance abuse as "continued use despite physical or psychological problems caused or exacerbated by the substance" with a focus on negative consequences, but still "limited to physical or psychological problems and not extended to social or interpersonal problems" [26] (p. 60). Since 2007, a Substance-Related Disorders Work Group has worked with a DSM-5 Task Force to formulate new criteria for diagnosing substance use and dependence, removing the earlier distinction between excessive use and dependence as separate disorders, and making recommendations for analysis to examine potential biases related to gender, age, and ethnicity in diagnostic criteria [26].

As a result, when the DSM-5 was published in 2013, substance abuse, addiction, and alcoholism were changed to encompass both drugs and alcohol with new definitions: Substance Use Disorder (SUD), which includes both, and Alcohol Use Disorder (AUD), which includes only alcohol [27]. In 2017, the Office of National Drug Control Policy issued a federal memorandum addressing the stigma of terminology associated with substance use disorder. This aligned with the updated DSM-5 which required the use of person-first language like "person with a substance use disorder," removing negative connotations and distinguishing the person from their diagnosis [28]. Despite the more inclusive language, expanded research, advances in diagnostics, and increase in therapeutic treatments and pharmacological agents, substance use disorders remain vastly undertreated [29]. Inequities in healthcare largely contribute to many of the existing barriers that prevent treatment, including "the lack of resources at the individual level, a dearth of trained providers and appropriate treatment facilities, racial biases, and the marked stigmatization that is focused on individuals with addictions" [19] (p. 1015). In addition to studies highlighting

the disparity of negative impacts related to mental health and increased risk factors for substance use during the COVID-19 pandemic for women, research has also shown an increase in intimate partner violence and sexual abuse.

2.2. Sexual Assault and Intimate Partner Violence (IPV)

In Women and Madness, Chesler raised the necessity of bearing witness as a mechanism for providing support to the victims of violence. Problematic perceptions and stereotypes about sexual violence can impact recognition and confidence that the survivor's experience is to be believed. The harm engendered through bystander apathy can be even more traumatizing for the survivor through its cacophonous silence. Chesler proposed more education, transformation and enforcement of victim centered laws, increased research on associated psychological trauma, and a political movement focused on human rights and self-esteem. When her book was reprinted in 2005, the introduction demanded change, reminding us that all too often the "active process of bearing witness inevitably gives way to the active process of forgetting" [2] (p. 37). A little over a decade ago, research estimated that between 50% to 80% of sexual assaults were committed by someone known to the victim, with a meager average of 15% of cases reported ever being prosecuted; at that point sexual assault within workplaces had been recognized as a public health crisis for more than 40 years with no industry or occupation immune to its occurrence [30].

Despite sounding the alarm decades ago, there is still much work to be done to address sexual violence and while it is not an issue that only affects women, the greater percentage of victims are women and groups that are marginalized. In 2018, a national representative study on sexual harassment and assault in the U.S. reported that within their lifetime, 81% of women had experienced some form of sexual harassment or assault, whereas only 43% of men had [31]. In terms of location, 38% of women had reported sexual harassment within the workplace and 35% of women reported interpersonal violence such as sexual assault within their residence [31]. Additionally, data showed greater percentages of sexual harassment and assault incidence based on disability status, sexual orientation, and racial/ethnic group [31]. These alarming statistics highlighted the imperative to, once again, acknowledge the prevalence of sexual assault and to engage in more action to prevent sexual violence in workplaces and in the home. Worldwide statistics are even more alarming. A 2018 analysis by the World Health Organization of data from more than 160 countries covering a timespan of nearly a decade found that 30% of women had experienced sexual or physical violence and nearly one in three women aged 15–49 reported having been subjected to either sexual or physical intimate partner violence [32].

As the world braced for the COVID-19 pandemic, quarantine policies and stay-at-home orders were implemented, and as a serious consequence, the incidence of intimate partner violence (IPV) increased. During the pandemic and due to quarantining, victims of IPV, physical, psychological and sexual violence in the form of abuse or aggression within a current or former romantic relationship, were left trapped with their abusers. Reporting in the U.S. showed a 20% increase in calls related to IPV across 20 metropolitan cities, and global data showed an increase across several countries as well [26]. However, the economic impact and unemployment catalyzed by the pandemic created financial and psychological stressors that simultaneously increased the risk of occurrence of IPV while also reducing the potential for victims to seek help [33]. IPV rates still rose exponentially. Statistics indicate that IPV is found across all "races, cultures, genders, sexual orientations, socioeconomic classes and religions with one in four women and one in ten men experiencing IPV; however, such violence has a disproportionate effect on communities of color and other marginalized groups" [34] (p. 2302).

IPV has profoundly negative societal impacts as well as chronic health outcomes for the victims. Negative physical health outcomes may be associated with neurological, gastrointestinal and reproductive problems, and there is considerable comorbidity with mental health issues such as depression and post-traumatic stress disorder (PTSD) [33]. Furthermore, while there are complex mental health consequences associated with intimate

partner violence, PTSD is the most common [35]. Significant connections have also been found for women with SUD and profiles of comorbid PTSD caused by sexual or physical abuse trauma, compared to males with SUD [36]. Additionally, women with severe sexual abuse and emotional abuse profiles were found to significantly predict initiation of substance use. Childhood trauma exposure was also found to be associated with earlier use of substances [36]. The trauma profile of severe sexual abuse and emotional abuse is related to "more severe sociophobic symptoms, i.e., aspects of low self-confidence" and "a negative self-concept, including low self-confidence as typically seen in individuals with complex PTSD" [36] (p. 10). Within the U.S., close to three out of four women who experience severe forms of IPV are diagnosed with one or more mental health disorders, and those in substance use treatment programs also report increased occurrences of IPV [25]. Mason and O'Rinn's (2014) systematic review of research on the relationship between IPV and substance use disorder showed that the occurrence of sexual violence led to an increase in susceptivity to SUD through self-medication and psychological vulnerabilities, such as low self-esteem, depression, and anxiety [25].

2.3. Self-Concept Clarity

As part of our biography, our identities form, evolve, and change in concert with our learning through experiences. These experiences are influenced by both internal and external factors: family, friends, geographic location, religious faith, culture, race, ethnicity, socioeconomic status, perceptions of stress and opportunity, and society. Being is the embodiment of our living existence. As such, it changes throughout our lives such that our biography, our being, is formed through learning acquired from the collective sum of our life's experiences [37]. Our biography is an "unfinished product constantly undergoing change and development—either through experiences that we self-initiate or else through experiences which are initiated by others" [37] (p. 25). Self-concept clarity reflects an individual's internal self-beliefs and is characterized by consistency and temporal stability [38]; however, it may also fluctuate contingent upon the influence of environmental factors [39]. Self-concept has been found to be correlated with psychological well-being and resiliency in adapting to stressors [40,41]. Furthermore, the evaluative self-analysis component of self-concept clarity is correlated with self-esteem, or individual discernment of value [42]. For those that experience IPV, there is a clear association with the self-doubt and loss of agency that negatively affects women's identities [43]. The "certainty about one's beliefs regarding his or her personal attributes" is knowledge integrant of self-esteem and can be influenced by individual perceptions of stress, psychological resiliency, and excogitative behaviors [42] (p. 486). Psychological stresses such as those associated with IPV elicit self-discontinuity or individual perceptions of past and present discontinuity, which necessarily compromise the clarity of self-views. Given that self-concept clarity was found to mediate the relationship between stress and perceptions of well-being, it is paramount that the effects of IPV on identity and concept of self be integral to addressing complex mental health issues [43,44]. This is especially critical given the previously discussed increased prevalence of comorbid mental health factors associated with women.

3. Implications

It has been suggested that women with poor self-esteem may be at greater risk for developing drug use disorders compared with men; however, research has shown mixed results related to self-esteem enhancing measures as they influence effective treatment outcomes. For example, Trucco et al.'s (2007) alcohol dependence research showed no correlation between self-esteem and the occurrence of relapse or successful treatment outcomes [45]. As such they suggested that while self-esteem may have a role in the development of substance use disorder, increased levels of self-esteem do not necessarily lead to treatment success [45]. Future research focused on "aspects of self-perception" rather than self-esteem as a general construct when looking to develop effective prevention and relapse measures may elucidate mitigation measures [45]. Prior research on self-

concept clarity has focused on distinctions within self-analysis, particularly between the two aspects of self-consciousness: private (attention to one's own thoughts and feelings) and public (awareness of oneself as a social object [46,47]. Women have an increased occurrence of self-reflection upon their own personality characteristics, suggesting higher private self-consciousness and validating prior hypotheses regarding gender differentiation of the self-consciousness trait [47]. Furthermore, women tend to be more open to the experiences of self and others through self-reflection, whereas "individuals higher in masculinity (agency) represented their own and others' emotions in less complex ways" [47] (p. 479). Yet, increased private self-consciousness or self-reflection may exacerbate potential negative self-perception in women. Rumination, the act of engaging in repetitive negative thoughts, "enhances the effects of depressed mood on thinking, impairs effective problem solving, interferes with instrumental behavior, and erodes social support", so that "the initial symptoms of depression among people who chronically ruminate are likely to become more severe and evolve into episodes of major depression" [48] (p. 367). Gender differentiation research in rumination found increased rates of rumination and reflection in women compared to men, with greater statistical significance for those in childhood and adolescence [48].

It is imperative that we gain a clearer understanding of women's lived experiences and values as they relate to the complex nature of mental health, including both IPV and SUD associated outcomes. Individualized interventions that recognize the role that gender, and intersecting identities have on women's experiences will help to potentially reduce stigma and treat trauma. Notably, research on mice has shown epigenetic inheritance of perpetuated trauma through the transformation of genomic changes found in subsequent generations [49] (p. 20). While there is a clear gap in the literature regarding human studies focused on the effect of traumatic stress on inheritance, several studies have shown increased inheritance susceptibility for PTSD [49,50]. Additional research on genetic epidemiology and environmental interactivity associated with SUD is also needed [51]. With the potential for inherited trauma and associated negative biological and psychological outcomes for future generations, we must acknowledge and address symptoms at inception.

The pervasive and expensive nature of complex mental health conditions has created a behavioral health crisis with exorbitant costs for organizations due to employee turnover, and reduced productivity and healthcare. However, companies that ensure that mental health resources and services are accessible improve employee outcomes, thereby increasing organizational performance. In a McKinsey study of more than 1000 employers, greater than 90% reported that the COVID-19 crisis has affected employee productivity and behavioral health [52]. Shortly before the pandemic spread across the globe and ensuing quarantine measures were implemented, published research illustrated the profound need for organizations to focus on mental health. At that time, 91% of respondents believed companies should be concerned about mental health, while 85% who were considering a new job were evaluating associated mental health benefits [53]. Estimates of behavioral health impacts of COVID-19 on the healthcare system in the U.S. alone may reach $200 billion annually; this does not even factor in vulnerable or at-risk populations [52].

4. Recommendations

The COVID-19 pandemic has taken a tremendous toll on the status of both individual and collective mental health. To better address our current reality, while also preparing for future crises, we must expand research, implement policies and interventions, and provide inclusive and accessible resources that include awareness and representation of marginalized groups. With the extreme negative mental health outcomes associated with the pandemic, employers will need to expand their focus on mental health and well-being beyond traditional employee assistance program referrals. Nelson (2020) prescribes fostering a workplace culture of health with strategies to address both short-term treatment and long-term sustainable well-being goals for employees [54].

4.1. Destigmatizing Mental Health Conditions in the Workplace

To address the mental health needs of employees, organizational members and leaders must work to destigmatize workplaces by focusing on eliminating the perception that utilizing mental health services through employers might be detrimental to job security. Stigma directed towards people with mental health conditions and substance use disorder can manifest as discrimination, shaming and prejudice [55]. These negative behaviors perpetuate barriers with profoundly harmful outcomes for those in crisis, typically preventing them from asking for help. A recent survey of nearly 1000 employees and more than 500 U.S. benefit program decision-makers during the pandemic found that 37% of employees avoided treatment for mental illness and 52% for substance use disorder because they were fearful of others becoming aware of their condition [55]. Toth and Dewa (2014) report that stigma associated with disclosure of mental disorders in the workplace severely limits employees from seeking assistance [56]. "Individuals who possess a stigmatizing attribute that is concealable often live in constant fear of being discovered, and significant stress results from seeking to keep the attribute hidden and making decisions about disclosure" [56] (p. 733). According to Nelson (2020), 68% of employees are afraid to ask for help and yet NAMI, the National Alliance on Mental Health reports that eight out of ten people experience mental health conditions [54]. Workplace culture is critical in terms of ensuring an environment that supports disclosure decisions by employees. Moreover, Toth and Dewa (2014) point out that organizational goals should not be focused on the act of disclosure itself; "rather, the organization should strive to create an environment in which employees feel safe to disclose should they wish to do so" [56] (p. 743).

The pandemic has catalyzed employee demand for workplace environments focused on mental health inclusivity. More than 90% of employees want their employers to provide personalized benefits that accommodate their unique individual needs, age and life circumstances [57]. With five generations currently represented in the workforce, meeting distinctive behavioral health needs is paramount. The greatest percentage of healthcare users in the workplace are the traditionalist generation or those born between 1925 to 1945 who make up 2% of the current workforce, while Baby Boomers born between 1946 to 1964 comprise only 25% of the workforce but are the second highest user of healthcare at 60% [57]. Over 53% of workers from Generation X, born from 1965 to 1980 and representing 33% of the workforce, are looking for all encompassing wellness programs [57]. Comprising 35% of the workforce, approximately 85% of Millennials or those born between 1981 to 1996 report that their healthcare insurance has contributed to their decision to remain with their existing employer, when services focused on both holistic physical and mental health were included [54,57]. Finally, 65% of Generation Z, or those born between 1997 and 2012 report that they pursue employment opportunities based on benefits, specifically companies with Employee Assistance Programs (EAPs) and benefits that include mental health [57]. Therefore, organizational culture that communicates well-being across all levels of the organization combined with whole-person healthcare strategies that are adaptable to employees' changing mental health needs will contribute to successful attraction, hiring and retention goals.

4.2. Strategies for Addressing Discriminatory Behavior and Misperceptions

Organizational leaders need to confront structural stigmas such as cultural norms and institutional practices that limit resources and negatively impact employee well-being. There are several strategies that can be implemented within the workplace to promote inclusion and to address misperceptions and discriminatory behavior towards people with mental health conditions.

Integrate person-first language within all communications. Ensure this inclusionary practice is incorporated into all workplace internal and external communications. Placing the emphasis on people rather a particular condition or diagnosis "frames the disease of substance use disorder as a negative characteristic of the individual and brings moral judgment. By utilizing person-first language, an individual is no longer defined by their

condition. The person is placed first with the condition being secondary, which helps to eliminate stereotypes and biases" [58] (pp. 3, 5). Furthermore, communicating the treatable nature of mental health conditions and substance use disorders through recovery programs helps to mitigate discrimination that propagates the shame that people with behavioral health needs often experience.

Implement mental health literacy education programs. Ensuring educational awareness programs are accessible to all employees helps to address stigma and concepts of moral failing that many associate with mental health conditions. For example, the Mental Health First Aid (MHFA) standardized training program, developed in Australia in 2001, has proven to be a globally effective program for improving "participants' knowledge, attitudes and behaviours related to mental ill-health" [59] (p. 467). This evidence-based approach to increasing confidence in one's ability to recognize the signs of mental health and substance use disorders empowers organization-wide support by employees for those in distress.

Review workplace mental health policies and practices. Creating an environment in which employees feel comfortable discussing mental health issues enables the development of policies that meet legal requirements while also incorporating aspects that truly fulfill employee needs.

4.3. Creating a Psychologically Safe Environment

The more generalized actions previously discussed can facilitate changes within the workplace to reduce stigma. However additional measures should be taken to implement destigmatizing strategies that acknowledge and address the needs of marginalized groups that have been more profoundly impacted.

Promote a psychologically safe culture. A workplace environment that includes a psychologically safe climate empowers employees to feel comfortable being themselves. Organizational culture represents a group identity constructed through a process of learning that evokes purpose within all organizational activities. The phenomenon of cultural DNA becomes integrated within organizations to the degree that beliefs become accepted assumptions which provide structural stability regardless of transitions in workforce membership [60]. Recognizing and addressing organizational disparities in the distribution of influence, authority and power that negatively affect marginalized groups is paramount to developing a psychologically safe culture. When a supportive and trusting organizational culture is the norm, employees "feel able to show and employ one's self without fear of negative consequences to self-image, status, or career" [61] (p. 708). Marginalized social identity groups such as women, people with mental or physical disabilities, racial and ethnic groups, immigrants, native and Indigenous communities, and LGBTQ+ people encounter exclusion and stigma. Therefore, it is even more critical that leaders "display behaviors that promote an employee's perceptions of belongingness while also experiencing that they are valued for their uniqueness" [62] (p. 11). Shore and Chung (2021) point out that for stigmatized social identities, inclusionary treatment that values uniqueness in concert with fostering belongingness creates a foundation for psychological safety [62]. Below are several recommended actions adapted from Schein and Schein (2017) and Shore and Chung (2021) that can be implemented to create workplace psychological safety [60,62].

Acknowledge limits of leadership knowledge, including past mistakes and establish accountability, ensuring that leaders clearly articulate these demanding inclusive practices within performance management at all levels of the organization. *Remove* literal and figurative barriers, systems and structures that promote exclusionary and discriminatory behaviors. Create or fix systems and structures, providing equal access to tools and opportunities, thereby recognizing that marginalized employees do not have the same advantages, opportunities, or experiences. *Promote* inclusive leadership practices by valuing the unique perspectives contributed by a diverse workforce. Diversity and inclusion are not interchangeable concepts. Where legislation and policy can specifically mandate diversity, inclusion is a voluntary action that must be taught, promoted, and integrated. *Ensure* that diversity, equity, and inclusion agendas include neurodiversity that also en-

compasses behavioral-health conditions, thereby creating a supportive workplace that removes barriers for people with mental health issues, whether disclosed or undisclosed. *Provide* resources, support groups, and diverse ways for employees to openly share ideas, experiences, and feedback. Organizations that promote a psychologically safe culture and integrate inclusivity practices as a desirable environment increase organizational capacity to adapt, especially in times of extreme crisis like that caused by the COVID-19 pandemic.

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