

Stigma as Related to Mental Disorders

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Key Words

stigma, mental illness, evolutionary psychology, discrimination, implicit attitudes, attribution theory

Abstract

Individuals with mental illness receive harsh stigmatization, resulting in decreased life opportunities and a loss of independent functioning over and above the impairments related to mental disorders themselves. We begin our review with a multidisciplinary discussion of mechanisms underlying the strong propensity to devalue individuals displaying both deviant behavior and the label of mental illness. Featured is the high potential for internalization of negative perceptions on the part of those with mental disorders—i.e., self-stigmatization. We next focus on several issues of conceptual and practical relevance: (a) stigma against less severe forms of mental disorder; (b) the role of perceptions of dangerousness related to mental illness; (c) reconciliation of behavioral research with investigations of explicit and implicit attitudes; (d) evolutionary models and their testability; (e) attributional accounts of the causes of mental illness, especially to personal control versus biogenetic factors; and (f) developmental trends regarding stigma processes. We conclude with a brief review of multilevel efforts to overcome mental illness stigma, spanning policy and legislation, alterations in media depictions, changed attitudes and practices among mental health professionals, contact and empathy enhancement, and family and individual treatment.

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Stigma: a combination of stereotyped beliefs, prejudiced attitudes, and discriminatory behaviors toward outgroups—but transcending each component, given the global nature of the aspersions cast—resulting in reduced life opportunities for those who are devalued

INTRODUCTION

Stigma is a hot topic in multiple disciplines, such as clinical and social psychology, public health, sociology, psychiatry, services research, and related fields. A host of social groups receives stigmatization: for example, members of racial and ethnic minorities, adoptees, gay and lesbian individuals, those with physical disabilities, and individuals with AIDS and other chronic illnesses. The term originates from ancient Greece, denoting a physical brand or mark applied to social

outcasts (e.g., slaves, traitors) to indicate socially devalued status (Goffman 1963). Currently, stigma carries a far more psychological connotation, referring to the majority’s tendencies to distance from and limit the rights of those in disparaged groups, the global nature of the aspersions cast, and the potential for internalization of such degraded status by those who are discredited—i.e., self-stigma (for a review, see Jones et al. 1984). Stigma involves stereotypes, referring to cognitive labels that characterize members of devalued groups in blanket terms; prejudice, the negatively toned affect that often emerges toward such individuals; and discrimination, the curtailing of rights and life opportunities of those who are degraded. Stigma processes transcend these phenomena, however, given the global nature of the characterizations made, the shame and degradation foisted on those who are stigmatized, and the deeply troubled nature of ensuing social contacts—including anxiety, hostility, and rejection (Crocker et al. 1998, Goffman 1963, Link & Phelan 2001, Major & O’Brien 2005).

Over the past 60 years, increasing attention has been paid to the stigmatization of mental illness. Along with homelessness and substance abuse, which are themselves highly linked with mental disorder, mental illness receives extreme castigation (Hinshaw 2007). In fact, despite clear gains in public knowledge related to mental illness over the past half-century, levels of stigmatization as appraised by attitude surveys appear to have increased rather than decreased in the United States, at least toward the most serious forms of mental disorder (Link et al. 1999, Phelan et al. 2000). At the same time, behavioral research reveals that the label of mental illness promotes rejection and suboptimal social interactions. Furthermore, legal restrictions and discriminatory practices throughout society convey evidence of the restricted life opportunities of individuals with mental disorders (Corrigan et al. 2004, Thornicroft 2006). Stigmatization of mental illness is an international phenomenon, appearing

cross-culturally and cross-nationally (e.g., Guimon et al. 1999).

As a result, mental health providers, research investigators, policymakers, members of influential commissions, and noted commentators have converged on the contention that the stigmatization of mental illness is a topic of central importance for all aspects of mental health. Indeed, stigma promotes lower rates of research funding for mental illness in comparison with physical diseases, predicts distressingly low levels of employment and independent housing (thus contributing to lowered levels of productivity), portends major family burden for relatives, is a major contributor to poor access to care and treatment, and produces shame and despair for countless individuals (Hinshaw 2005, Sartorius 1998, U.S. Dept. Health Human Serv. 1999). Importantly, controlled research indicates that the negative impacts of stigmatization outweigh the impairments related to various forms of mental disorder themselves, in that stigma processes predict poor outcome even when initial levels of symptomatology or functioning are statistically controlled (Link et al. 1997, Wright et al. 2000). As stated by Hinshaw (2007), “. . . the pain engendered by mental illness is searing enough, but the devastation of being invisible, shameful, and toxic can make the situation practically unbearable” (p. xi).

In this necessarily selective review, we first briefly define mental illness and highlight the increasing recognition that mental disorders are among the most disabling conditions that exist worldwide. We then briefly address historical trends, appraise evidence for stigma from empirical research and from indicators in the general culture, discuss theoretical accounts of relevant mechanisms, and address internalization and self stigma. From a long list of potential themes of interest, we cover six topics that are priorities for increased research: stigmatization of relatively less severe forms of mental illness; the role of perceived dangerousness in the stigmatization of mental disorders; convergence and

divergence among behavioral, implicit, and explicit measurement strategies to appraise mental illness stigma; the testability and viability of evolutionary psychological accounts of stigmatization; the particular difficulties faced by attribution theory in explaining and reducing the stigma related to mental disorders; and the developmental progression of views on mental illness through childhood and adolescence. We close with a brief review of viable strategies for reducing the stigmatization of mental illness.

BACKGROUND THEMES

Definitions and Impact of Mental Illness

The behavioral and emotional displays associated with the most severe forms of mental illness almost certainly engender negative reactions in observers, independent of explanations or diagnostic labels (Hinshaw 2007). Still, because attitudes toward social phenomena are inextricably linked with accounts of the nature of such phenomena, it is essential to consider how mental disorders are understood. But this is not a simple question, as the nature of mental illness remains the subject of voluminous debate. For millennia, scholars, physicians, clergy, and the public at large have debated whether abnormal behavioral displays are a product of evil spirits, a lack of moral fiber, social inequities, or disease states residing within the individual. The very adjective “mental” connotes the dualistic view that behavioral deviance is of the mind and not the body—giving rise to the belief that the individual in question may be malingering or not truly disordered—yet this contention is increasingly challenged by integrated conceptions of brain and behavioral functioning (Cicchetti 2006).

Professional and scientific views on mental illness span a variety of perspectives, with statistical deviance, violations of social norms, and ethical breaches among the primary contenders as defining characteristics

Stereotype: a cognitive “shorthand” to describe a given social group, which may contain a germ of truth but which is likely to lead to rigid characterizations of group members

Prejudice: literally “prejudgment,” this term refers to negatively tinged affective responses to members of outgroups

Discrimination: the limitations on the rights of outgroups or those who are socially castigated; the behavioral component of stigmatization, beyond cognitive stereotypes and affective prejudices

Mental illness: a term referring to a wide variety of categories of deviant, dysfunctional behavioral and emotional patterns, subject to variegated definitions but constituting hugely impairing conditions for individuals, families, and societies at large

Dangerousness: a rampant stereotype of people with mental illness, often promoted by public media, is that they are chronically violent and dangerous; this belief may underlie stigmatizing attitudes

Attribution theory: a social psychological perspective holding that causal ascriptions for an actor's behaviors lead to characteristic emotional, attitudinal, and behavioral responses to the actor in question

of mental disorders. Regarding the latter, even though demonologic and religious accounts of abnormal behavior have receded in modern societies, the perspective that deviant behavior is immoral still pervades public attitudes. For instance, homosexuality was listed as a mental disorder until the early 1970s in the *Diagnostic and Statistical Manual of Mental Disorders* (Spitzer 1981), and moral judgments still pervade public accounts of substance abuse problems and psychotic behavior (Hinshaw 2007).

Medical models of mental illness have reascended in recent decades, and such views reflect increasingly strong evidence that genetic predispositions underlie many of the major forms of mental disorder (Beauchaine & Hinshaw 2008). Whereas such ascriptions to biogenetic etiologies might be thought to reduce stigmatization because these causes are noncontrollable, the actual evidence is far from clear, as we discuss below. A key point in this regard is that medical-model accounts are often reductionistic, failing to take into account (a) ecological perspectives involving person-environment fit, (b) views that incorporate both social deviance and mental dysfunction in an evolutionary sense, or (c) biopsychosocial and developmental models emphasizing interaction and transaction across individual vulnerability and contextual influence in the genesis of mental disturbance (e.g., Bronfenbrenner 1979; Cicchetti & Cohen 2006; Engel 1977; Wakefield 1992, 1999). Although these latter, multidisciplinary frameworks have received the most research support, they are notoriously difficult to convey in "headline" format to members of society.

What does the public actually believe to underlie mental illness? Lay conceptions of mentally disordered behavior fall into several patterns (see Haslam 2005, Haslam et al. 2007), with such folk views of mental illness involving dimensions of (a) pathologizing (judgments of statistical deviance and social norm violations), (b) moralizing (perceptions of ethical violations or weak personal

will), (c) medicalizing (essentialist beliefs that the deviance is unintentional and categorically distinct from the norm), and (d) psychologizing (views that deviant behavior is lawful and rooted in life history, but not the direct result of overtly medical causes). These perspectives are likely to predict differential responses to mentally disturbed behavior, an area mandating further research.

Regardless of explanatory models, mental illness is real, distressingly prevalent, and devastating in its consequences for individuals, families, communities, and nations. In fact, given their prediction of low economic productivity and high morbidity and even mortality (including suicide), coupled with their high prevalence, mental disorders are among the most disabling conditions and illnesses on earth (Murray & Lopez 1996, World Health Org. 2001). The most serious forms of mental disorder occur in about 6% of the U.S. population, with many more individuals suffering from mild to moderate variants (Kessler et al. 2005). Crucially, most mental disorders have their onset in childhood and adolescence, mandating developmental perspectives on mental illness—and attendant stigma (Hinshaw & Cicchetti 2000). Furthermore, as highlighted by Wang and colleagues (2005), people with mental illnesses typically delay the seeking of treatment for protracted periods of time, often decades, because of ignorance, shame, and other by-products of stigma. Despite attacks on the validity of mental illness diagnosis and treatment by antipsychiatrists and other critics of mental illness (e.g., Kutchins & Kirk 1997), the reality of mental disorders, as well as their huge impacts on life functioning, is undoubted.

Historical Trends

The history of mental illness stigmatization parallels overall human history, given (a) the existence of serious forms of mental illness throughout the historical record and (b) the longstanding tendency toward distancing from and devaluation of people

with mental disorders (Zilboorg & Henry 1941). The predominant perspective on mentally disordered behavior has undoubtedly been demonologic in nature, whereby deviant patterns of behavior and emotion are attributed to possession by evil spirits, animal spirits, or the devil. Although such views are clearly linked to harsh moral judgment and extreme castigation, it is noteworthy that other views emanating from religious and moral perspectives have promoted care and compassion. Indeed, religious views emphasizing hope and habilitation have been associated with periods of humane care and reform throughout history (Hinshaw 2007).

Naturalistic, disease-oriented views of mental disorder have periodically come into ascendancy—for example, the model of Hippocrates from ancient Greece emphasizing imbalances in vital bodily humors as determining mental functioning. Although these models have initially engendered more positive and less blameworthy responses, Hippocratic and more recent biomedical perspectives led eventually to bloodletting and other nonsupported, sometimes barbaric treatments (cf. twentieth century psychosurgery). Biological/medical models can also be associated with a sense of chronicity and hopelessness regarding mental disturbance; they underlay the growth of large state institutions that symbolized repression and hopelessness. Overall, there is no one-to-one correspondence between moral versus medical/naturalistic perspectives on the one hand and cruel versus humane care on the other (Zilboorg & Henry 1941).

Furthermore, reform efforts emanating from spiritual, humanistic, or biomedical perspectives can become misguided when hopes of immediate success are not realized (Grob 1994). For example, despite the noble objective of closing down horrendously overcrowded state hospitals and despite real progress in mental health care across recent decades (Frank & Glied 2006), the deinstitutionalization movement of the past 50 years in the United States has fostered homeless-

ness and, in many respects, recapitulated the ills of large state institutions in a number of community-based facilities. The lack of commitment by state legislatures to provide sufficient support for community-based alternative care has fueled stagnation, despair, and a sense that serious mental disorders are intractable (Grob 1994). It is noteworthy that state institutions originating during the nineteenth century in the United States were themselves an attempt to reform the problems of almshouses and orphanages. To provide optimal mental health care and reduce stigmatization, it will be essential to avoid overly optimistic predictions, to promote multifactorial perspectives on causation and rehabilitation, and to attempt realistic rather than idealistic solutions.

Empirical and “Cultural” Evidence

The evidence for stigma related to mental illness is plentiful. Research on this topic emerged around the end of World War II, and attitude surveys from the 1940s through the 1960s provided consistent evidence that the American public knew little about mental illness and desired considerable social distance from individuals so described or so labeled (Rabkin 1972). Adjectives used to describe mentally disordered individuals were extremely disparaging, with parallels to previous attitudes toward leprosy; systematic reviews of media portrayals of mental illness showed an almost exclusive focus on stereotypical depictions of incompetence and violence (Nunnally 1961). Both depictions of mentally disturbed behavior and the mental illness label itself were found to be linked to pejorative attitudes (Phillips 1966).

Although some investigators inferred an improvement in expressed attitudes during the 1970s (Crocetti et al. 1974), the public may have been simply becoming more sophisticated in terms of framing responses in socially desirable terms. In fact, Link & Cullen (1983) showed that the wording of attitude surveys could greatly influence stigmatizing

versus accepting responses toward mental illness. Additional attitudinal studies over the past three decades have continued to yield evidence for major stigmatization of mental disorders. For example, for decades research has shown that when compared with a host of other stigmatized conditions, mental illness is typically the worst ranked or near the bottom, competing with homelessness and substance abuse (Albrecht et al. 1982, Tringo 1970; see review in Hinshaw 2007). Moreover, despite major gains in knowledge about mental disorders during the second half of the twentieth century, attitudes have apparently worsened, at least toward the most serious forms of mental disorder, linked to a growing perception that mental illness portends danger and violence (Phelan et al. 2000). Because investigations make the key point that different forms of mental illness are differentially stigmatized (Crisp et al. 2000), future research should specify the type of mentally disordered behavior under consideration (unless the explicit focus is on the overall label of mental illness itself).

Furthermore, results of experimental, behavioral investigations—in which direct discrimination and distancing can be observed—continue to demonstrate negative effects of the label of mental illness. That is, when individuals believe that they will be interacting with social partners who suffer from mental illness, they behave in wary and even punitive fashion (e.g., Mehta & Farina 1997). Property owners are extremely unlikely to make potentially available apartments ready for viewing when they believe that prospective renters have a mental illness history (Page 1995). Even a given individual's belief that a social partner has knowledge of the individual's mental disorder—whether or not the partner actually has such knowledge—can negatively influence social interchange. In addition, family members of individuals with mental illness experience both objective burden, related to high costs and enormous investments of time and effort in obtaining services, and subjective burden, signifying embarrassment and shame

over the behavior patterns in question, fueling secrecy and concealment, which intensify the vicious cycle of stigmatization (Lefley 1989). Relatives are prone to receive what Goffman (1963) termed a “courtesy stigma” in relation to mental illness, a term reserved to denote the distancing and rejection that attend to individuals who are associated with members of a socially devalued category. Finally, professional and scientific views from much of the twentieth century held strongly to the view that mental illness is caused by faulty parenting and family socialization, fueling family blame, secrecy, and shame.

Which receives the greatest stigma: behavior patterns consistent with mental illness or the label itself? In head-to-head comparisons, behaviors receive higher levels of social distance and rejection than labels per se; yet when behavior patterns are ambiguous or in the normal range, the label of mental disorder predicts a large degree of stigmatization, particularly when observers believe that mental illness is linked to violence (Link et al. 1987). In short, behavior patterns and labels are both influential, and an association between mental illness and dangerousness clearly accentuates negative effects of the mental illness label.

Beyond formal empirical research, wide-ranging cultural practices also reveal substantial evidence for discrimination and stigma. At the policy level, state and federal statutes directly restrict the rights of those who divulge mental illness histories, and parity in health insurance coverage for mental disorders is not yet a full reality (Corrigan et al. 2004). Furthermore, recipients of care often perceive mental health professionals as showing insensitivity and low expectations (Wahl 1999). As noted above, public media present sensationalized and highly stereotypic depictions of mental illness, which promote messages of incompetence and major propensities toward violence (Coverdale et al. 2002, Wahl 1995). Regarding everyday language, many of the most disparaging expressions used by children and adults to castigate unliked or devalued peers involve colloquial terms

related to mental illness or mental retardation (e.g., retard, psycho, nuts, deranged; see Hinshaw 2007). Increasingly prevalent personal and family narratives also reveal major stigmatization and shame related to the experience of mental illness (e.g., Hinshaw 2008). Consequences for those with mental disorders include alienation, decreased productivity, and low motivation to seek treatment, perpetuating a vicious cycle of ignorance and fear. Importantly, as stated above, the effects of perceived rejection, discrimination, and stigma outweigh the impairments related to mental illness itself in predicting subsequent demoralization and isolation (e.g., Markowitz 1998, Sirey et al. 2001).

Mechanisms Underlying the Stigma of Mental Illness

In the wake of the greatly expanded knowledge base on mental illness and the increasing development of evidence-based treatments with proven efficacy (Nathan & Gorman 2007), the immediate question is why the stigmatization of mental illness continues to be so pervasive and persistent. Considerable work in the fields of social psychology, sociology, and evolutionary psychology has examined this issue. First, at a basic social psychological level, all societies are marked by ingroups—those in which the individual is embedded through the institutions of family, neighborhood, or other social entities that provide protection and care—versus outgroups (Allport 1954). A number of mechanisms accompany the strong proclivity for humans to identify with ingroups quickly and nearly automatically (Tajfel & Turner 1979), including stereotyping and related social-cognitive processes that accentuate the individual identities and positive traits of ingroup members and portray outgroup members homogeneously and negatively. Thus, individuals with mental illness—who are prone to act in socially deviant ways—receive stereotypes and stigmatization in automatic fashion. At least some stigmatiza-

tion is likely to be inevitable, although conscious efforts to overcome stigma can and do succeed (Devine 1989).

It is the threat conveyed by both mentally disordered behavior and the label of mental illness that accentuates and intensifies stigmatizing responses. Flagrant forms of irrational, psychotic behavior may directly threaten the personal space or safety of observers. Other types of disturbance (e.g., despair related to depression, unrealistic fears in anxiety disorders, agitation accompanying a variety of conditions) may threaten a sense of the observer's stability and disrupt perceptions that one is always in control of one's mind and behavior (Stangor & Crandall 2000). An important corollary is provided by terror management theory (e.g., Pyszczynski et al. 2005), which holds that when thoughts of death are primed, defensive and stigmatizing responses result. With its connotations of disorder, threat, and demise—undoubtedly fueled by media images and general cultural lore—mental illness may well be a case in point.

At least in the short run, the act of denigrating outgroup members provides a boost to the self-esteem of observers (Fein & Spencer 1997). Regarding mental illness, which receives nearly universal stigmatization, there is likely to be little cost to the observer who engages in such stigmatization, given the few sanctions that exist against mocking or castigating such a devalued group. Self-esteem enhancement is therefore a potential mechanism underlying the propensity to devalue those with mental disorders. Still, stigmatization is not the exclusive province of those with low self-esteem; indeed, individuals with relatively high baseline self-esteem are likely to denigrate others after receiving ego-threatening feedback (Vohs & Heatherton 2001). Also, self-esteem enhancement does not do an adequate job of explaining the likely targets of stigmatization or of facilitating knowledge regarding why victims of stigma come to take on the relevant stereotypes and biases.

In terms of structural factors, Link & Phelan (2001) make the important point that

stigmatization always exists in the context of social power. In other words, stigma occurs only when a group with social power denigrates a less powerful group, a situation that clearly pertains to individuals with mental illness, who experience political and social disenfranchisement. This view is reminiscent of “system justification” models of social hierarchies, whereby those in power tend to blame those of lower status for their own plights, as such views relieve the observers of guilt for the inequalities built into the system (for a related view, see the “just world” hypothesis, Lerner 1980). The key point is that stigmatization is not simply a product of cognitive processes and biases; it exists and perpetuates itself in the context of social inequality.

Given the pervasive and long-standing stigmatization of mental illness, is there a deeper, underlying, biologically driven propensity to denigrate individuals with mental disorders? Evolutionary psychologists have entered the discussion about mechanisms underlying stigmatization, providing intriguing arguments. Echoing the conceptual model of Goffman (1963), who posited three classes of individuals who receive stigma (abominations of the body, character flaws, and “tribal” differences), Kurzban & Leary (2001) hypothesize that three modules of social exclusion have evolved in human history, conferring survival advantage in the constant dynamic between the need for social contact and the reciprocal need for judicious judgments related to avoiding exploitation or disease. They argue that humans have developed naturally selected internal programs related to the following: (a) disgust with and avoidance of fellow humans who pose a threat of contagion or contamination, (b) anger with and punishment of those who may not reciprocate socially or who display low social capital, and (c) hate for and exploitation of those in ethnic or racial groupings outside one’s mainstream. Mental illness would appear to be relevant to the first two modules, given that individuals with severe mental disorder may be disheveled (signaling threat of contagion) or are

perceived as selfish, noncollaborative, and/or of low socioeconomic means (signaling low potential for collaboration or social reciprocation). Although the third module of nationalistic or tribal stigma does not initially appear relevant to mental illness, we discuss subsequently the possibility that this module may be enacted as an inadvertent consequence of views of mental illness in biological, genetic, essentialist terms.

Self-Stigma

What are the psychological effects of stigmatization on its recipients? Research across the past two decades indicates that demoralization and lowered self-worth among victims of stigma are *not* inevitable. Indeed, many in racial minorities or other stigmatized groups show levels of self-esteem fully as high as those of majority group members (Crocker & Major 1989, Crocker & Quinn 2000). Yet, as argued in Stier & Hinshaw (2007), the case is likely to be different for individuals with mental disorders.

First, the very symptoms and features of many forms of mental disorder involve pessimism, despair, and lowered self-worth. Hence, the nature of mental illness makes the internalization of negative social messages quite likely. Second, there are few possibilities for natural connections with or solidarity toward fellow individuals with mental disorders, given the historical isolation, invisibility, silence, and disenfranchisement of such individuals. It is for this reason, in fact, that self-help and advocacy movements for people with mental disorders are of such potential importance.

Third, a history of mental disorder is usually concealable, and stigmatized conditions that can be hidden (as opposed to those that are visible) yield considerable anxiety and stress for those who have them (Goffman 1963, Pachankis 2007, Quinn et al. 2004). In fact, Frible and colleagues (1998) discovered higher levels of distress and lower levels of self-esteem among individuals with

concealable than visible stigmas (Frable et al. 1998). Concealable stigmas promote troublesome issues regarding whether to disclose and whether “leakage” will occur. Vigilance, preoccupation, and suspiciousness may result, with a variety of affective and behavioral consequences for individuals with the concealable stigma and their interaction partners (Pachankis 2007). Indeed, the cognitive effort involved in hiding a mental illness history may yield thought intrusions and “rebound” intensification of the individual’s recall of underlying mental distress, promoting further anxiety and straining attempts at friendship and intimacy (Smart & Wegner 1999). Thus, even low levels of mental illness stigma are likely to taint social interactions—yet the evidence reviewed herein supports the contention that the stigmatization of mental illness is actually quite strong, meaning that the potential for social and personal disruption is great.

A major conceptual advance in understanding the impact of stigma on its victims is provided in Major & O’Brien (2005), whose identity threat model encompasses several levels of analysis. These include representations of denigrated outgroups in a given society (i.e., some outgroups are harshly castigated, others less so); situational factors (e.g., the number of stigmatizing majority group members with whom one interacts); personal variables (such as the propensity to have high or low sensitivity to interpersonal rejection); and the appraisals made by those who are denigrated (e.g., those that minimize versus those that accentuate the stigmatizing messages). Although the identity threat model has only begun to be applied to mental illness phenomena, its potential for increased specificity in accounting for individual responses is great, given that some individuals with mental disorders appear to essentially ignore the negative messages received, others actually thrive and use such messages to inspire others, and still others appear to be overwhelmed and defeated by demeaning ideologies and portrayals (Corrigan & Watson 2002).

KEY ISSUES

The above analysis reveals that mental illness stigmatization has a huge, negative impact on individuals with mental illness, their families and communities, and society. It also appears that, despite greater knowledge of mental disorders in current times, stigma may actually be increasing, particularly related to the most serious forms of mental disorder (Phelan et al. 2000). Possible reasons include the increasing technological sophistication in modern societies—along with the attendant pressure for conforming, uniform behavior—and the role of the mass media in promoting deleterious stereotypes (see Sartorius 1999). Below, we highlight several crucial issues and themes related to mental illness stigma, from the many that surround the topic of interest. This list is certainly not exhaustive, but the issues below are emblematic of the fascinating and troubling problems facing investigators, clinicians, individuals, and family members who confront mental illness stigma.

Stigmatization of Less Severe Forms of Mental Illness

Most work on the stigma of mental illness has been based the most serious and chronic forms of mental disorder: Schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, autism, eating disorders, and the like. Yet many forms of mental disturbance are not as disruptive, threatening, or irrational as such conditions. What are the implications for stigma of learning disorders, mild attentional problems, phobias, and the like? Certainly, such conditions can yield clear impairment; but they are not, on average, as devastating in their consequences or their threat value as the disorders noted above.

One relevant fact is that current psychiatric nomenclatures now incorporate a huge number of syndromes and problems that used to fall within the bounds of normal human variation (Am. Psychiatr. Assoc. 2000). Because the terms “mental disorder” or “mental illness”

now encompass a wide variety of behaviors and emotional styles, more forms of deviance are likely to receive stigma, related to the invocation of the mental illness label. Indeed, as noted above, the label of mental disorder exerts its strongest effects when it accompanies normal-range behavior patterns or mild disturbance.

Additional consequences accrue from broadening conceptions of mental disorder. Many in the general population are bound to be skeptical of the idea that 25% or more of the current population suffers from a mental disorder or that the lifetime risk is nearly 50% (Kessler et al. 2005). The perception that the pharmaceutical industry is pushing an agenda to lower the thresholds for diagnosis and treatment of a large number of physical and mental disorders, in order to maximize profits, is now widespread (Moynihan & Cassels 2005). As a form of reactance, there may be a trend toward discounting the reality of *any* form of mental illness. From a slightly different perspective, although the increased numbers of people diagnosable with a mental illness could reduce stigma—as a function of greater identification and as a result of widespread use of psychotherapy and medication treatments—it is possible that mental illness may become trivialized, as a function of the newly stretched boundaries.

Additionally, less severe variants of mental disorder may incur substantial stigma precisely because they are not as noticeable, irrational, or pervasive as other forms of disturbance. In other words, if persons look, act, and seem “normal” much of the time but show problems only in certain situations (e.g., situation-related fears for individuals with phobias; personal interactions for those with high-functioning autism; classroom settings for those with attention-deficit/hyperactivity disorder), the attribution may emerge that they are willfully acting out during the selected time periods. It may also be believed that they (or, in the case of children or adults, their family members) are not exerting sufficient control. The sporadic presentation of

the symptoms, along with the recognition that the individual is not pervasively disturbed, could engender higher expectations and a consequent increase in stigma when deviance does emerge. All too little is known about this set of issues, which require creative research efforts for full elaboration (see, for example, Gray 2002).

Perceptions of Dangerousness

As noted above, media portrayals emphasize extremely high potential for violence and danger in persons with mental disorders (Wahl 1995). Although a clear implication is that such depictions promote stigma, it is possible that they are accurate. In other words, do individuals with mental disorders actually display an increased propensity toward violence?

In the aggregate, there is a significantly elevated overall risk for violence among the population of those with mental illness. Yet this risk is relatively small (lower than the risk of being male, for example), and it varies greatly with regard to the type of mental disturbance in question. In fact, only a few forms of mental disorder show any increased risk for dangerous behavior over base rates—e.g., antisocial personality disorder and psychopathy, intermittent explosive disorder, alcohol and substance abuse, and a particular form of psychosis involving delusions of being under attack (Corrigan & Cooper 2005, Link et al. 1999, Steadman et al. 1998). Thus, media depictions that routinely and inevitably link all forms of mental disorder with physical violence are stereotypic and inaccurate. Indeed, empirical data reveal that people with mental illness are far more likely to be victims of violent crime than are other individuals, and far more likely to be victims than to be perpetrators of violence (Teplin et al. 2005). Yet media portrayals almost never reveal this fact.

What other factors might influence the strong association in the public’s mind between mental disorders and violence? For one thing, deinstitutionalization has fostered homelessness and an underclass of severely

impaired individuals with mental illness who provide negative role models on urban streets. Furthermore, as argued by Phelan & Link (1998), changes in civil commitment laws enacted throughout the United States during the 1970s made it extremely difficult to institutionalize individuals against their will. One of the few, highly publicized exceptions constitutes the categories of “danger to self” or “danger to others.” Thus, the public may well have come to associate severe mental illness with high levels of danger and violence.

The entire issue is of central importance, given that public attitudes toward mental illness are shaped largely by associations made between violence and mental disorder (Link et al. 1987). Conveying accurate information about actual levels of violence in people with mental illness is a priority for efforts to reduce stigmatization. In addition, treatment strategies that reduce the likelihood of substance abuse and resultant violence, and that can target individuals with paranoid, psychotic behavior, are essential to change the landscape of stigma.

Reconciling Behavioral Research with Studies of Explicit and Implicit Attitudes

Most empirical research in the field has utilized explicit attitudinal measures as the sole indicators of stigma. Past work on prejudice and stereotyping suggests strongly that self-reported, explicit measures of bias, prejudice, and stigma in many domains (e.g., race, sex, age) are subject to social desirability and often correlate poorly with alternative measures of stigma that focus on less consciously exhibited attitudes or on behavioral discrimination (Dovidio et al. 1997, Greenwald & Banaji 1995). In terms of mental illness stigma, the typical response format used for measurement of explicit attitudes is also susceptible to socially desirable response tendencies (Link & Cullen 1983). Also, because explicit attitudinal measures typically require forced-choice

responses, a more complex understanding of mechanisms underlying expressed attitudes cannot be gained. Given that it is often no longer socially acceptable to express prejudice overtly, even individuals who hold deeply seated negative beliefs may present accepting attitudes on explicit measures. Overall, although explicit attitudinal measures provide a valuable initial assessment of stigmatizing beliefs, much of the literature on stigma and mental illness may actually underestimate actual, less censored attitudes. Furthermore, participants in intervention studies designed to reduce stigmatization may be particularly likely to feel significant social pressure to suppress underlying bias or stigma following their participation; explicit outcome measures could provide an incomplete or even inaccurate picture of the intervention's success.

A significant advance in research on stigma has been the development of measures that assess implicit attitudes, defined as those covert beliefs that exist without the conscious knowledge of the respondent. Individuals are posited to have significantly less control over their responses on such tasks than on explicit measures, suggesting that implicit measures can more accurately assess underlying attitudes, particularly when these are socially unacceptable. One such measure is the Implicit Association Test, or IAT (Greenwald & Banaji 1995); another is the Go/No-go Association Test, or GNAT (Nosek & Banaji 2001). Implicit measures appear to tap important processes that exist below the level of consciously controlled responses; they can predict actual discrimination better than explicit measures. Existing studies, in fact, reveal a differential pattern of correlation between (*a*) implicit versus explicit measures and (*b*) criterion measures of interest (see Shelton et al. 2005, Teachman et al. 2003).

Relevant research on implicit attitudes about mental illness is in its infancy. Teachman and colleagues (2006) recently found that although explicit reports of attitudes toward mental illness were neutral, they were relatively more negative than explicit reports

Implicit attitudes: as contrasted with attitudes obtained via overt self-reports, implicit attitudes are those believed to be unconscious and not easily accessible, requiring atypical measurement strategies

Implicit Association Test (IAT): a measure of a person's unconscious bias toward a devalued social group or trait (contrasted with a positive attribute), measured via reaction time

Go/No-go Association Test (GNAT): a measure of a person's unconscious bias toward a devalued social group or trait (without a contrasting attribute), measured via reaction time

of attitudes toward physical illness. Furthermore, participants showed negative implicit attitudes toward mental illness: Most associated the concepts “bad,” “blameworthy,” and “helpless” with mental illness, demonstrating additional absolute bias against mental illness. In future work, implicit measures could be used to replicate these preliminary findings in culturally and socioeconomically diverse samples and to assess the degree to which an individual endorses other stereotypes with respect to mental illness, such as association with violence or incompetence.

Other “unconscious” measures are likely to provide valuable information about underlying mental illness stigma. For example, Graves et al. (2005) found that increases in physiological reactivity to depictions of schizophrenia predicted preferences for expressed social distance against individuals with this label, suggesting that exposure to serious mental illness spurs automatic responses that are likely to influence subsequent behavior in a negative direction. As a notable exception to the general lack of implicit work on mental illness stigma, such psychophysiological approaches could prove useful in the accurate identification of current levels of stigma against mental illness.

In addition, despite a rich history of behavioral research paradigms in the field (e.g., Farina et al. 1971), relatively little research currently focuses on direct behavioral measures to assess stigma and discrimination against mental illness. As noted above, behavioral assessments evaluate effects of mental illness labels (or behavioral depictions of mental disorder) on social interaction patterns, including analysis of conversational patterns or behavioral indicators of social distance. An example is provided in a study by Corrigan and colleagues (2002), who found that fear of dangerousness negatively predicted helping behavior toward individuals with mental illness. Measures of actual behavioral responses and discrimination have great potential for supplementing appraisals of overt attitudes and for complementing implicit measures of bias.

In many respects, such behavioral indicators are the gold standard, given that the real question of interest is whether individuals with mental disorders will be approached and accepted in general society.

There is a great need for sophisticated behavioral indicators of stigma. Behavioral methods from social psychology research paradigms, such as the helping paradigm of Macrae & Johnston (1998), have the potential to further advance such valuable approaches in the mental illness domain. Another example is the behavioral “social distance” measurement strategy of Bessenoff & Sherman (2000), who measured how far away research participants chose to sit from overweight participants. Such measures are far less subject to the desire for positive self-presentation than are explicit attitude scales.

Incorporating explicit attitude scales, implicit measures, and direct behavioral indicators with the same participants is a clear research priority. Careful attention to research design is required for such studies, in order that one class of measure would not prime or taint another. Without better knowledge of the actual levels of conscious and unconscious attitudes and the relation of each to actual social interchange, the mechanisms underlying the development of stigma will remain obscure.

Testability of Evolutionary Models of Mental Illness Stigma

As discussed above, the pervasive and cross-cultural display of mental illness stigma throughout history has reinforced the view that certain classes of deviant behavior promote naturally selected exclusion modules. Avoidance of contagion or parasitic infestation, anger toward social exchange violators or those with low social capital, and extreme fear of those with “tribal” differences are three pertinent modules in this regard (Kurzban & Leary 2001). As noted earlier, the first two seem particularly linked to mental illness stigma, for which the behaviors in

question signal contagion, threat of exploitation in social exchange, or a potential drain on group resources. Evidence for such hypotheses has been found in research on communicable physical illnesses such as AIDS. For example, although participants' stigmatization of homosexuality is correlated with their desire for symbolic social distance, their willingness to physically interact with someone with AIDS is strongly related to their perception of the contagiousness of the disease but only weakly correlated with its association with homosexuality (Rao et al. 2007).

Although evolutionary models of stigma have excellent face validity and although they would appear to provide support for the long-standing and cross-cultural nature of mental illness stigma, they are often extremely difficult to test. How, after all, can selection pressures to develop exclusion modules earlier in human history be examined empirically? Although it is likely that evolutionarily adaptive cognitions have contributed to the development and/or maintenance of stigma against mental illness, it is particularly difficult to determine relative weights of such cognitions relative to other factors such as self-esteem maintenance or terror management. Experiments in the domain of mental illness might include measures of belief in the contagion of mental illness versus the degree to which an individual with mental illness is costly to the individual's ingroup. To provide initial evidence, such variables could be associated with measures of mental illness stigma, either explicit or implicit. If scores on such measures differentially predicted disgust versus anger in regard to mental illness, as would be predicted on the basis of evolutionary psychological models (Kurzban & Leary 2001), initial support would be gained. Yet determining whether such cognitions drive discriminatory behavior is not simple. As in other areas of evolutionary psychology, moving beyond speculation and association to underlying, naturally selected mechanisms, and gaining an understanding as to how such mechanisms could drive stigma-

tizing behaviors in daily interactions, are key priorities.

Attributional Models: How Important is Personal Control?

A central tenet of attribution theory is that when the negative behaviors of an actor are ascribed to volition or personal control, blame and harsh responses are expectable from observers. On the other hand, when such problematic actions are attributed to non-controllable causal factors, such as medical conditions, observers will show considerably less blame and will actually be empathic toward the individual in question (Weiner et al. 1988). The implications for mental illness stigma are seemingly clear: When the public accepts biomedical or genetic theories of causation—which have been in ascendancy in recent decades—then the denigration of mental disorders will substantially recede. In fact, a central premise of advocacy groups for individuals and family members, as well as of biologically oriented research perspectives, is that mental illness is a “disease like any other” or a “brain disease.” The assumption is that public acceptance of this fact will reduce blame and stigma (e.g., Johnson 1989; for discussion, see Corrigan & Watson 2004).

But the story is not this clear-cut. First, it is quite clear that harsh stigmatization can attend to attributes that are completely outside of one's personal control. Consider, for example, minority ethnicity and race, which have received extreme stigmatization throughout history. In other words, the belief that negative but uncontrollable traits are always viewed benignly is simply wrong.

Second, disturbed behavior may well engender social distancing and revulsion reflexively, prior to any attributional accounts. Forms of mentally disturbed behavior that threaten observers are likely to be feared and rejected prior to any attributional analysis. In short, attribution theory may not always matter (see Haslam 2000).

Third, the actual ascriptions made for deviant behavior are bound to be more complex than those allowed in forced-choice research paradigms. For instance, across much of human history, demonologic accounts of the individual's possession were the main causal accounts of mental illness. Although such possession is, by definition, the result of an outside, noncontrollable force, personal weakness or lack of faith may well have been judged to lead to the demonic takeover. Individuals with disturbed behavior may well find themselves in "double jeopardy" in terms of attributional models, with external, noncontrollable causes for deviant actions emanating from internal, controllable flaws or weaknesses. Even within medical model accounts, which are assumed to be paradigmatic of models of uncontrollable attributions, it may be perceived that unstable or weak character traits preceded and facilitated the development of symptoms.

Fourth, biogenetic accounts are likely to breed attitudes that the underlying disorder is immutable and hopeless. After all, if the condition resides deep within the individual's biological core, change is unlikely. Such accounts may also fuel perceptions that violent behavior may emerge at any moment and in uncontrolled fashion—and that individuals with mental illness need protection rather than independence (Corrigan & Watson 2004).

Finally, attribution of mentally disturbed behavior to faulty genes and/or neurochemical abnormalities may promote the attitude that the individual in question is inferior, even subhuman. Indeed, accounts of mental illness in exclusively biological and medical-model terms can promote an essentialist belief in the fundamental difference of the person from the rest of humanity (Haslam & Ernst 2002). In this way, the "tribal" exclusion module from evolutionary accounts, which does not initially seem relevant in models of mental illness stigma, may become quite salient (Hinshaw 2007). Overall, even though biogenetic attributions may reduce expressed

blame, the desire for social distance from biological relatives, who are linked genetically to the individual in question, may increase (Phelan et al. 2002), and punitive responses against the person with mental illness are likely to emerge (Mehta & Farina 1997). For further discussion, see Hinshaw (2007) and Read (2007).

Still, just as it is inaccurate and unhelpful to attribute all forms of mental illness exclusively to biogenetic causal factors, a reversion to former views that mentally disturbed behavior is immoral or caused mainly by faulty family dynamics will also promote continued misinformation and stigma. Survey data reveal that the public actually holds multidimensional views of the causation of mental illness, blending life stresses and biological markers as risk factors (Wright et al. 2000). Clearly needed is research that allows for ascertaining, in open-ended fashion, the public's beliefs as to causation of mental illness, as well as its treatment and rehabilitation. The failure of attribution theory to account for the complexity of this matter may rest, in part, on the use of fixed, forced-choice measures, which suppress the complex nature of ascriptions and explanatory models.

Positive responses to mental illness on the part of observers may well be fueled by the perspective that despite the biological and genetic risk for severely mentally disordered behavior, concerted efforts from the individual and family are crucial to effect meaningful change. Careful research attention should be paid to the viability of promoting the complexity and accuracy of interactive models, which emphasize that genetic risk does not rule out psychosocial and personal effort in the lives of people with mental illness. This "dual attribution" is likely to elicit the blame-reducing properties of uncontrollable, medical-model attributions regarding the causes of mental disorder with the hopeful, realistic, and humanistic connotations of personal control ascriptions for the outcomes of mental illness.

Developmental Perspectives

Despite the enormous problems related to mental illness stigmatization, all too little is known about the stigma of mental disorders that emerge during childhood and adolescence and about the emergence of stigmatizing attitudes across the developmental spectrum. We briefly review what is known and pose questions for needed research.

First, relevant studies have revealed negative effects of child and adolescent diagnostic labels. When adolescents are adjudicated and labeled as delinquent, for example, a host of processes is set in motion, such as negative expectancies or court procedures, which amplify dissociation from mainstream society (Farrington 1977). Being labeled as sexually abused may also have deleterious consequences (Holguin & Hansen 2003). Negative effects of labels extend to the earliest ages, as experimental data indicate that labeling of infants as “cocaine exposed” or “depressed” produces pejorative ratings of the babies by observers or parents (Hart et al. 1997, Woods et al. 1998). Yet appropriate diagnosis and labeling may yield positive effects as well, including empowerment, guilt reduction, and appropriate intervention planning (Klasen 2000).

Children appear to acquire stigmatizing views of peers with mental illness and mental illness labels at least as early as middle childhood. Gillmore & Farina (1989) had fifth- and eighth-grade boys interact with a peer, who was actually an experimental confederate, branded as a child who was ordinary, emotionally disturbed, or mentally retarded. The participants expressed desire for greater social distance from the labeled children, in contrast to the ordinary child, and behaved in a less friendly and more negative fashion to the labeled youth. Also, Harris and colleagues (1992) had elementary-school-aged children interact with an age-mate, with the manipulated variables including the actual diagnosis of the peer (attention-deficit hyperactivity disorder versus no disorder) and the child’s

expectation for the partner’s behavior (i.e., labeling as “behavior problem” or no label). Both factors negatively influenced the child’s response to the peer, with the labeling effect suggesting strongly that stigma processes are active in middle childhood.

In terms of children’s development of stigmatizing views, an important line of research has emerged about racial prejudice and its unfolding (see Aboud 2003). Evidence exists that cognitive developmental processes emerge with age, such that knowledge of group differences unfolds during the preschool years and knowledge of stigma-related processes is present by middle childhood, particularly for youth who have themselves received discrimination (McKown & Weinstein 2003). Still unknown, however, are the relative roles of cognitive unfolding, family socialization, or media exposure in predicting prejudice and stigma regarding mental illness.

Extant research shows that children have more difficulty recognizing age-mates as the victims of mental illness than they do in comprehending that adults can have such difficulties. As for general age trends, children’s accurate knowledge of mental disturbance grows during the period from early childhood through adolescence (see review in Wahl 2002). During this same age period, youth are increasingly likely to claim that internal, psychological problems are appropriate to treat. On the other hand, even children ages 7 to 9 attribute negative qualities to behaviors that receive a label of mental illness (Spitzer & Cameron 1995). In one of the few longitudinal studies in existence (Weiss 1994), the desire for social distance from a “crazy person” increased from childhood through adolescence, such that by eighth grade, the crazy person label had replaced “convict” as the least acceptable category. Whereas knowledge of mental disturbance increases throughout childhood, stigmatizing attitudes intensify as well.

By adolescence, stigmatizing attitudes have solidified. A random telephone dialing

survey of adolescents and young adults revealed that although general knowledge of depression, bipolar disorder, schizophrenia, and eating disorders is high, stereotypes abound, with propensities toward violence and low academic performance ascribed to each condition (Penn et al. 2005). Overall, adolescents hold the same stereotypes and prejudices regarding mental illness as do adults.

In all, the stigmatization of mental disorder begins early in development. Much needs to be learned about the processes that fuel such negative attitudes and behaviors, both those related to cognitive development and those that emanate from socialization experiences, such as family communication or media exposure. In addition, little is known about the impact of stigma on youth who have experienced it themselves.

Efforts to Reduce Stigma Related to Mental Illness

Space allows only brief coverage of attempts to reduce mental illness stigmatization. At the outset, we highlight the warning of Link & Phelan (2001) that efforts in this domain need to be multifaceted, lest change be cursory and short-lived. In other words, unless strategies for change include altered laws and social policies *and* meaningful efforts to change fundamental attitudes in members of society, the likelihood is that reform will be piecemeal and even counterproductive. As articulated in Hinshaw (2007), it will take revisions in policy, greater accuracy in media portrayals, enhancement of sensitivity and responsiveness in mental health workers and professionals, changed views on the part of the general public, increased involvement of family members, and greatly increased access to services and treatment for individuals with mental disorders—as well as increments in their ability to cope with discrimination and stigma—to enact important, multilevel change. If stigma reduction is to be successful and long-lasting, strategies that are both top-down (beginning

with changed laws and policies) and bottom-up (starting with alterations in individual attitudes and empathy) are required.

We note at the outset that concerted efforts to reduce the stigmatization of mental illness are now in place worldwide. The United Kingdom embarked on a systematic five-year campaign (Crisp 2000), and the World Psychiatric Association is involved in a multinational Mental Health Global Action Program, with programs in different countries tailored to divergent means of reducing stigma (Sartorius & Schulze 2005).

Intriguingly, some efforts to change views on mental disorder and to reduce stigma may yield unintended consequences. As noted in Stier & Hinshaw (2007), the increasing acceptance of alcoholism or substance abuse as disease states may serve to decrease individual motivation and self-efficacy to control maladaptive levels of drinking behavior. In other words, another potentially deleterious effect of reductionistic medical-model perspectives on mental illness could be to undermine personal responsibility for effecting essential behavioral change (“it’s a disease, so my personal efforts don’t really matter”). Once again, perspectives on mental disorder that emphasize the dual components of (*a*) psychobiological risk with respect to causation and (*b*) individual and family responsibility for securing treatment are bound to be the most productive.

Another example pertains to certain written materials and websites (known as “pro-Ana”) that glorify emaciated body types and restrictions of eating behavior in young women. The explicit attempts of such messages to demedicalize and destigmatize pathological eating behaviors, through branding them as volitional lifestyle choices, may well serve to increase the prevalence of and relapse into severely destructive restricting and purging behaviors. Within such messages, it is difficult to escape a strong tone of denial of the realities of the ravages of eating-related symptomatology; for this very reason, the messages

have strong power to persuade individuals with eating disorders that nothing is wrong (and many things considerably right) with the view that further restrictions of caloric intake are a personal and political necessity. In all, without foresight, it is possible that forms of activism and different types of destigmatizing messages could well yield significant clinical problems in the arena of mental health.

Social Policy and Legislation

First, in terms of social and legal policy, laws are on the books that mandate nondiscrimination in the workplace and in public settings for individuals with physical or mental disabilities (e.g., Americans with Disabilities Act). Yet only a tiny fraction of relevant complaints and suits are initiated with respect to mental disorders, given the typical stance of shame, silence, and internalized stigma (MacDonald-Wilson et al. 2002). The paradox here is that requests for accommodations on the part of people with mental disorders are typically low cost and easily implemented (e.g., flexible work scheduling, changes in supervision, hours off for attending therapy). In addition, although affordable housing is a crucial aspect of fostering independence and self-worth in adults with mental disorders (see Corrigan & Kleinlen 2005, Willis et al. 1998), the average cost of even small apartments in most urban areas in the United States far exceeds monthly stipends available from public-assistance programs like Supplemental Security Income (Hinshaw 2007). Such programs also provide disincentives for individuals to find meaningful work, as benefits typically must be forfeited if gainful employment is secured.

Second, a number of state laws are inherently discriminatory toward individuals with mental illness (Corrigan et al. 2004). For instance, those persons who disclose a history of mental disorder often cannot receive or renew a driver's license, vote or serve on a jury, hold office, or maintain custody of their chil-

dren. Crucially, it is solely the mental illness history and not any demonstrable disability (e.g., visual impairments that could directly affect one's ability to drive) that restricts one's rights in these instances.

A third critical policy issue hinges on parity in insurance coverage for mental disorders in relation to so-called physical conditions. It is difficult to conceive of a more concrete example of stigma: Physical illnesses receive one level of compensation, whereas mental illnesses receive another, lower level. As a result, even if individuals recognize and seek treatment for their mental disorders—a major step itself—the lack of parity means that they typically cannot afford such treatments or can afford only substandard care. One argument against adopting tighter legislation related to mental health parity is that insurance premiums would skyrocket, but actual estimates suggest premium increases of approximately 1%, which must be weighed against the tens or even hundreds of billions of dollars per year associated with lost worker productivity linked to mental illness (PatientView 2004). Furthermore, parity legislation applies only to workers and citizens who hold health insurance, meaning that additional policies are needed at a more basic level for those nearly 60 million Americans who are uninsured.

Finally, increasing trends toward the criminalization of a number of status offenses, such as vagrancy, and drug-related offenses, such as pedestrian open-alcohol container laws, paired with the wholesale closing of most mental hospitals in the United States, mean that vast numbers of people with mental disorders are currently held in jails and prisons, facilities with a notorious lack of mental health services (Corrigan & Kleinlen 2005, Lamb & Weinberger 1998). The largest public mental hospital in the nation, if not the world, is currently thought to be the Los Angeles County Jail, with its daily population of thousands of essentially untreated, mentally disturbed inmates. It will take thoughtful approaches

to legislative reform aimed at decriminalization, provision of psychological and psychiatric services in detention and jail facilities, and training of police and law enforcement personnel in dealing with offenders displaying mental health problems (Watson et al. 2005) to effect meaningful change.

Altered Media Portrayals

We have already noted the massive tendencies toward stereotypic and biased portrayals of individuals with mental illness in public media (see Wahl 1995 for devastating examples). Accurate messages that convey hope are a clear antidote. Indeed, many individuals with mental disorders, particularly those with access to treatment, have long periods of time when they are in good mental health. Basing hiring practices on the media-fueled perception that future episodes of mental illness are inevitable is inherently discriminatory, analogous to employers' avoidance of hiring women because female employees might become pregnant and be less productive.

In addition to protests of stereotyped media presentations (Corrigan & Penn 1999), Sullivan et al. (2005) present an array of ways in which different types of social marketing could convey altered depictions of mental illness and of the helping professions. Sorely needed here is a clearer conceptual basis for understanding the ways in which media portrayals effect fundamental changes in attitudes and behavior (Gerbner et al. 2002). A core premise, along these lines, is that accurate portrayals and disclosures of the realities of mental illness in individuals and in families can go a long way toward avoiding the dual poles of demonization versus heroicism all too often conveyed by the media (Hinshaw 2008).

Attitudes and Practices of Mental Health Professionals

Although it might be thought that those working in the mental health arena would be ex-

remely unlikely to hold stigmatizing attitudes toward recipients of their care, empirical data reveal a discouraging tendency for at least some members of the profession to engage in denigration of people with mental illness and to hold low expectations for improvement (Wahl 1999). Indeed, even a small amount of stigma among professionals will translate into many thousands of negative social interactions in any given year, with the potential for long-term damage to morale and the promotion of stigma by the very personnel entrusted with helping those with mental illness.

In the first place, mental health professions are low in status. The whole enterprise may well be the recipient of courtesy stigma through its association with a clientele that is viewed as weak, unproductive, and blame-worthy (Goffman 1963). Indeed, pay scales for mental health workers are on the low end of ranges for other professionals, and those working in these areas must contend with derogatory media images of mental illness and of helping professionals (Gabbard & Gabbard 1992). The work can be stressful, with inadequate social support. Medicine itself tends to stigmatize mental illness, with a pervasive view that admitting weakness may demean one's stature as a helping professional (Myers 2003). And, because the theoretical models embraced by psychology and psychiatry for much of the twentieth century were extremely likely to view family socialization and weak individual character as central to the genesis of mental disorder, professional stigmatization was embedded in the core of helping disciplines.

As detailed in Hinshaw (2007), several steps may be useful in turning the tide: (a) providing increased status for those working in the field, which could involve the upgrading of training in evidence-based interventions and a process of social marketing of the benevolent, progressive qualities of workers and professionals (Sullivan et al. 2005); (b) promoting the cultural competency of professionals (Sue 2003) so that practice can be responsive to the increasing diversity of contemporary

populations; (c) engaging in heightened respect for the perspective of the client or patient, in order that intervention becomes a more collaborative and empowering enterprise (Corrigan & Lundin 2001); and (d) realizing the need for psychological support for providers, given the stresses inherent in mental health work (Hinshaw & Cicchetti 2000).

Enhancing Social Contact and Fostering Empathy

How can the attitudes and behavioral practices of social observers move toward greater knowledge, acceptance, and empathy? This has been a major topic in social psychology for decades, chiefly in relation to reducing racial prejudice (Allport 1954, Gaertner & Dovidio 2000). The bulk of evidence suggests that whereas enhanced knowledge about stigmatized conditions can facilitate improved attitudes and social interactions, effects of purely educational efforts are inconsistent and small (Hinshaw 2007). Actual contact between the majority and members of the outgroup—and providing means of enhancing empathy—are likely to provide larger and more sustainable effects.

The contact hypothesis posits that facilitating interactions between individuals can, in and of itself, produce more harmonious relationships. Pettigrew & Tropp (2000) have provided meta-analytic findings attesting to the success of contact between ingroups and outgroups in reducing prejudice (for supportive evidence with respect to mental health, see Couture & Penn 2003, Kolodziej & Johnson 1996). Yet in appraising relevant research, it is crucial to know the nature of the samples involved, the kinds of outcome measures selected (for a review of mental health stigma measures, see Link et al. 2004), and the type and duration of the contact that occurs. Indeed, investigators have come to realize that there are certain conditions of social interaction that are far more likely to facilitate positive intergroup relations than others (Watson & Corrigan 2005).

Perhaps the most important of these conditions is that when majority group members and stigmatized individuals have relatively equal power and status, contact is far more likely to promote positive attitudes than when there is a marked power imbalance. Contact with stereotypic representatives of people with mental illness (e.g., through encountering homeless persons with mental illness on city streets or visiting a mental hospital) is likely to reinforce the belief that such persons are deviant, powerless, potentially freakish, and extremely difficult to deal with. It will take changes at the level of social structure and social policy (e.g., provision of jobs and availability of affordable housing; reductions in overt discrimination), as well as enhanced access to needed treatments, to facilitate this crucial condition of contact.

Other conditions are salient. First, when contact is informal, casual, and regular, rather than formally arranged, stiff, and occasional, the perceptions and behaviors of stigmatized group members are most likely to improve. Second, social institutions need to support these kinds of contact. If, for instance, school systems and teachers are opposed to mainstreaming, both “regular” students and those with mental disorders will undoubtedly notice the resistance, and attitudes toward classmates with mental and emotional disorders are not likely to improve. A parallel clearly exists with respect to employers and their efforts to promote meaningful contact between newly hired employees with mental disorders and the rest of the workforce. Third, and crucially, when ingroup and outgroup members have shared goals, working toward common ends with superordinate objectives (Sherif & Sherif 1953), attitude change is likely to be positive and contact is likely to continue. Such mutuality of goals can reduce the perception of threat from an outgroup member; it can also help to facilitate a more human, universal standard of comparison between ingroup and outgroup members.

Beyond contact, additional means of reducing stigma include the provision of

Contact hypothesis: a venerable perspective that social contact is the optimal means of overcoming prejudice, discrimination, and stigma; certain conditions of contact (equal status, informal contact, institutional support) appear optimal in this regard

counter-stereotypic imagery (e.g., Blair et al. 2001, Bodenhausen et al. 1995), reconstructing ingroup versus outgroup status through a wider conception of the ingroup (Gaertner & Dovidio 2000)—for example, through mutual work in self-help and advocacy groups—and directly enhancing empathy for members of outgroups through exposure to meaningful personal narratives and on the potential for change and adaptation (rather than difference per se).

Family and Individual Efforts

Family members are often the unsung heroes in coping with both mental illness in their relatives and the stigma that attends to mental disorder (see Wahl & Harman 1989). If families can get accurate information about the causes of and treatments for mental disorders, they will be able to recognize and discount outmoded, prejudiced beliefs from friends or even some professionals. Family engagement in support and advocacy groups can help to overcome isolation and foster a sense of group action toward larger ends. Family involvement in treatment has an increasingly strong evidence base with respect to many forms of child and adolescent disorders as well as many adult conditions.

As for individuals with mental disorders themselves, procuring effective treatment is not only essential for relief of symptoms and distress but also for stigma reduction. That is, not only can pain and suffering be reduced, but engagement with peers, classmates, workmates, and social observers in general can occur, with resultant benefits in terms of positive expectations and attitudes. We caution, however, that there is potential danger in pushing

this perspective too far: It would be a mistake to think that individual treatment of mental illness is the primary means of reducing stigma. Indeed, people with mental illness require rights, respect, and responsibility, even if they continue to show some forms of deviant behavior. Stigma is a form of social injustice, and solutions at the levels of social policy and reduction of discrimination are a major part of the equation (Corrigan 2005). Furthermore, stigma will not disappear overnight, and individuals with mental disorders may well require tools and coping skills to deal with discrimination, prejudice, and stigma (Hinshaw 2007).

In all, mental disorders are not just “differences” across human beings (like skin color), but instead constitute hugely impairing conditions that mandate responsive and affordable treatment. Gaining access to such care can be liberating for the individuals and family members in question, with the added benefit of helping to change societal belief systems that mental illness is intractable and chronically disabling.

The challenge ahead is to use the considerable knowledge base that is accumulating about mental disorders, their treatments, and the stigma that surrounds mental illness to promote multilevel, integrated means of advancing evidence-based treatments, which can produce improvement in symptoms and impairment, while simultaneously prioritizing reductions in discrimination, enhancement of empathy, and promotion of optimal social contact. Because mental illness is everywhere, with pervasively negative impact on individual, family, and community functioning, all of humanity stands to gain from reducing stigma.

SUMMARY POINTS

1. Stigmatization of devalued traits and conditions, which appears universally and which involves stereotyping, prejudice, and discrimination, is highly predictive of lowered life opportunities for those who are stigmatized, with the stigma against mental illness now receiving considerable research attention.

2. The study of mental illness stigma is of crucial importance, given the high prevalence and marked disability associated with mental disorders and the pernicious effects of stigmatization, which outweigh the impairments related to mental illness per se.
3. A number of social functions are related to the rampant stigmatization of mental illness (e.g., self-esteem enhancement, reinforcement of existing social inequalities, defenses against the threatening nature of mentally disturbed behaviors); empirical evidence as well as examination of practices in everyday society provide ample documentation of the high levels of stigma that attend to mental illness.
4. Mental illness stigma is highly related to public perceptions—often fueled by biased and misleading media portrayals—that mental disorders are strongly linked to danger and violence.
5. Research on the stigmatization of mental illness requires attention to both unconscious, implicit measurement strategies and behavioral indicators of bias and discrimination, over and above more traditional “explicit” attitude measures.
6. Biogenetic models of the causation of mental illness are now in ascendance, but despite assumptions from attribution theory that ascriptions of social deviance to uncontrollable causes (like medical, genetic conceptions of mental illness) will automatically reduce stigma, such reductionistic attributions may actually increase punitive social responses and may increase negative attitudes toward relatives of those with mental illness.
7. Much remains to be learned about the developmental origins of the propensity to stigmatize peers with mental disorders and about the effects of stigmatization on children and adolescents who experience behavioral and emotional disorders.
8. It will take multilevel practices to overcome mental illness stigma, including changes in social policy, altered portrayals in the public media, changed attitudes and practices among mental health professionals, contact between the general public and persons with mental illness under conditions of equity and parity, family support, and access to evidence-based treatments for individuals with mental illness.

DISCLOSURE STATEMENT

The authors are not aware of any biases that might be perceived as affecting the objectivity of this review.

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Innovative and scholarly account of the naturally selected cognitive “modules” that may underlie the stigmatization of mental illness.

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