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Labeling and Stigma

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This chapter provides a frame for examining extant issues and evidence concerning labeling and stigma as they pertain to mental illnesses. The issues addressed are (1) the conceptualization of labeling and stigma, (2) evidence about trends in stigma-relevant public attitudes and beliefs, and (3) how labeling and stigma affect individuals who develop mental illnesses. Both modified labeling theory and the conceptualization of stigma developed by Link and Phelan point to the importance of attitudes and beliefs, leading to questions about how such attitudes and beliefs are faring over time. The research reviewed in this chapter shows that the public recognizes mental illnesses as illnesses with genetic and biological bases; however, the core stereotypes of dangerousness and incompetence have either changed little or actually become stronger. No change in social distancing responses has accompanied the increasingly medical conception of mental illnesses. Discrimination against people with mental illnesses occurs through multiple mechanisms, including direct person-to-person discrimination, discrimination operating through the stigmatized person, discrimination that emerges silently but perniciously through social interaction, and structural stigma. What are the policy implications of this chapter?

Introduction

When we ask who is labeled mentally ill and what the consequences of such labeling are, we ask questions that are central to the sociological understanding of mental disorder. Such questions are relevant to those who are concerned that so many people with serious mental illnesses go unlabeled and untreated (Regier et al., 1993; Wang et al., 2005). Such questions are also relevant to people attempting to recover from mental illnesses, who often feel that they suffer as much from being labeled mentally ill as they do from mental illnesses itself (Deegan, 1993).

As a society, we have created specific professions (including psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing) on whose members we confer the authority to define, label, and treat mental illnesses. Social processes determine who encounters these professionals and many of the important consequences that might follow from such an encounter. The treatment patients receive may ameliorate their symptoms, improve their well-being, and enhance their social and occupational functioning. At the same time, along with treatment comes the possibility of pejorative labeling and stigma. Social science research on labeling and stigma can help us understand the processes involved and, by bringing those processes to light, open the possibility of addressing some of their negative consequences.

This chapter begins with some background on how a consideration of these issues developed in mental health sociology. This selective review provides a frame for examining extant issues and evidence concerning labeling and stigma as they pertain to mental illnesses. The issues addressed are (1) the conceptualization of labeling and stigma, (2) evidence about trends in stigma-relevant public attitudes and beliefs, and (3) how labeling and stigma affect individuals who develop mental illnesses.

The Labeling Debate

The issue of whether and to what extent labeling and stigma are important in the area of mental illness was brought into sharp relief by the labeling debate that emerged within sociology in the 1960s and 1970s. Scheff (1966/1984) constructed a formal labeling theory of mental illnesses that strongly endorsed labeling processes in the production of stable mental illnesses. In Scheff's theory, the act of labeling was strongly influenced by the social characteristics of the labelers, the person being labeled, and the social situation in which their interactions occurred. Labeling was driven as much by these social factors as it was by anything that might be called the symptoms of mental illness. Moreover, according to Scheff, once a person is labeled, powerful social forces come into play to produce a stable pattern of "mental illness." Key aspects of Scheff's theory are captured in the following quotation:

> In a crisis, when the deviance of an individual becomes a public issue, the traditional stereotype of insanity becomes the guiding imagery for action, both for those reacting to the deviant and, at times, for the deviant himself. When societal agents and persons around the deviant react to him uniformly in terms of the stereotypes of insanity, his amorphous and unstructured rule-breaking tends to crystallize in conformity to these expectations, thus becoming similar to behavior of other deviants classified as mentally ill and stable over time. The process of becoming uniform and stable is completed when the traditional imagery becomes a part of the deviant's orientation for guiding his own behavior (Scheff 1966/1984, p. 82).

Critics of the theory, especially Walter Gove, took sharp issue with Scheff's characterization of the labeling process. Gove argued that labels are applied far less capriciously and with many fewer pernicious consequences than the labeling theory indicates. In Gove's view, research supports the idea that, if people with mental illnesses are rejected, it is because of responses to their symptomatic behavior rather than because of any label they received. Moreover, he argued, labeling is not an important cause of further deviant behavior. "The available evidence," Gove concluded, "indicates that deviant labels are primarily a consequence of deviant behavior and that deviant labels are not a prime cause of deviant careers" (Gove, 1975, p. 296).

Although some observers despaired at the protracted and seemingly irresolvable labeling debate, the sharply opposed stances that Scheff and Gove provided served to clarify what was at issue and thereby set the stage for subsequent theory and research.

Modified Labeling Theory

In the 1980s Link and his colleagues developed a "modified" labeling theory that derived insights from the original labeling theory, but stepped away from the claim that labeling is a direct cause of mental illness (Link, 1982, 1987; Link et al., 1989). Instead the theory postulated a process through which labeling and stigma jeopardize the life circumstances of people with mental illnesses, harming their employment chances, social networks, and self-esteem. By creating disadvantage in these domains and others like them, people who have experienced mental illness labels are put at greater risk of the prolongation or reoccurrence of mental illness. The "modified" labeling theory also provided an explanation as to how labeling and stigma might produce these effects and how key concepts and measures could be used in testing the explanation with empirical evidence.

The theory begins with the observation that people develop conceptions of mental illness early in life as part of socialization (Angermeyer & Matschinger, 1996; Scheff, 1966/1984; Wahl, 1995). Once in place, people's conceptions become a lay theory about what it means to have a mental illness (Angermeyer & Matschinger, 1994; Furnham & Bower, 1992). People form expectations as to whether most people will reject an individual with mental illness as a friend, employee, neighbor, or intimate partner and whether most people will devalue a person with mental illness as less trustworthy, intelligent, and competent. These beliefs have an especially poignant relevance for a person who develops a serious mental illness, because the possibility of devaluation and discrimination becomes personally relevant. If one believes that others will devalue and reject people with mental illness, one must now fear that this rejection will apply personally. The person may wonder, "Will others look down on me, reject me, simply because I have been identified as having a mental illness?" Then, to the extent that it becomes a part of a person's world view, that perception can have serious negative consequences. Expecting and fearing rejection, people who have been hospitalized for mental illness may act less confidently and more defensively, or they may simply avoid a potentially threatening contact altogether. The result may be strained and uncomfortable social interactions with potential stigmatizers (Farina et al., 1968), more constricted social networks (Link et al., 1989), a compromised quality of life (Rosenfield, 1997), low self-esteem (Wright, Gronfein, & Owens, 2000), depressive symptoms (Link et al., 1997), unemployment, and income loss (Link, 1982, 1987).

To test this explanation, Link (1987) constructed a 12-item scale measuring the extent to which a person believes that people who have been labeled by treatment

contact will be devalued and discriminated against. Respondents are asked the extent to which they agree or disagree with statements indicating that most people devalue current or former psychiatric patients by seeing them as failures, as less intelligent than other persons, or as individuals whose opinions need not be taken seriously. The scale also includes items that assess perceived discrimination by most people in jobs, friendships, and romantic relationships. The scale was administered to people with mental illnesses and to community residents from the same general area of New York City in a case-control study of major depression and schizophrenia. Link (1987) showed that the degree to which a person expects to be rejected is associated with demoralization, income loss, and unemployment. This association occurs in individuals labeled mentally ill but not in unlabeled individuals, thereby supporting the idea that labeling activates beliefs that lead to negative consequences.

Link and colleagues (1989) extended the forgoing reasoning in two ways. First they brought into the analysis empirical measures of coping orientations of secrecy (concealing a history of treatment), withdrawal (avoiding potentially threatening situations), and education (attempting to teach others in order to forestall the negative effects of stereotypes). Consistent with the idea that the stigma associated with mental illness creates expectations of rejection, they showed that people with mental illnesses tend to endorse these strategies as a means of protecting themselves. Second, the researchers extended the analysis to a consideration of the effects of these processes on social network ties. They found that people who fear rejection most and who endorse the strategy of withdrawal have insular support networks consisting mainly of household members.

Aspects of the theory have since been tested with a broader range of outcomes, in different samples, by different investigators, and often using longitudinal data. These studies generally showed that the perceived devaluation-discrimination measure is associated with outcome variables including quality of life (Rosenfield, 1997), low self-esteem (Link et al., 2001, 2008; Wright et al., 2000), social networks (Link et al., 1989; Perlick et al., 2001) depressive symptoms (Link et al., 1997; Perlick et al., 2007), treatment adherence (Sirey, Bruce, Alexopoulos, Perlick, Friedman, et al., 2001), and treatment discontinuation (Sirey, Bruce, Alexopoulos, Perlick, Raue, et al., 2001). But one particular aspect of the theory, the idea that cultural conceptions (perceived devaluation and discrimination) have effects on outcome variables in labeled persons but not in unlabeled ones, has not been as thoroughly tested in subsequent research. One study that did do so was undertaken by Kroska and Harkness (2006) using samples of psychiatric hospital patients and community residents in Indianapolis. This study operationalized cultural conceptions in a completely different way than Link and his colleagues did. Patients and community residents were asked to evaluate the concept of "mentally ill person," using a seven-point semantic differential scale with opposing adjectives such as "good/bad," "useful/useless," and "powerless/powerful." Respondents also rated

the concepts of "myself as I really am" and "myself as others see me" with the same adjective pairings. The researchers' modified labeling theory hypothesis was that associations between ratings of the concepts of "mentally ill person" and "myself as I really am" and "myself as others see me" would be stronger in the labeled group (where a mental illness label is potentially personally relevant) than in the unlabeled group (where it is not personally relevant). Their results were generally consistent with this prediction, providing additional support for this key prediction of modified labeling theory.

Understanding the "Package Deal"

Evidence from modified labeling theory and other approaches to labeling, stereotyping, and rejection strongly suggest that negative consequences associated with labeling are experienced by many people. At the same time, evidence from a voluminous body of research indicates that a variety of psychotherapies and drug therapies can be helpful in treating many mental illnesses. Given this, existing data simply do not justify a continued debate concerning whether the effects of labeling are positive or negative – clearly they are both. Rosenfield (1997) was the first to bring this point to light in a single study. She examined the effects of both treatment services and stigma in the context of a model program for people with severe mental illnesses. She showed that both the receipt of services (specific interventions that some people in the program receive and others do not) and stigma (Link's 1987 measure of perceived devaluation and discrimination) are related – in opposite directions – to multiple dimensions of a quality of life measure. Receipt of services had positive effects on dimensions of quality of life, such as living arrangements, family relations, financial situation, safety, and health, whereas stigma had equally strong negative effects on such dimensions.

A second study that explores the idea of joint effects in opposite directions is one by Link and colleagues (1997). In a longitudinal study, men who were dually diagnosed with mental disorder and substance abuse were followed from entry into treatment (when they were highly symptomatic and addicted to substances) to a follow-up point 1 year later (when they were far less symptomatic and largely drug and alcohol free). Despite these dramatic benefits, the results also showed that perceptions of devaluation and discrimination and reported experiences of discrimination continued to affect the men's level of depressive symptoms. Similar results, showing evidence of improvement in symptoms with treatment but enduring effects of stigma on self-esteem, were reported in a recent study by Link and colleagues (2008). The effects of stigma and discrimination endure and are apparently unaffected by any benefits of treatment.

Thus the evidence indicates a bundling of labeling effects that are currently joined in a kind of "package deal." People seeking mental health treatment navigate this deal in one way or another. Sometimes they do so in ways that mental

health professionals think they should not, such as avoiding treatment, denying their illness, or ending treatment earlier than their treatment team thinks they should. A kind of collective finger wagging ensues that at times shifts from admonitions and warnings to using the "leverage" of housing or financial benefits to ensure treatment compliance (Monahan et al., 2001). If leverage fails, more direct forms of coercion are also possible such as involuntary inpatient commitment or the ascendant "outpatient commitment" (Hiday, 2003). Of course, there is an intense debate about the utility and effectiveness of leverage and coercion, with some believing that these practices are necessary (Torrey & Zdanowicz, 2001) and others seeing them as counterproductive (Pollack, 2004). What a sociological perspective adds to this debate is evidence that there is indeed a package deal and that people face real choices and real dilemmas as they navigate its parameters. It also suggests that the ingenuity invested in constructing strategies to leverage compliance or to coerce it needs to be complemented or replaced by efforts that really change the balance of the package deal to one that delivers more benefit and less stigma. When that happens, more people will choose treatment, and less leveraging and coercion will be required. Mental health sociologists can help by continuing to unpack the package deal so that its existence is more widely acknowledged and our understanding of the mechanisms that undergird it more complete. Recent research by mental health sociologists is engaged in precisely these issues. Rosenfield (2008), for example, queried people with mental illnesses as to sources of stigmatizing reactions and found that the reactions of treatment providers are the ones that have the most harmful impact. Markowitz and Angell (2008) elaborated on the modified labeling theory to probe more deeply into the mechanisms involved by including the reflected appraisals of family members in their empirical analysis. Phelan, Lucas, and Link (2008) conducted experimental work integrating paradigms from the expectation-states tradition in sociology (Berger, Cohen, & Zelditch, 1972) with work in psychology on the sources of stigma in interaction processes to investigate whether and to what extent a mental illness label reduces influence in interactions and engenders behavioral social distance. Morrison (2008) described an effort to break the cycles of stigma by developing a kind of rapid-response mechanism that includes the evaluations of consumers of mental health treatment in planning services that suit their needs. Identifying sources, probing mechanisms, and evaluating novel attempts to respond to stigma will deepen our understanding and enable us to address the stigma processes that affect people with mental illnesses.

The Rise of Interest in Stigma

Although the reasons are far from fully understood, it is very clear that there has been a dramatic increase in interest in stigma since the labeling debate emerged and Goffman's (1963) seminal book was first published. One indicator of this rise

in interest is the number of published articles with the word *stigma* in the title or abstract. According to Link and Phelan (2001) the number of such articles in 1980 stood at 19 for Medline and 14 for Psych Info, but rose dramatically by the end of the century in 1999 to 114 for Medline and 161 for Psych Info. Incredibly, just 6 years later in 2006 the numbers had more than doubled to 416 for Medline and 462 for Psych Info. This crude quantitative accounting coheres with evidence from other sources, including the prominence given to stigma in Surgeon General Satcher's report on mental health (1999, p. 6). This report described the importance of stigma as follows:

> Stigma erodes confidence that mental disorders are valid, treatable conditions. It leads people to avoid socializing, employing or working with, or renting to or living near persons who have a mental disorder, especially a severe disorder like schizophrenia. Stigma deters the public from wanting to pay for care and, thus, reduces consumers' access to resources and opportunities for treatment and social services. A consequent inability or failure to obtain treatment reinforces destructive patterns of low self-esteem, isolation and hopelessness. Stigma tragically deprives people of their dignity and interferes with their full participation in society. It must be overcome.

From what could be a long list of additional indicators of a growing interest in stigma, we mention only two more. First, the National Institute of Mental Health (NIMH) convened a "stigma working group" and released a Request for Applications designed to stimulate research aimed at reducing the impact of stigma on people's lives. Second, enormous effort has been undertaken to address aspects of the stigma of mental illness in the United States and around the world. In the midst of all of this interest, questions have arisen as to precisely what the term *stigma* means and whether it is the most appropriate concept to use to convey the circumstances that people with mental illness confront.

Conceptualizing Stigma in Relation to Labeling, Stereotyping, and Discrimination

In the literature on stigma, the term has been used to describe what seem to be quite different concepts. It has been used to refer to the "mark" or "label" that is used as a social designation, the linking of the label to negative stereotypes, or the propensity to exclude or otherwise discriminate against the designated person. Even Goffman's (1963) famous essay included somewhat different, albeit very instructive, definitions. As a consequence of this variability in its usage, there has been confusion as to what the term means. Additionally, an intense dissatisfaction with the concept emerged in some circles for at least two reasons. First, it was argued that the stigma concept identifies an "attribute" or a "mark" residing in the person as something the person possesses. The process of selecting and affixing labels was not taken to be as problematic as it should have been. In

particular, far too little attention was focused on the identification of only a single characteristic for social salience from a vast range of possible characteristics that might have been selected instead. Second, too much emphasis was placed on cognitive processes of category formation and stereotyping and too little on the broad and very prominent fact of discrimination and the influence that such discrimination has on the distribution of life chances.

In light of this confusion and controversy, Link and Phelan (2001) put forward a conceptualization of stigma that recognized the overlap in meaning among concepts like stigma, labeling, stereotyping, and discrimination. The conceptualization they offered defined stigma in the relationship among those interrelated components. It also responded to criticisms of the concept by making the social selection of designations a prominent feature, by incorporating discrimination into the concept, and by focusing on the importance of social, economic, and political power in the production of stigma. Link and Phelan described their conceptualization as follows:

> In our conceptualization, stigma exists when the following interrelated components converge. In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labeled persons to undesirable characteristics – to negative stereotypes. In the third, labeled persons are placed in distinct categories so as to accomplish some degree of separation of "us" from "them." In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Stigmatization is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination. Thus we apply the term stigma when elements of labeling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows them to unfold (Link & Phelan, 2001, p. 367).

Although a detailed exposition of each of these components is available elsewhere (Link & Phelan, 2001), we provide a brief description of each component as follows.

Distinguishing and labeling differences. The vast majority of human differences, such as hairy ears or preferred vegetables, are not considered to be socially relevant. However, some differences, such as skin color and sexual preferences, are currently awarded a high degree of social salience. Both the selection of salient characteristics and the creation of labels for them are social achievements that need to be understood as essential components of stigma.

Associating differences with negative attributes. In this component, the labeled difference is linked to negative stereotypes in such a manner, for example, that a person who has been hospitalized for mental illness is thought to represent a violence risk.

Separating "us" from "them." A third aspect of the stigma process occurs when social labels connote a separation of "us" from "them." For example, certain ethnic

or national groups (Morone, 1997), people with mental illnesses, or people with a different sexual orientation may be considered fundamentally different kinds of people from "us."

Emotional responses. The Link and Phelan conceptualization of stigma was expanded to include emotional responses in Link and colleagues' (2004) paper on measuring mental illness stigma. They noted that the stigmatizer is likely to experience emotions of anger, irritation, anxiety, pity, and fear. These emotions are important because they can be detected by the person who is stigmatized, thereby providing an important statement about a stigmatizer's response to them. Second, emotional responses may shape subsequent behavior toward the stigmatized person or group through processes identified by attribution theory (Weiner, Perry, & Magnusson, 1988). From the vantage point of the person who is stigmatized, emotions of embarrassment, shame, fear, alienation, or anger are possible. Thomas Scheff (1998) has, for example, argued that the emotion of shame is central to stigma and that shaming processes can have powerful and hurtful consequences for stigmatized persons.

Status loss and discrimination. When people are labeled, set apart, and linked to undesirable characteristics, a rationale is constructed for devaluing, rejecting, and excluding them. This process can occur in several ways that we describe more fully later in the chapter.

The dependence of stigma on power. A unique feature of Link and Phelan's (2001) conceptualization is the idea that stigma is entirely dependent on social, economic, and political power. Groups with lower amounts of power (e.g., psychiatric patients) may label, stereotype, and separate themselves from higher power groups (e.g., psychiatrists). But in these cases, stigma as Link and Phelan define it does not exist, because the potentially stigmatizing groups do not have the social, cultural, economic, and political power to imbue their cognitions with serious discriminatory consequences.

The Link and Phelan (2001) conceptualization is meant to be useful, not definitive or comprehensive. Readers interested in the stigma concept should attend to other conceptualizations, especially for particular purposes. If the project seeks to understand how stigma differs from circumstance to circumstance, the Jones et al. (1984) conceptualization of dimensions of stigma is particularly useful. It identifies six dimensions: concealability (how obvious or detectable the characteristic is), course (how reversible the condition is), disruptiveness (the extent to which a designation leads to strained interactions), aesthetics (the extent to which a condition elicits an instinctive and affective reaction of disgust), origin (how the condition came into being), and peril (the extent to which the condition induces fear or threat in others). Readers especially interested in the issue of what causes people to stigmatize should refer to the evolutionary psychology theory of Kurzban and Leary (2001) and to the social science perspective of Phelan, Link, and Dovidio (2008). Kurzban and Leary identified three potential evolutionary

origins of stigma. They argued that humans have developed cognitive adaptations designed to avoid poor social exchange partners (e.g., cheaters and individuals with little social capital), to compete with and exploit outgroups, and to avoid individuals likely to carry communicable pathogens. Each of these strategies, they argue, is likely to have survival value from an evolutionary perspective. Phelan, Link and Dovidio (2008) also identified three functions of stigmatization: exploitation and domination, norms enforcement, and disease avoidance. Readers with an anthropological bent should refer to the conceptualization of Yang and colleagues (2007) that identifies stigma in "moral experience" and argues that what matters about stigma is rooted in a local context of meanings. Readers interested in a mapping of concepts and theories relevant to stigma are referred to Phelan, Link and Dovidio (2008) and Pescosolido, Martin, Lang, et al. (2008).

Trends in Public Attitudes Relevant to Stigma

An interest in public attitudes and beliefs assumes that such attitudes and beliefs are important. But do public attitudes and beliefs matter in the lives of people who develop mental illnesses? Some argue that it matters little whether members of the public harbor negative attitudes or false beliefs. What matters is whether they actually discriminate against people with mental illnesses. But both the modified labeling theory and the Link and Phelan conceptualization of stigma assign critical importance to the ambient attitudes, emotions, and beliefs of dominant groups in their relations between a more powerful "us" and a less powerful "them." For modified labeling theory, these attitudes, emotions, and beliefs are what people learn early in life that then confound their capacity to obtain desired goals at some later point in their lives when they develop a mental illness. In Link and Phelan's article, "Conceptualizing Stigma," attitudes, emotions, and beliefs are, along with power differences, the prime drivers of stigma processes.

From these vantage points, an inclination to focus only on blocking discrimination misses the capacity of more powerful groups to find new, perhaps less obvious ways to discriminate. Indeed if the attitudes, emotions, and beliefs remain unchanged and power differences also remain unchanged, blocking one form of discrimination is likely to simply increase the need for new and perhaps more subtle forms. Consistent with this idea is Monahan et al.'s (2001) observation that in the period of deinstitutionalization with its quest for "least restrictive environments," a powerful new form of control has emerged and spread in the form of "leveraging." Instead of old forms of control conferred by the mental hospital system, a new form that restricts access to housing and withholds benefits until "compliance" is secure has emerged and proliferated. For all of these reasons, the extant attitudes and beliefs of the general public are important to the stigma of mental illness. Whether and to what extent these attitudes are changing over time and

whether new knowledge about the determinants of mental illnesses is influencing attitudes in expected directions are matters of considerable importance.

The Dangerousness Stereotype from 1950 to 1996

In 1996, teams of investigators at Columbia and Indiana Universities constructed the MacArthur module of the General Social Survey (GSS; Pecosolido, Martin, Long, et al., 2008a). Interested in trends over time, the team directed attention to the first nationwide study of public attitudes conducted in 1950 by Shirley Star. Unfortunately, the questions in the original study generally used language that had become "dated" by 1996. However, the following open-ended question was available and could be repeated: "Of course, everyone hears a good deal about physical illness and disease, but now, what about the ones we call mental or nervous illness. . . . When you hear someone say that a person is "mentally-ill," what does that mean to you?" In both the Star study and the MacArthur module of the 1996 survey, answers were recorded verbatim. Fortunately, every tenth interview of the original Star survey had been saved by the librarian at the National Opinion Research Center in Chicago where both studies were conducted. This allowed trained coders to reliably rate the 1950 and 1996 responses to this question with respect to whether the respondent spontaneously referred to violent behavior in describing a person with mental illness. Thereby the study allowed a rare glimpse at trends in one key stereotype associated with the stigma of mental illnesses involving psychosis. Remarkably, the analysis revealed that, despite massive efforts to educate the public about mental illness and enormous advances in treatment, respondents whose descriptions indicated a person with psychosis were nearly two and a half times as likely to mention violent behavior in 1996 (31.0%) as in 1950 (12.7%; Phelan, Link, Stueve, & Pescosolido, 2000). Whatever the reasons for this change, at the very least, it represents a discomforting fact for people with a psychotic illness who are seeking broader social acceptance.

Trends in Causal Attributions, Stereotypes, and Social Distancing Responses, 1996–2006

In keeping with an interest in monitoring trends in public attitudes and beliefs, the same team of investigators involved in the 1996 MacArthur module secured funding from NIMH to replicate the identical module in 2006. Both studies used identical vignettes describing individuals with major depression, schizophrenia, alcohol dependence, and, to provide a no-disorder contrast, a so-called troubled person who has mild worries but no diagnosable disorder. Each respondent was randomly assigned one of these vignettes and then asked questions about what might have caused the problem, whether the described person should seek medical

or psychiatric help, whether the person was a violence risk, and whether the person would be able to manage his or her own money, as well as social distance questions that asked the respondent whether he or she would be willing to interact with the described person in a variety of circumstances. In keeping with a strong push to educate the public that mental illnesses were illnesses like other illnesses, respondents in 2006 as compared to those in 1996 were more likely to see the conditions as caused by biological and genetic factors. Additionally, respondents to the 2006 survey were more likely to recommend medical and psychiatric treatment for the described cases. At the same time, there was no evidence whatsoever that stereotypes of violence and incompetence, or the willingness to interact with people with mental illnesses, changed for the better over the period between the studies. This evidence challenges the idea that stigma will dissipate when the public is moved toward a more medical view of mental illnesses (Pescosolido, Martin, Long, et al., 2008a).

Reflecting on these trends can induce either pessimistic or optimistic thoughts about the future of mental illness stigma. From a pessimistic stance, at least one highly touted approach to addressing mental illness stigma seems to have yielded few if any benefits for stereotyping or social distance. From a more optimistic vantage point, however, one notes that the public was receptive to the main message delivered – mental illnesses are biologically based and can be effectively treated by medical professionals. From this optimistic vantage point, the reason the public has not changed beliefs about dangerousness or incompetence or its attitudes toward interacting with people with mental illnesses is that these beliefs and attitudes were not directly targeted. The GSS studies have shown that attitudes can change; we just need to complete the process by addressing a fuller range of attitudes and beliefs with effective messages.

A pessimistic response takes two forms. The first argues that stereotypes of dangerousness and incompetence are inherently more intransigent than the beliefs that have changed. They are intransigent because they are strongly supported by countervailing forces such as the portrayal of people with mental illness in the media as violent and incompetent and the "kernel of truth" idea that says that sometimes people with mental illnesses are violent because of their illness. The second pessimistic response contends that the selection of attitudes and beliefs targeted for change was driven by powerful forces with different aims than the eradication of stigma. For psychiatry, promulgating the idea that the disorders its treats are valid, biologically based illnesses counters stereotypes about psychiatry and brings this specialty more fully and equally into the medical fold. Additionally, the interests of pharmaceutical companies are strongly served when the public sees mental illnesses as biologically based conditions that can be medically treated with the compounds the industry has developed for sale. If it takes clout to target and change attitudes, what will the interests be that push for change in stereotypes and social distancing responses?

Geneticization and Stigma

One emerging social phenomenon that is likely to alter causal attributions for mental illness is the genetics revolution. Research focusing on genetic sources of mental illness and a general focus on genetics and genomics are pervasive in the current culture. What will the consequences be for stigma? To address this question, Phelan (2005) conducted a vignette experiment in which a person with schizophrenia or major depressive disorder was described and causal attribution (genetic or not genetic) was randomly varied. She found that genetic attributions affected respondents' perceptions and beliefs about the illness; for example, they increased the perceived seriousness and persistence of the mental illness and the belief that the mentally ill person's siblings or children might develop the same problem. Looking at more direct indicators of stigma, a genetic attribution did not significantly affect blame, anger, sympathy, or social distance from the ill person, but it did increase social distance from the person's sibling, particularly regarding intimate forms of contact such as dating, marriage, and having children. These findings suggest that "associative stigma" affecting biological family members of people with mental illness may be the aspect of stigma that is most strongly affected by geneticization.

How Labeling and Stigma Affect the Lives of People with Mental Illnesses

People who have been hospitalized for serious mental illnesses are disadvantaged when it comes to a general profile of life chances like income, education, psychological well-being, housing status, medical treatment, and health (e.g., Druss et al., 2000; Link, 1987). How does this happen? Although some part of the difference may be due to the directly debilitating consequences (given existing social circumstances) of the illness, we attend to ways in which stigma-related processes may be involved.

Status Loss

An almost immediate consequence of successful negative labeling and stereotyping is a general downward placement of a person in a status hierarchy. The person is connected to undesirable characteristics that reduce his or her status in the eyes of most others. The fact that human beings create hierarchies is, of course, evident in organizational charts, who sits where in meetings, who defers to whom in conversational turn-taking, and so on. One strand of sociological research on social hierarchies, the so-called expectation-states tradition, is particularly relevant to the study of stigma and status loss (Berger, Fisek, Norman, & Zelditch, 1977;

Ridgeway & Walker, 1995). Based on finding a reliable tendency of even unacquainted individuals to form fairly stable status hierarchies when placed in group situations, researchers set out to understand these processes. This research showed that external statuses, like race and gender, shape status hierarchies within small groups of unacquainted persons, even though the external status has no bearing on proficiency at a task the group is asked to perform. Men and Whites were more likely than women and Blacks to attain positions of power and prestige – they talked more frequently, had their ideas more readily accepted by others, and were more likely to be voted group leader (Mullen, Salas, & Driskell, 1989). This finding implies that status loss has immediate consequences for a person's power and influence and thus his or her ability to achieve desired goals.

Discrimination

We conceptualize four broad mechanisms of discrimination as part of the stigma process: individual discrimination, discrimination that operates through the stigmatized individual, interactional discrimination, and structural discrimination.

Individual discrimination. What usually comes to mind when thinking about discrimination is the classic model of individual prejudice and discrimination, in which Person A discriminates against Person B based on Person A's prejudicial attitudes or stereotypes connected to a label applied to Person B (Allport, 1954). For example, if, as in Page's experimental study (Page, 1977), a landlord learns about a renter's history of psychiatric hospitalization and consequently denies that an advertised apartment is available, we would say that individual discrimination has occurred. This rather straightforward process doubtless occurs with considerable regularity, although it may often be hidden from the discriminated-against person; one rarely learns why one is turned down for a job, an apartment, or a date. We believe, however, that this relatively straightforward process represents the tip of the discrimination iceberg. Most discrimination, we argue, is extremely subtle in its manifestation, if not in its consequences, and occurs without full awareness. For example, Druss et al. (2000) have shown that people with schizophrenia are less likely to receive optimal treatment for heart disease even after controlling for the nature of the condition and the availability of services. This is an instance of individual discrimination, as it results from the behavior of individual physicians who make treatment decisions. Yet it is unlikely that the physicians are aware of their discriminatory behavior or the reasons for it. Comparing demographically similar samples of medical and psychiatric inpatients, Bromley and Cunningham (2004) found that, whereas the medical patients received gifts like flowers, balloons, and chocolate, psychiatric patients generally received more practical gifts of toiletries, nonluxury foodstuffs, and tobacco. Again, this differential gift-giving behavior on the part of friends and family members is surely not deliberate or conscious; rather it reflects and reinforces societal attitudes about what it means to

have a medical versus a psychiatric problem. Individual discrimination can come from many sources, including community members, employers, mental health caregivers, family members, and friends (Dickerson et al., 2002; Wahl, 1999).

Discrimination that operates through the stigmatized individual. Another form of discrimination that is subtle in its manifestation and insidious in its consequences operates within stigmatized individuals themselves. As explicated earlier, Link and colleagues (Link, 1982, 1987; Link et al., 1989, 1997) proposed in their modified labeling theory that all people are exposed to common, ambient stereotypes about mental illness as part of socialization. If a person then develops a mental illness, these beliefs about how others will treat a person with mental illness become personally relevant (Link, 1982; Link et al., 1989). This process has been referred to as "internalized stigma" and is central to understanding the inner psychological harm caused by stigma (Corrigan, 1998; Corrigan & Watson, 2002). Internalized stigma consists of the devaluation, shame, secrecy, and withdrawal triggered by negative stereotypes that one believes that others harbor (Corrigan, 1998).

Interactional discrimination. A third type of discrimination emerges in the back-and-forth between individuals in interaction. A classic study that brings this form of discrimination to light was an experimental study conducted by Sibicky and Dovidio (1986). In the study, 68 male and 68 female introductory psychology students were randomly assigned in mixed-sex pairs to one of two conditions. In one condition, a "perceiver" (random assignment here as well) was led to believe that a "target" was recruited from the psychotherapy clinic at the college. In the other condition, the perceiver was led to believe that the individual was a fellow student in introductory psychology. In fact, the target was always recruited from the class, and targets and perceivers both were led to believe that the study was focusing on "the acquaintance process in social interaction." Each member of a pair completed a brief inventory of his or her courses, hobbies, and activities. Then the experimenter exchanged the inventories and provided the perceiver with the labeling information (student or therapy client). Subsequently the two engaged in a tape-recorded interaction that was later reliably evaluated by two raters blind to the experimental conditions. Even before meeting them, perceivers rated the therapy targets less favorably than the student targets. Moreover the judges' ratings revealed that, in their interactions with therapy targets, perceivers were less open, secure, sensitive, and sincere. Finally, the results showed that the behavior of the labeled targets was adversely affected as well, even though they had no knowledge of the experimental manipulation. Thus, expectations associated with psychological therapy color subsequent interactions, actually calling out behaviors that confirm those expectations.

An important lesson for stigma researchers is embedded in these studies of interactional discrimination – substantial differences in influence and social distance can occur even when it is difficult for participants to specify a discriminatory event that produced the unequal outcome.

Structural discrimination. Finally, structural discrimination occurs when social policy, laws, or other institutional practices disadvantage stigmatized groups cumulatively over time. Prominent examples are the policies of many health insurance companies that provide less coverage for psychiatric illnesses than they do for physical ones (Schulze & Angermeyer, 2003) or laws restricting the civil rights of people with mental illnesses (Corrigan, Markowitz, & Watson, 2004). Structural discrimination need not involve direct or intentional discrimination by individuals in the immediate context (Corrigan et al., 2004); it can result from a practice or policy that is the residue of past intentional discrimination. For example, if a history of not-in-my-backyard (NIMBY) reactions has influenced the location of board-and-care homes over time so that they are situated in disorganized sections of the city where rates of crime, violence, pollution, and infectious disease are high, people with serious mental illnesses are more likely to be exposed to these noxious circumstances as a consequence. Again, although the unequal outcomes resulting from structural discrimination – unequal coverage for mental and physical health problems or undesirable location of board-and-care homes – may be readily apparent, the fact that these outcomes represent discrimination is only obvious on reflection and analysis.

Summary and Conclusion

The original labeling theory of mental illness strongly emphasized the negative consequences of labeling and stigma, whereas the critics emphasized the benefits of treatment and denied those negative consequences. The strongly stated positions in this debate brought into focus key issues that mental health sociologists have effectively pursued in subsequent research. Modified labeling theory stepped back from direct etiological claims to indicate how individuals' employment opportunities, social networks, self-esteem, and quality of life are influenced by labeling and stigma. As evidence supporting modified labeling theory grew, a potential resolution of the more strongly stated positions of the original theorists began to emerge. Both positions were partially correct: Labeling induced both positive and negative consequences in a sort of "package deal." On average, treatments and services brought benefits, whereas stigma and the discrimination it entails produced harm. As evidence from modified labeling theory and other approaches within mental health sociology evolved, a parallel explosion of interest in stigma emerged in the social science literature more generally. But with this growth came confusion about the stigma concept and whether it was a useful concept at all. Link and Phelan (2001) responded by defining stigma as a phenomenon dependent on the exercise of power that inheres in the confluence of labeling, stereotyping, setting apart, status loss, and discrimination. Both modified labeling theory and the Link and Phelan conceptualization of stigma point to the importance of attitudes and beliefs, leading to questions about how such attitudes and beliefs are faring in

trends over time. In this regard, research shows that progress toward a recognition of mental illnesses as illnesses with genetic and biological bases has emerged and grown over time, but that core stereotypes of dangerousness and incompetence have either changed little or actually become stronger. No change in social distancing responses has accompanied the increasingly medical conception of mental illness. Discrimination against people with mental illnesses occurs through multiple mechanisms, including direct person-to-person discrimination, discrimination operating through the stigmatized person, discrimination that emerges silently but perniciously through social interaction, and structural stigma.