
Stigma and mental disorder: Conceptions of illness, public attitudes, personal disclosure, and social policy

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Abstract

The end of the last millennium witnessed an unprecedented degree of public awareness regarding mental disorder as well as motivation for policy change. Like Sartorius, we contend that the continued stigmatization of mental illness may well be the central issue facing the field, as nearly all attendant issues (e.g., standards of care, funding for basic and applied research efforts) emanate from professional, societal, and personal attitudes towards persons with aberrant behavior. We discuss empirical and narrative evidence for stigmatization as well as historical trends regarding conceptualizations of mental illness, including the field's increasing focus on genetic and neurobiological causes and determinants of mental disorder. We next define stigma explicitly, noting both the multiple levels (community, societal, familial, individual) through which stigma operates to dehumanize and delegitimize individuals with mental disorders and the impact of stigma across development. Key developmental psychopathology principles are salient in this regard. We express concern over the recent oversimplification of mental illness as "brain disorder," supporting instead transactional models which account for the dynamic interplay of genes, neurobiology, environment, and self across development and which are consistent with both compassion and societal responsibility. Finally, we consider educational and policy-related initiatives regarding the destigmatization of mental disorder. We conclude that attitudes and policy regarding mental disorder reflect, in microcosmic form, two crucial issues for the next century and millennium: (a) tolerance for diversity (vs. pressure for conformity) and (b) intentional direction of our species' evolution, given fast-breaking genetic advances.

In 1999, two unprecedented events occurred in the United States, each at the highest levels of government. Both events were hugely symbolic of the public visibility of mental disorder as a serious societal problem. First, in June, President Clinton, along with Tipper Gore, sponsored the White House conference

on Mental Health, the first such conference ever held in the nation (see Rabasca, 1999). Speakers at the conference elucidated the impact of mental disorders on individuals of all ages, highlighted contemporary preventive efforts and treatments, and dispelled myths about the nature, causes, and determinants of mental illness—for example, pointing out that mental disorders transcend social class and racial and ethnic background, afflicting a sizable proportion of families across the nation. A key theme of the conference was that persons with mental disorders must be accorded the same respect and access to care as persons with any other illnesses, given that individuals with severe mental illness are disparaged more often than persons suffering from physical illnesses (Corrigan, River, Lundin, Penn, Wasowski, Campion, Mathisen, Gagnon, Berg-

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man, Goldstein, & Kubiak, 1998; Fink & Tasman, 1992; Weiner, Perry, & Magnusson, 1988).

Second, in December, the Surgeon General, David Satcher, M.D., released a precedent-setting report on mental disorders in America, the first such report ever to emanate from that office (U.S. Department of Health and Human Services, 1999). The report highlighted critical national needs in the areas of conceptualization, research, prevention, and treatment. It gave explicit recognition to the vast numbers of afflicted individuals; the lack of appropriate diagnosis; the extremely poor access to care for most citizens; and the devastating personal, familial, and societal costs attributable to mental disorder. For example, based on findings from the Global Burden of Disease Study, the report noted that, in the United States, "mental disorders collectively account for more than 15 percent of the overall burden of disease from *all* causes and slightly more than the burden associated with all forms of cancer" (p. 3; see Murray & Lopez, 1996, for a more complete description of the Global Burden of Disease Study). Indeed, worldwide, 4 of the 10 leading causes of disability are mental disorders (depression, schizophrenia, bipolar disorder, and obsessive-compulsive disorder), with depression soon to become the number one cause of disability among those over 5 years of age. Such data clearly underscore the urgency of preventing and treating mental disorders and of promoting mental health. Devastatingly, however, approximately two thirds of all persons with mental disorders do not seek treatment (Kessler, Nelson, McKinagle, Edlund, Frank, & Leaf, 1996; Regier, Narrow, Rae, Mandercheid, Locke, & Goodwin, 1993); stigma associated with mental illness appears to be a crucial deterrent in many cases. In fact, the report declared that stigma was the "most formidable obstacle to future progress in the arena of mental illness and health" (U.S. Department of Health and Human Services, 1999, p. 3).

In addition to the White House conference and the Surgeon General's report, another key theme from the end of the last millennium is the ever-increasing numbers of personal and

family accounts of mental disorder that have mushroomed in the popular and scientific literature (e.g., Sommer, Clifford, & Norcross, 1998). This set of disclosures supplements a long history of depiction of mental illness in visual and written arts (Gilman, 1988) as well as seminal personal accounts from the earlier part of the 20th Century (e.g., Alvarez, 1903; Beers, 1908/1945; Kaplan, 1964; Schreber, 1903/1955). As formerly with cancer and more recently with AIDS—two diseases formerly considered "unspeakable" but now lying in the realm of acceptable discourse (e.g., Sontag, 1978/1989)—mental disorder appears to be emerging from a legacy of silence and shame to enter public discussion and debate. In this regard, Wahl (1999b) recently provided systematic first-person accounts of stigma related to mental disorder from national survey and interview data, yielding a sobering quantitative and narrative picture regarding the pernicious effects of stigmatization.

In addition, policy initiatives towards mental disorder are in transition. The federal government has begun to implement a policy of "parity" for mental health insurance coverage for over 10 million federal employees (Martin, 2000). At the same time, municipalities, counties, states, and the federal government are searching for means of compensating for the legacy of neglect ushered in by the worst elements of the state institution movement beginning in the late 1800s and the well-intentioned but poorly funded deinstitutionalization movement of the past several decades. Important international efforts to recognize mental health needs and destigmatize mental disorder also are underway (see James, 1998). We discuss such efforts in more detail subsequently.

Finally, public awareness campaigns have taken on a new level of sophistication and candor. For example, the National Mental Health Awareness Campaign has recently aired media "commercials" about depression, suicide, and eating disorders on MTV, and the major networks are soon planning to pick up on these realistic, multiethnic depictions. (For details, see www.NoStigma.com.)

Considering such political recognition, per-

sonal and family disclosures, policy initiatives, and media exposure, it is difficult to escape the conclusion that societal attitudes and responses toward mental disorder are undergoing a “sea change.” As we enter the new millennium, the time is ripe for a critical evaluation of several pertinent questions. Specifically, what is the evidence for stigma and discrimination? Do they continue to exist regarding mental disorder? If so, how problematic are they? In terms of background, in what ways, across history, have underlying conceptions of mental disorder shaped the perspectives of society and families regarding care and treatment? Are our current perspectives more enlightened? How should stigma be specifically defined, and what is its importance for personal adjustment, familial reaction, and policy? What developmental themes are salient regarding stigma’s influence across the life span? Does the field of developmental psychopathology have contributions to make regarding our understanding of stigmatization? In what ways does the current genetic and biochemical zeitgeist influence stigma and prejudice—does it reduce the perception of control and culpability, thereby decreasing aspersion; or does it paradoxically increase stigma by increasing the perception of inborn differences? What does research tell us about the optimal ways to reduce stigmatization, bias, and discrimination? Which kinds of policy changes appear most promising? In the end, can increased openness, exposure, and access to treatment put a significant dent in the legacy of stigma regarding mental disorder? Although addressing such issues fully would require far more space than allotted herein, we focus on these and related questions in this article. Our ultimate aim is to elucidate the kinds of changes in policy, attitude, and behavior that could, at multiple levels, reduce the legacy of stigma that pertains to mental disorder.

Presence and Impact of Stigma

Amidst the current flurry of written materials, web sites, personal accounts, and policy initiatives of recent years, we state at the outset our belief that stigmatization of mental illness

continues to be a problem of deep importance and lasting impact. At the levels of policy and economics, such realities as lack of housing, job discrimination, disastrous deinstitutionalization policies, and lack of medical insurance and care are rampant (see Holmes, Corrigan, Williams, Canar, & Kubiak, 1999; Torrey, 1997). Similarly, at the levels of individuals and families, self-blame, silence, shame, and familial mystification and mistrust are pervasive (e.g., Tessler & Gamache, 2000; Wahl, 1999a, 1999b). Indeed, families clearly perceive stigma to be a major problem for themselves and the afflicted family member (Lefley, 1992; Wahl & Harman, 1989). Regarding the media, inaccurate and unfavorable depictions of individuals with mental disorders are salient, with particular emphasis on bizarreness, social incompetence, and propensities toward violence (Torrey, 1997; Wahl, 1992, 1995). In addition, particular age groups, such as children and the elderly, may be disproportionately affected by stigma. For example, the Surgeon General’s report discusses barriers that exist in the organization and financing of services for elderly persons with mental illness, including problems with Medicare, Medicaid, nursing homes, and managed care (U.S. Department of Health and Human Services, 1999).¹

Regarding current perspectives, we quote three authoritative sources (selected from a host of possible candidates) on the impact of stigma regarding mental disorder. First, ac-

1. A key example of society’s perceptions of persons with mental illness can be found in public attitudes toward the legal culpability of those diagnosed with a psychiatric disorder. Following the “not guilty by reason of insanity” verdict received by John Hinckley, Jr., following his assassination attempt on then President Ronald Reagan, many states sought to emulate the state of Michigan’s “guilty but mentally ill” verdict. The rationale was to hold persons with mental disorders responsible for their actions while recognizing their mental illnesses and making treatment available. By mid-1998, an estimated 283,000 offenders with a mental illness were held in the nation’s federal and state prisons and local jails (Ditton, 1999). Although states and localities are increasingly mandated to provide mental health treatment for inmates, only 60% of inmates with mental disorders in state or federal prisons and only 41% of those in jails were receiving any mental health treatment (Ditton, 1999; Torrey, 1997).

According to Wahl (1999b), "It is still socially acceptable for cartoonists, policy-makers, health-care professionals, and the public-at-large to mock, stereotype, avoid, and otherwise denigrate people who experience a mental illness" (p. ix). Second, Corrigan and Penn (1999) state that "stigma's impact on a person's life may be as harmful as the direct effects of the disease" (p. 765). Third, Attkisson, Cook, Karno, Lehman, McGlashan, Meltzer, O'Connor, Richardson, Rosenblatt, and Hohmann (1992) contend that "research about stigma is not merely a curiosity: It is a vital component of the effort to enable severely mentally ill people to lead decent lives in the community" (p. 619). Overall, the consensus from policymakers, patient support groups, clinicians, and the research community is that stigma is an issue of paramount importance.

Evidence from empirical research

A thorough review of empirical research on stigmatization is far beyond the scope of this article (see, e.g., reviews by Link, Cullen, Mirotznik, & Streuning, 1992, and Wahl, 1999b, chap. 2). Investigations on the stigmatization of mental illness began in earnest in the mid-20th century; the detailed reviews of Rabkin (1972, 1974) are essential for coverage of such early research. We note also that Goffman's (1963) qualitative analysis of social dynamics surrounding stigma is still seminal.

Two key conclusions emanated from investigations in the 1950s and 1960s: (a) individuals with mental disorders were socially rejected and (b) both the behaviors associated with severe mental illness and the label itself were associated with fear, distrust, and dislike (see, e.g., Nunnally, 1961). Indeed, in investigations utilizing measures of "social distance"—meaning the degree of closeness or distancing desired by a research participant with regard to a hypothetical person (see Whatley, 1959)—mental disorder was ranked dead last (i.e., most distance desired) among 21 different disability groups (Tringo, 1970). Whereas Rabkin (1974) reports that the early experimental and survey research alternated between utter pessimism (i.e., that those with

a mental disorder were uniformly shunned and stigmatized) and some optimism (i.e., that the movement toward community treatment and higher degrees of public awareness mitigated this general trend), the overall conclusion was that individuals with a mental disorder were clearly the subject of bias and prejudice. Primary reasons for stigmatization were the unpredictability and lack of accountability of the behavior patterns and the fear engendered by the label of mental illness itself.

By the 1980s, research on stigma had advanced to higher levels of sophistication (see, e.g., Jones, Farina, Hastorf, Markus, Miller, & Scott, 1984). Link et al. (1992) cogently appraised this second generation of research in the field, emphasizing the overwhelming evidence in support of the pernicious effects of stigmatization but also pointing to alternative conclusions from some reports. Specifically, several investigations from the 1970s and 1980s held that the effects of stigmatization were overstated (e.g., Crocetti, Spiro, & Sissasi, 1974; Weinstein, 1983). Such evidence, however, was based on surveys (of either persons with mental disorders or the general public), which are severely compromised because of the strong tendency for survey responses to be colored by social desirability (see later section on Assessment of stigma) or on experimental investigations that did not fully disentangle the disturbed behavior patterns of individuals with mental disorder from the mental illness label itself. In addition, the recent report of Swindle, Heller, Pescosolido, and Kikuzawa (2000) found some evidence for reduction of stigma over the last 40 years in the United States; but its conclusions are questionable because of the outmoded terminology ("nervous breakdown") employed.

Indeed, a far larger number of methodologically stronger investigations have provided clear evidence that mental disorder is the subject of strong stigmatization and discrimination (e.g., Link & Cullen, 1983; Mechanic, McAlpine, Rosenfield, & Davis, 1994). For example, in a series of rigorous and creative experimental investigations, Farina, Allen, and Saul (1968) and Farina, Gliha, Boudreau, Allen, and Sherman (1971) found that both normally functioning college students and pa-

tients with mental disorders altered (negatively) their interactional style with interviewers when they were led to believe that the interviewer had knowledge of their (i.e., the participants') prior mental hospitalization. The independent variable—belief that the interviewer had such knowledge—was experimentally manipulated; the interviewers actually had no such knowledge. Nonetheless, participants in the experimental condition interacted with more tension, anxiety, and negativity and were more likely to be rejected by the interviewer–interaction partner. The belief or expectation that interpersonal contacts know about mental illness thus itself damaged the social interactions of persons with mental disorders (for related research with similar conclusions, see Link, 1987; Siblicky & Dividio, 1986).

Furthermore, in a rigorous investigation that teased apart the effects of (a) the label of mental illness and (b) the types of disturbed behavior presented, Link, Cullen, Frank, and Wozniak (1987) found that ascriptions of mental illness evoked expectations of dangerousness, which increased social distance regardless of the levels of disturbed behavior presented to respondents. Thus, both disturbing behavior and the label of mental disorder fuel stigmatization. Tellingly, in another experimental study Page (1995) provided evidence that landlords quickly made rental apartments “unavailable” if the prospective renter disclosed a history of mental hospitalization. Page contrasted these findings with those from some survey research in which the general public did not disclose discriminatory attitudes, contending that self-reported attitudes in surveys may belie the public's actual beliefs and practices. Finally, Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999) recently found that, although public recognition of mental disorder and its multifaceted causation has increased, desire for social distance and perception of dangerousness is still strong.

In all, despite a handful of counterexamples from investigations with inferior methodology, the bulk of attitude-based research—and nearly all of the corpus of more careful experimental research—provides strong evi-

dence for the pernicious effects of stigmatization. Both the aberrant behavioral patterns of those with mental disorders and the label of mental illness (or the information that one has received treatment for mental illness) receive disapprobation. Perceptions of dangerousness are particularly salient (Link et al., 1999). Because no quantitative reviews are available, measures of effect size cannot be neatly summarized. Nonetheless, effects from both early (e.g., Tringo, 1970) and more recent (e.g., Page, 1995) research point to the large and clinically meaningful impact of stigmatization.

Other types of evidence

We are not convinced, however, that empirical research has even begun to document the actual levels of harm related to the stigmatization of mental disorder. It is one thing to note effects of experimental manipulations, as compelling as such findings have been, but it is another to contemplate the potentially large-scale effects of stigmatizing attitudes and discriminatory behavior for millions of persons with mental disorders in our society, much less across the world. As noted above, it is not a simple task to document empirically the impact of stigma, in part because of methodologic difficulties in getting people to admit to prejudicial attitudes in survey research (e.g., Brockington, Hall, & Murphy, 1993; Kreisman & Joy, 1974) and in part because of the small size of most extant surveys. At another level, however, the very pervasiveness of stigmatizing attitudes (Wahl, 1999a) may delimit its detection in research investigations.

Regarding this point, we see parallels between measuring stigma towards mental disorder in our society and measuring anti-Semitic attitudes in nations like Germany in the 1930s. In analyzing the latter topic, Goldhagen (1996) incisively observed the difficulty inherent in inferring anti-Semitic attitudes and beliefs in pre-World War II Germany from analysis of individuals' belief patterns. Such a counterintuitive notion, contends Goldhagen, is the case “precisely because the anti-Semitic creed was essentially unchallenged in

Germany . . . far less 'evidence' as to the existence and nature of each people's beliefs . . . rises to the surface" (p. 33). In other words, when the cognitive models of a given society are so monolithic and uncontested that they become part of nearly every member's world view, there is little individual evidence for that view or model, because it is incorporated into everyday discourse and practice without special notation or commentary. Goldhagen contends, for example, that attempts to measure pro-democracy attitudes in contemporary American society would be similarly thwarted, precisely because of the thorough acceptance of such attitudes. In Germany, the history of anti-Semitic policies and practices had become so pervasive as to escape detection from analysis of individual viewpoints. Only larger societal policies and literature from the time period yield conclusive evidence of the virulent anti-Semitism of the time (Goldhagen, 1996).

Similarly, we contend that the fear and scapegoating of persons with mental disorders is extremely pervasive in our culture. Witness, for example, such occurrences as children's first name-calling of disliked peers as "crazy" or "nuts" or "retarded," the commonplace newspaper headlines of violent acts of "mentally deranged" individuals, the only recently challenged notion that involuntary mental hospitalization was appropriate treatment for uncontrolled or bizarre behavior, the deinstitutionalization policies that have placed cost savings ahead of quality care, and the pervasive discrimination in employment settings against persons with mental disorders (e.g., Wahl, 1999b). Hence, it may be difficult to find specific, supportive evidence in examination of private journals, questionnaires, or other records of society's members. More telling and more accurate, we believe, are (a) such statistics as those regarding discriminatory insurance policies and community fears regarding housing for former mental patients (Farina, 1998; Page, 1995; U.S. Department of Health and Human Services, 1999; Wahl, 1999b); (b) evidence regarding the lack of access to services for the majority of persons with mental disorders (Kessler et al., 1996); (c) stigmatizing media portrayals of mental

disorder (Torrey, 1997; Wahl, 1995); and (d) personal and family accounts of the struggles of individuals with mental disorders and their families regarding such issues as disclosure, shame, and secrecy (e.g., Duke & Hochman, 1992; Hinshaw, 2000; Jamison, 1995; Lachenmeyer, 2000; Neugeboren, 1998; Shannonhouse, 2000; Styron, 1990; see also the first-person and family accounts in each issue of *Schizophrenia Bulletin*). The representative, national survey of Wahl (1999b) expands upon such publications by providing both quantitative and qualitative evidence of the multiple levels through which stigmatization influences the lives of persons with mental disorders. In short, formal research data on attitudes and stigma, although plentiful and compelling, pale in comparison with economic, media-related, and narrative evidence.

To set the stage for the present article, we direct the reader's attention to a special section of *The Lancet* that appeared several years ago (James, 1998). Here, in a collection of brief essays, autobiographical statements, poems, and visual arts, contributors to this prestigious medical journal spoke vividly about the contention that stigma may well be, in fact, the most important issue facing the mental health field. Taking this issue head on, Sartorius (1998) eloquently stated the following:

Why then invest in programmes that might change attitudes and improve the acceptance of those with mental illness? Because stigma and discrimination are the most significant obstacles to the development of mental health care and to ensuring a life of quality for those suffering from mental illness. Because there is enough money around to help those with mental illness and their families but it is not available because of the attitude of most decision makers and a large part of the general public towards mental illness and all that surrounds it. Because all other efforts that are undertaken to treat mental illness and rehabilitate people impaired by it are likely to be of little use if . . . we cannot ensure that patients and their families do not suffer from discrimination, exclusion, and injustice because of their illness. (p. 1058)

In the foreword to the *Lancet* section, James (1998) contended that a diagnosis of mental illness is indeed still devastating, given that it is

linked with job loss, relationship breakdown, and social rejection. Why is mental illness so subject to stigmatisation? Fear is one factor. Mental illness is perceived to be dangerous, and the rare but widely publicised violent incidents associated with mentally ill patients serve to fuel that fear. An element of personal culpability is another common perception, which leads to the belief that treatment will not help and may even be inappropriate. Assumed communication difficulties and social non-productivity reinforce the tendency to discriminate against mental illness . . . losing one's mind is for many the worst imaginable illness, which may prove the biggest obstacle to ridding mental illness of all forms of stigmatisation. (p. 1048)

We agree that the stigmatization of mental illness continues to exert a dominating influence on all levels of research and care. To reiterate, such indicators as job discrimination, lack of adequate insurance coverage of treatments for mental disorder, deplorable conditions in many institutional facilities, deinstitutionalization practices driven by cost savings rather than human dignity, and legacies of despairing and nonproductive lives are rampant. Given our far-from-complete knowledge about mental functioning in general and psychopathology in particular, severe mental disorder raises thorny, unanswered questions regarding etiology, treatment, and care in and of itself. When blame, castigation, branding as deficient and dangerous, and exclusion from society's mainstream are added to the equation, the odds against rehabilitation are considerably magnified. We note also, however, that stigmatization provides an important window on coping strategies and positive outcomes for many resilient individuals with mental disorders (e.g., Hinshaw, 2000; Wahl, 1999b, chap. 9). In sum, despite the growing sense of openness and change and despite efforts and inroads that have been made, the journey ahead is still long.

To begin our analysis, we take a brief tour of key historical conceptions of mental disorder, concluding with the neurobiological and genetic approaches that are in ascendancy today. Our goal is to link societal attitudes with the predominant conceptualizations of mental disorder from different historical periods. An implicit question throughout is the degree of

progress that we have made in explaining and accounting for mental disorder: Have our presumably more scientific and accurate accounts served to decrease stigma and discrimination, or do fundamental societal attitudes of fear and prejudice continue to flourish? If so, then what sorts of changes would need to accompany our ever-increasing scientific knowledge?

Historical Conceptions of Mental Disorder

Despite the tendency to characterize historical trends in progressive, sequential fashion, historical "eras" are neither linear nor mutually exclusive. Cyclic processes are closer to the truth, wherein themes of biological versus environmental causation or of banishment versus humane care wax and wane over time—albeit with gradually increasing sophistication on the part of scientific accounts. Indeed, the perspective that mental disorder is related to imbalances in biological systems—a viewpoint clearly in ascendancy today in terms of neurotransmitter systems (Charney, Nestler, & Bunney, 1999; Siever & Davis, 1985)—has its origins in the work of Hippocrates nearly 2500 years ago (Durand & Barlow, 2000). In this section, we trace several historical perspectives, highlighting that (a) a fundamental reaction to deviant behavior has been one of fear, castigation, and derision, regardless of worldview and (b) when such perspectives also incorporate the view that individuals with mental disturbances are subhuman, extreme practices of exclusion, including torture and even extermination, are not far behind. Our coverage is, of necessity, cursory; more complete historical views are both fascinating and important to consider (e.g., Alexander & Selesnick, 1966; Foucault, 1988; Mora, 1992; Zilboorg & Henry, 1969).^{2,3}

2. We note, in passing, historical perspectives regarding the role of emotion (and emotion–cognition disequilibrium) in the unfolding of psychopathology. Several themes are present in earlier views (see Cicchetti, Ackerman, & Izard, 1995). One suggests a dysregulating, negative role for the emotions, where psychopathology is conceptualized as the result of unrestrained emotions. Another theme revolves around the regulating role of reason, which is seen as the check by which emotions can be kept under control. From this view-

Demonology

For much of human history, severely disturbed behavior was viewed as the product of supernatural forces, reflecting a fundamental battle between good and evil. Demonology has thus been the perspective on dysfunctional behavior with the greatest longevity (Alexander & Selesnick, 1966). As a vivid example of the longstanding nature of such beliefs, fossil evidence for trephination—the surgical cutting open of circular pieces of skull, presum-

point, psychopathology is understood as resulting from deficits in reason that allow the emotions to become unrestrained. A third, albeit less frequent theme is that psychopathology results from the imbalance between cognition and emotion. Implicit in all of these perspectives is that emotion and reason are viewed as distinct domains, reflecting a key split in both popular and scientific views—namely, that reason is controlled and good, whereas emotion is irrational and destructive. Only relatively recently has scientific credence been given to the beneficial effects of emotion for fully integrated and regulated behavior (Emde, 1980; Salovey, Rothman, Detweiler, & Steward, 2000; Sroufe, 1979, 1996).

3. In addition, space does not permit a separate historical accounting of the status of children and the treatment of child and adolescent disorders. We mention several key themes for the interested reader. (a) Childhood was conceived as essentially indistinguishable from adulthood until the 17th century (Aries, 1962); the institution of “childhood” as qualitatively separate from adulthood is a relatively recent construction. (b) It was not until the 19th century that child psychopathology began to emerge, initially as a largely descriptive field. Only then did systematic protections for children begin to emerge, including compulsory education, child labor laws, and improved health practices (White, 1996). (c) By the end of the 19th century and the beginning of the 20th century, professions and services for troubled children were greatly expanded (e.g., juvenile courts, foster care, asylums for orphans), which were attributable to such forces as the rise of developmental and clinical psychology, increased awareness within psychiatry and pediatrics, concern with delinquency, the rise of child welfare and social reform movements, and the appearance of Mental Hygiene and Child Guidance movements (see Parry–Jones, 1994; White, 1996). (d) During the past century, psychoanalytic, social learning, community mental health, and family therapy schools all promoted important perspectives on the psychopathology of childhood. However, it is still true that the majority of children with diagnosable mental disorders do not receive identification or treatment and that stigmatization of the child and the family is a key barrier to appropriate care.

ably to release evil spirits—dates from over 500,000 years ago (Comer, 1999). The ancient Greeks blended demonologic–magical and biological (i.e., humoral) theories and treatments for mental disturbance (see below), but such aberrant behavior still invoked considerable shame in Greece (Simon, 1992).

In the more recent historical past, namely the Middle Ages and Renaissance, exorcisms (designed to coax evil spirits from the body), starvation and torture, and execution of witches by fire (in Europe and in Salem, Massachusetts) were viewed as necessary means of ridding the person of evil, satanic influences. Clearly, when the dominant worldview is that inexplicable behavior is evidence of darkness and evil, few means will be spared to rid the person of such influence (Mora, 1992). To the extent that disturbed behavior is viewed in such moralistic terms, we can expect that extreme measures will be taken to purge the evil, with justification provided by the forces of religion and “right” living. Despite the downfall of overtly demonologic perspectives in modern times, moralistic ascriptions still underlie public attitudes towards mental disorder—see, for example, the repulsion and blame with which homelessness, bizarre behavior, substance abuse, and lack of control are currently viewed (e.g., Weiner et al., 1988), as well as the more subtle blaming of seriously mentally ill persons for their plight (Sontag, 1978/1989).

Medicalization and asylums

As noted above, Hippocrates believed that abnormal behavior originated from internal, bodily causes, particularly imbalances of the four basic fluids (yellow bile, black bile, phlegm, and blood). Advocated by Plato and Aristotle and further promoted by Galen in the 2nd century A.D. (see Kagan, 1994), this medical tradition was quite modern in many respects. Hippocrates believed the brain to be the seat of mental and emotional functioning, and treatments for extreme imbalances (e.g., for melancholia, believed to reflect an excess of black bile) relied on biological and environmental manipulations to restore the imbalances. Thus, mental disturbance was believed

to be an illness and not an indication of possession by evil spirits.

At the beginning of the Renaissance, European doctors, looking to the classics for guidance, rediscovered such biological approaches. For example, Weyer, the “father” of the modern science of psychopathology, was a 16th-century German physician who contended that the mind, like the body, was susceptible to illness (Comer, 1999). Providers once again took up biological treatments for mental conditions, including such practices as bloodletting and induced vomiting. Thus, we note that if biological theories and treatments are based on inadequate knowledge of underlying pathology, then there is no guarantee that related interventions will be benign—consider the recent history of such “treatments” as lobotomies and seclusion.

Humane care did arise at such sites as Gheel, in Belgium, reflecting the view that mental disorder was a treatable sickness as opposed to a sign of evil (Durand & Barlow, 2000). With its system of foster-care-like protection, this “colony” was a forerunner of modern community mental health interventions. Yet economic pressures, along with a pervasive attitude that individuals with mental disorders were frightening and essentially subhuman, fueled the growth of asylums—converted hospitals and monasteries devoted to warehousing the mentally ill in dungeon-like filth and squalor. By the 16th and 17th centuries, at such locales as Bethlehem Hospital in London (“Bedlam”) and the Lunatics’ Tower in Vienna, local citizenry paid for the privilege of touring the facilities and observing the inmates, who were chained and often raving. To brand such “treatment” as subhuman is an understatement. Asylums became the predominant modality for housing the mentally disordered, even in the New World. This sobering historical trend points out how quickly a supposedly more benevolent ascription (i.e., “mental disorder” instead of possession) can lead to extreme maltreatment, when the signs of disorder are irrational and frightening behaviors, when the afflicted individual is still blamed for weakness or vulnerability, when efficacious treatments are not available, and when underlying motivations of profes-

sionals and “well” individuals are exclusionary (see also Goffman, 1961, and Rabkin, 1974). In addition, following the Reformation, notions of individual conscience, will, and guilt had come to replace the dominant theocratic beliefs of the previous centuries (Mora, 1992), doubtless fueling stigmatization and blame for disordered emotions and behavior.

Indeed, although attribution theory tells us that ascription of disordered behavior and emotion to illness (a noncontrollable cause) should theoretically lead to more benign appraisals and consequences, the label of mental disorder or mental illness can indeed be accompanied by anger, punitive reactions, and exclusionary “treatment” (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Weiner et al., 1988). Clearly, mentally disturbed behavior is still viewed as far more controllable than so-called physical illnesses; when the behavior in question is particularly frightening or noxious, fear appears to overtake more humane social reactions. The afflicted person may come to be blamed for susceptibility to having become “ill,” especially given that the symptoms of the illness are disturbed emotions and behavior patterns, over which people are typically held to exert control. Note, then, an intriguing parallel between demonologic and medical-model perspectives: both attribute abnormal behavior to noncontrollable causes (i.e., demonic influence or mental illness), with the potential for increasing sympathy toward and reducing blame of the afflicted individual. Yet both also have led to extremely harsh, punitive reactions and interventions, because of fear, the tendency to blame the person for susceptibility to either “possession” by spirits or illness, and the typical perception that behavior and emotion should be controllable and controlled.

Sontag (1978/1989) has eloquently argued that poorly understood diseases throughout history (e.g., tuberculosis, cancer) become metaphors—for vulnerability, weakness, and a host of blameworthy personality characteristics. Furthermore, in the cases of AIDS and mental disorders, the perception that the person is responsible (through either acts of com-

mission or vulnerable characteristics) leads to ascriptions of indulgence and “delinquency,” which clearly color society’s responses. The history of our species is permeated with repeated tendencies for social entities to seek and define ingroups and outgroups—a distinction perhaps necessary for survival when enemy clans, tribes, or nations are threatening, but one that can easily lead to stereotyping and prejudice in the absence of actual threat (Brown, 1965). When outgroups become branded as less than human—an ascription that may be fueled when persons exhibiting bizarre, irrational behavior are deemed as either possessed or ill—the conditions are ripe for exclusion, brutality, imprisonment, and even genocide. Moreover, the concept of efficacious treatments and their availability is again relevant, as fears accompanying lack of treatment for disorders may lead to exclusionary policies. For example, the existence of sanitarium for those with tuberculosis, and of leper colonies for persons with leprosy, are but two examples of medical conditions that engendered fear and subsequent isolation of affected individuals. We posit that emphasizing the essential humanity of even the most disturbed individuals is necessary to counteract strong societal tendencies to exclude and punish, even under the name of “treatment.”

Moral treatment and state institutions

Around the time of the French Revolution, Pinel in France and Tuke in England began fundamental reforms in care for the mentally disordered. Philippe Pinel demanded the taking away of chains in the asylums of La Bicetre and La Salpetriere, replacing warehousing with humanitarian ideals as well as sunlit lodging and supportive advice. William Tuke established the York Retreat, which constituted country housing in Northern England emphasizing rest, prayer, and manual labor (Comer, 1999). These latter models of so-called “moral treatment” were based on the notions that mental disorders would respond to support and quiet living and that afflicted individuals were fully human but highly stressed, neither demonized nor possessed by runaway biology. Moral treatment denigrated

the use of restraints and seclusion and focused on a general program of healthy living to enhance self-control (see Brizendine, 1992).

Benjamin Rush promoted such ideals in the nascent United States, suggesting, for example, that attendants be well trained, listening to patients and walking with them. When the educator and reformer Dorothea Dix, who succeeded in moving mentally ill persons in the United States from poor houses, promoted state-funded mental hospitals throughout the country, her goal was to infuse them with the principles of moral treatment (Comer, 1999). Her words to the Massachusetts State Legislature in 1843 exemplify her aspirations: “I come as the advocate of helpless, forgotten, insane, idiotic men and women . . . of beings wretched in our prisons and more wretched in our almshouses” (cited in Comer, 1999, p. 13). Dix’s reform movement led to most states’ adoption of legislation to create state facilities.

By the latter part of the 19th century, however, the movement towards funding and building of state institutions had become itself a nightmare, with overly large and overcrowded facilities recapitulating many of the horrors of asylums from earlier eras (Brizendine, 1992; Sarason & Doris, 1969). The placement of such institutions a day’s carriage ride outside of major cities, along with their being populated largely with immigrant individuals who were the subject of prejudice, further isolated individuals with mental disorders or mental retardation and fueled longstanding attitudes of discrimination and neglect. Noteworthy here are the humanitarian origins of state facilities and the subverting of these initial aims by means of governmental neglect, lack of sustained funding, institutional isolation, and underlying fear and prejudice. Moral treatment’s rural venues and integration of afflicted individuals into local life could not be sustained when large institutional facilities came to replace in-home care and individual attention. State hospitals and state “schools” for the mentally retarded were a growth industry until the 1950s, when psychotropic medications and the subsequent community mental health movement led to precipitous reductions in censuses

(Blatt & Kaplan, 1966; Deutsch, 1948; Johnson, 1999).

20th-Century models

Given the increasingly complex and disparate strands of conceptual models and public attitudes regarding mental disturbance in the “modern” era, a description of 20th-century perspectives could easily take on book length. In our selective coverage, we point out first that in the latter half of the 19th century there was a tremendous resurgence of biological views about mental disorder, including (a) phrenology (the assessment of normal and abnormal personality through the patterns of bumps on the head); (b) preliminary behavior genetic investigations (e.g., those of Galton), demonstrating the heritability of many animal traits and of such human issues as criminality, eminence, and intellectual deficiency; (c) the “medical model” of Kraepelin (1921/1987) that emphasized onset and developmental course as key means of differentiating psychiatric syndromes; and (d) most dramatically, the revelation that the psychotic symptoms of general paresis had a bacterial (syphilitic) origin. Because of a lack of effective biological interventions beyond the treatment of syphilis, however, and because of the association of Kraepelinian nosologies with eugenic movements in Germany (Barondes, 1998), such perspectives faded, particularly in America.

We pause briefly to consider an unavoidable fact of the eugenic legacy of the behavior genetic views—namely, the forced sterilization of mentally retarded (and mentally disordered) persons in the United States and Germany and the extermination of such individuals in Nazi Germany, both performed in the name of eugenics (Sarason & Doris, 1969). As biological explanations of psychopathology ascend today and as more sophisticated means of “pruning” the gene pool come into existence, society must carefully appraise the implications, a point to which we return at the conclusion of this article.

In the United States, the predominant view came to be psychodynamic–environmental, with the wholehearted acceptance of Freudian postulates of early familial origins of mental

dysfunction and the value of psychotherapeutic means of treatment. The “locus” of psychopathology thus shifted to internal wishes and fantasies and to particular means of child rearing. Formal classification was eschewed as dynamic formulations were viewed as central to conceptualizing psychopathology. The lack of success of insight-oriented treatments for persons with psychotic-level mental disorders and other severe psychopathology, however, contributed to the warehousing of these individuals in large state facilities.

Once again demonstrating the cyclic nature of conceptual points of view, the accidental discoveries and subsequent development of more effective psychotropic medications in the 1950s and 1960s (e.g., antipsychotic, antidepressant, and anxiolytic agents) led to a resurgence of biological perspectives and the search for biologic underpinnings of psychopathology. Such medications have led to considerable benefits but also have had limitations, side effects, and a “cycle” of initial optimism followed by more realistic appraisals of benefit and cost (Valenstein & Charney, 2000). At the same time, in an attempt to place the field of psychopathology on more positivistic, scientific grounding, formal nosologic systems became priorities and psychiatry, in particular, limited its scope to mental illness instead of wider social or cultural perspectives (Wilson, 1993). Kraepelinian classification has witnessed a tremendous resurgence in the past 25 years, as exemplified by the latest editions of the DSM (American Psychiatric Association, 1980, 1987, 1994).

At a broader level, multiple paradigms of mental disorder and “mental health” are today competing for ascendancy, with a plethora of theoretical orientations (e.g., neo-Freudian, social learning, cognitive, humanistic existential, family systemic, somatic/biochemical, and genetic, to name only the most salient). Rather than elaborating on such “schools” of psychological and psychiatric thought, we focus briefly on three themes from the last 40 years with particular implications for mental disorder and its stigmatization.

Antipsychiatry. Reacting against the growing reinstatement of a medical model of mental

disorder, antipsychiatrists such as Laing (1965) and Szasz (1970) fundamentally challenged the very existence of mental illness as a parallel to medical disease (see also Micalé & Porter, 1994). It is noteworthy that several critics of the typical “public awareness” programs of educating citizens about medical-model views of mental disorder have invoked these antipsychiatric models (see Morrison, 1980; Sarbin & Mancuso, 1970). Implications were far reaching: whereas forced treatment and hospitalization were clearly at odds with the antipsychiatry model, notions of personal responsibility for “problems in living” tended to place the locus (and even the blame) for severely disorganized and irrational behavior on the individual and his or her rational choices, on discordant family interactions, or on a lack of ecological “fit” between community and individual (Morrison, 1980). Extreme antipsychiatric views have fallen dramatically into disfavor today. Yet the cautionary note from such perspectives that today’s socially deviant behavior may become tomorrow’s syndrome or disorder (thus delegitimizing any social or political meaning of the behavior) must clearly be heeded.

Indeed, the field is still grappling with how to define the essence of mental disorder. Thoughtful analysts such as Wakefield (1992, 1999) have attempted to place definitions of mental disorder on scientific footing by positing an evolutionary basis to its existence. Specifically, under Wakefield’s dual criterion of “harmful dysfunction,” the behaviors in question must not only be impairing or deviant (i.e., “harm” as the social-cultural definition) but must also represent clear dysfunction in an evolutionary sense. As the field debates the cultural and contextual specificity versus universality of mental disorder, critical appraisal of such attempts at scientific definition of mental disorder is an active enterprise (see Clark, 1999).

Community mental health/deinstitutionalization. With origins in several trends and themes—Scandinavian models of normalization, humanitarian ideals, civil rights political climates, and community psychological principles of prevention—the community mental

health movement gained momentum in the 1960s (Albee, 1996; Cowen, 1973; Johnson, 1990; Joint Commission on Mental Illness and Health, 1961). As noted earlier, the use of psychotropic medications had begun to lead to precipitous drops in the censuses of mental hospitals by the late 1950s (the peak year of institutionalization had been 1955). Moreover, the political climate was shifting towards protection of civil rights and of access to care for previously disenfranchised members of society. In one of the key pieces of domestic legislation enacted during his administration, President Kennedy promoted the Community Mental Health Centers Act of 1963. For the first time, the federal government mandated a series of community-based alternatives to hospital care. Although critics have contended that this act merely moved the pervasive “medical model” into storefronts and other community locations, avoiding a more fundamental community psychological orientation (e.g., Rappaport, 1977), it nonetheless signaled a key change regarding societal responsibility for care of mental disorders.

Deinstitutionalization proceeded quickly, even dramatically once momentum had built in the 1960s. Indeed, as one example, Massachusetts housed 23,000 persons in mental hospitals in the 1960s but only 2,000 by the mid-1980s (Farina, Fisher, & Fisher, 1992). Overall, the lack of adequate funding for community mental health facilities led, by the 1980s, to a crisis of rampant unemployment, considerable homelessness, pervasive despair, and even noteworthy rates of premature deaths among the hundreds of thousands of deinstitutionalized individuals across the nation (Farina et al., 1992; Jencks, 1994; Miringoff & Miringoff, 1999; Torrey, 1995, 1997). No longer hospitalized, such individuals were unaided by an infrastructure to provide adequate community support, care, or treatment. Presently, estimates of the percentage of the adult homeless population who suffer from some type of severe and persistent mental illness range from 20 to 37% (Federal Task Force on Homelessness & Severe Mental Illness, 1992; Torrey, 1997). In addition, approximately 5% of the estimated persons who have a serious

mental disorder are homeless at any given point in time (Federal Task Force on Homelessness & Severe Mental Illness, 1992).

Thus, as with the moral treatment movement of the early 1800s, the humanitarian ideals of the “normalization” and deinstitutionalization movements became overrun by concerns over cost containment and a lack of mandate for alternative care. The clear lesson is that humanitarian ideals are far from sufficient and that planning of and funding for integrated care must accompany even the best-intended plans. We point out as well the obvious point that release of hundreds of thousands of patients into the community does not guarantee acceptance. In fact, without housing, treatment, or rehabilitation, public attitudes may actually become more fearful and blaming towards such individuals (Farina et al., 1992; Penn, Guyan, Daily, Spaulding, Garbin, & Sullivan, 1994).

Biological models. As the new millennium begins, the zeitgeist of genetic, neurochemical, and neurobiological perspectives on the etiology and treatment of mental disorders is flourishing (Charney et al., 1999; Hyman & Nestler, 1993). Indeed, complete mapping of the human genome is at hand, with prospects for unprecedented advances in multiple aspects of health care (Lander & Weinberg, 2000). For rare, tragic conditions (e.g., Duchenne muscular dystrophy) with single-gene loci, the potential benefits of genetic treatments are undoubted; genetic testing is now available for genes underlying the propensity for many chromosomal abnormalities, even including some forms of Alzheimer’s disease. We also note that far more effective psychotropic medications (with fewer side effects) exist than were available a generation ago (Bloom & Kupfer, 1995). For example, the newer generation, atypical antipsychotic medications have led to unprecedented hope for many individuals with previously unresponsive, longstanding schizophrenia (Owens & Risch, 1998).

Yet several cautionary points are in order. First, most mental disorders are undoubtedly polygenic, with a number of “susceptibility” genes interacting with one another and with

shared and (largely) nonshared environmental influence, including the prenatal environment, to yield actual dysfunction (Cicchetti & Cannon, 1999a, 1999b; Goldsmith, Gottesman, & Lemery, 1997; Plomin & Rutter, 1998; Rutter, Dunn, Plomin, Simonoff, Pickles, Maughan, Ormel, Meyer, & Eaves, 1997). Efforts to uncover the single gene that is responsible may be misguided (Barondes, 1998). Second, there may be unintended attributional and attitudinal consequences to calling all mentally disturbed behavior “brain disorder” or “brain disease”—to cite currently favored terms (Johnson, 1989). Ascription to illness does not automatically lead to benign reactions, particularly when metaphor continues to accompany the disease (Sontag, 1978/1987). As we argue later in this article, transactional models that incorporate genetic vulnerability in conjunction with progressively unfolding environmental influences and with cascading interactional and transactional processes are more complex but more accurate (cf. Boyce, Frank, Jensen, Kessler, Nelson, & Steinberg, 1998; Cicchetti & Cannon, 1999b; Cicchetti & Tucker, 1994; Nelson & Bloom, 1997).

Summary

Our historical survey revealed that conceptual perspectives occur in cyclic, rather than linear, fashion. Crucially, despite their radical differences, both demonologic and medical-model perspectives convey the attributional consequence of lack of personal control or responsibility for disordered behavior. Whereas such attribution should theoretically lead to more benign reactions, fear of the disturbed behavior, blame for the person’s susceptibility to influence by evil or illness, and the typical perception that behavior is indeed controllable have all led instead to extremely harsh reactions to both conceptions of disorder. Proclivities to label the afflicted individual as different, even subhuman, have recurred throughout human history; accordingly, “treatment” has gravitated towards punitive, exclusionary practices, even with initially humanitarian intentions. Although alternative perspectives (e.g., moral treatment or antipsychiatry) initially appear less dehumanizing, these often

convey the view that the person is a victim of stressors or environmental forces, connoting helplessness as well as ascriptions of personal responsibility and blame and thus fueling punitive attitudes. The community–deinstitutionalization movement has been thwarted by a lack of responsible fiscal management of alternative care, potentially leading to worse stigmatization as communities confront untreated, severe mental disorder. Although increased scientific understanding is essential to yield answers to mental disorder, it alone will not be sufficient to dispel stigma and fear and could, in fact, promote a stronger impetus for eugenic sentiments and actions, given increasing genetic advances. Acknowledgment of the humanity of individuals with mental disorders and provision of opportunities for their engagement in community life are central to public acceptance and enlightened care.

Stigma, Prejudice, and Discrimination

Definitions and social context

Although our overview has provided considerable evidence for misunderstanding, maltreatment, and “stigmatization” of persons with mental disorders throughout history, we have not yet specifically defined the key terms in question. The *Oxford American Dictionary* (Erlich, Flexner, Carruth, & Hawkins, 1980) defines the noun *stigma* as “a mark of shame, a strain on a person’s good reputation” and the verb *stigmatize* “to brand someone as disgraceful” (p. 901). The *Webster’s III New College Dictionary* (1995) defines stigma as “a mark of infamy, disgrace, or reproach.” Relatedly, Goffman (1963) described stigma in terms of undesirable, “deeply discrediting” attributes (p. 3) that permeate social interactions and that motivate the stigmatized individual to hide the “mark” whenever possible.

Stigma had origins in ancient Greece, referring to “bodily signs designed to expose something unusual and bad about the moral status of the signifier: The signs were cut or burnt into the body and advertised that the bearer was a slave, a criminal, or a traitor—a blemished person, ritually polluted, to be avoided, especially in public places” (Goff-

man, 1963, p. 1). Also from antiquity, the plural term *stigmata* refers to marks on Jesus’ body from the nails and spear of the crucifixion, connoting visible signs of injury and humiliation. How clear are the “marks,” both visible and hidden, left by the stigmatization accompanying mental illness?

Related terms require definition and explanation. Corrigan and Penn (1999) distinguish *stereotyping*, social categorization that is inevitable among humans and that may be an efficient means of negotiating complex social interaction, from *stigma*, which is defined as negative stereotyping. The synonym *prejudice* is the “unreasoning like or dislike or opinion of something” or “harm to someone’s rights” (Erlich et al., 1980, p. 704). Note the qualifier “unreasoning”: Although some forms of mentally disturbed behavior may engender fear or disgust, prejudice connotes an irrational dislike above and beyond the initial reaction—a literal prejudging of others on the basis of the label alone. Finally, *discrimination* is defined as unfair treatment, usually resulting from prejudice and stigma (Erlich et al., p. 245). Thus, we refer to stigma and prejudice as attitudes toward a devalued individual or group and to discrimination as the societal or community-level operationalization of prejudice and stigma. Overall, as stated by Corrigan and Penn (1999), “In terms of mental illness, stigmas represent invalidating and poorly justified knowledge structures that lead to discrimination” (p. 766).

In appraising the stigma attached to mental disorder and its associated discrimination, we must consider both (a) the symptomatology and phenomenology of the disorder and (b) the societal acts of diagnosing, labeling, and reacting to persons with the disorder. Regarding the former, we highlight that severe psychopathology (e.g., psychosis, major depression, agoraphobia) encompasses symptoms that are fragmenting and damaging to the coherence of self (schizophrenia is particularly salient in this regard—see Frith, 1992), typically cutting the person off from meaningful social contact (American Psychiatric Association, 1994). In mania, although there may be creativity and productivity during initial stages, the inflated sense of self-worth typi-

cally pushes others away, and later stages are inevitably disorganizing and destructive, leaving in their aftermath considerable pain and fragmentation (Goodwin & Jamison, 1990). In severe anxiety disorders like panic and agoraphobia, inner terror and extreme isolation are part of the core syndrome (American Psychiatric Association, 1994). Other symptoms of severe mental disorder (e.g., ideas of reference, paranoid ideation, depressive cognitions, hallucinations and delusions, and plummeting motivation) may fuel a sense of difference and of disconnection from the world. Many persons with chronic mental disorders have difficulties with social skills and exhibit behaviors that are alienating to interpersonal contacts (see Farina et al., 1992). Furthermore, many childhood disorders (e.g., attention-deficit hyperactivity disorder [ADHD], conduct disorder, depression, autism) involve symptoms that single children out from their peers and lead to friction in adult encounters, promoting loneliness and isolation.

As the preceding text indicates, however, it is often difficult to separate the “core” symptoms from their social consequences. For example, the boundary between the symptoms of paranoia or loss of self and the ensuing social isolation is a blurry one. When a lack of social competence is met with stigmatization, a vicious cycle of rejection, discrimination, and demoralization may well ensue (Farina et al., 1992). Indeed, moving to the level of social ramifications per se, societal reactions (fear, castigation, rejection, distancing, insults) both amplify the effects of core symptoms and feed back to shape their very meaning.

To take a provocative example, whereas psychosis is typically feared and punished in our society, other cultures may *value* altered states of mind, at least in some contexts. Witness, for example, the authoritative role given to shamans in African societies (Alexander & Selesnick, 1966). The social network and the predominant cultural beliefs in which deviant behavior is embedded thus play a pivotal role in shaping the individual’s sense of belonging and core self-image (Garcia Coll, Akerman, & Cicchetti, 2000; Kleinman, 1988; Lopez & Guarnaccia, 2000). Moreover, anthropological

and cross-cultural studies reveal that cultural beliefs about the nature of mental illness influence the community’s view, the predominant treatment strategies, and even the prognosis and course of mental disorders (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1998; Littlewood, 1998).

Findings from cross-cultural research on psychopathology challenge the assumption that the expression and experience of mental illness are universal. For example, patterns of onset and duration of illness and the nature and clustering of specific symptoms vary widely across cultures (Hoagwood & Jensen, 1997). Through investigating and comparing the attitudes, behaviors, and biological and psychological processes of individuals with mental disorders across different cultures, scientists can elucidate how diverse social experiences and contexts influence individual functioning, both normal and psychopathological. Consider the striking finding that, despite similar prevalence rates for schizophrenia in industrialized versus nonindustrialized nations, the course and outcome of schizophrenia are appreciably better in non-Western societies (see review of supportive evidence in Lin & Kleinman, 1988). The presumptive mechanisms in this regard include (a) enhanced social connectedness and social support in more traditional cultures and (b) the ready availability of meaningful work in nonindustrialized societies (see Lin & Kleinman, 1988). In general, far more needs to be learned about the influence of social and cultural processes on the course of mental illness, the prognosis for recovery, patterns of caretaking, and basic attitudes toward mental disorder.

Moving again to the example of major depression, even if certain severe symptoms are inherently isolating and devastating, the familial and social tendencies to react with fear, reproachment, and blame (which quickly replace initial compassion and sympathy; see, e.g., Coyne, 1976; Coyne, Downey, & Boergers, 1992; and Hooley & Hahlweg, 1986) are highly likely to compound isolation. Furthermore, if depression becomes so severe as to engender suicidal ideation and especially sui-

cide attempt, then the shame related to perceptions of weakness, cowardice, and being “out of control” can only compound the devastation and desperation of the self-loathing and hopelessness accompanying the self-destructive urges (e.g., Jamison, 1999). At another level, societal reactions to family members left behind when a suicide occurs may range from pity to castigation and blame.

When the aberrant behavior also is viewed as the product of evil, depravity, or lack of willpower, familial and societal reactions are nearly certain to be punitive. As discussed above, medical-model ascriptions do not automatically fuel benign reactions, in that the individual may be viewed as flawed, blameworthy for the vulnerability to the mental disorder, or the product of defective biology. Goffman (1963) asserts that, by definition, stigma involves both generalization to a wide range of imperfections and perception of the stigmatized individual as less than fully human. Our culture’s general tendencies to exclude the afflicted individual from the mainstream are evidenced in many ways: the “disturbed” child’s being sent to special class, the depressed or acting-out adolescent’s exclusion from school, the psychotic adult’s loss of employment, the out-of-control patient’s forced hospitalization in a facility given more to warehousing than treatment, the mentally retarded adult’s enforced sterilization. Such exclusionary practices not only deprive the person of opportunities for social interaction (or, indeed, of the right to procreate) but also may well become part of a permanent school, employment, or insurance record, delimiting subsequent educational, vocational, or economic options. Note, for example, the exclusion clauses in health insurance policies for “prior conditions” such as depression or psychosis or the questions on employment forms about ever having been treated by a mental health professional. The resultant “stigmata” may not appear on the skin but may be as permanently “worn” in medical and employment records—equally concrete and nearly impossible to escape.

In addition, and crucially, such fearful reactions and exclusionary policies, along with the ascription of the problems to an intraindi-

vidual “disorder,” are highly likely to intrude upon the individual’s self-concept, self-understanding, and self-esteem (Corrigan & Penn, 1999; Mechanic et al., 1994). Goffman (1963), in fact, noted the inevitability of personal shame regarding conditions or traits stigmatized by society. Such internalization of stigma may have devastating consequences for the person with mental disorder. To have experienced profoundly disturbing and disturbed behavior; to worry about the consequences of such behavior (even if one doesn’t even recall its specifics); to be feared and excluded because of out-of-control actions; to be blamed for a failure of moral control or will; to be treated as a patient (of a mysterious affliction) with punitive “care”; to become doubting of one’s agency in effecting change in one’s condition; to be ashamed to admit to having the symptoms or illness for fear of further misunderstanding or castigation—all constitute the internalized stigma, self-blame, and self-doubt that are fueled by mental disorder and its reputation in society.

Levels of analysis

Implicit in our discussion has been the several levels at which stigmatization operates; we now outline these in more explicit fashion.

Social/legal. Starting with the widest level—that of social policy and legislation—a number of restrictions are placed on persons with mental disorders, evidencing discrimination. Mainstream schooling is a right that must be fought for, employment options are limited, employment termination is frequent, and adequate medical care or insurance coverage can legally be denied (Torrey, 1997; Wahl, 1999b). Furthermore, until relatively recently there were few, if any, legal safeguards against the involuntary hospitalization of those deemed to have mental disorders. More recently, with increasing restrictions on involuntary commitment, deinstitutionalized individuals have had limited access to responsive treatments. Thus, in school, at the workplace, and in the community at large, discriminatory policies thwart the rights of persons with mental disorders. Such discrimination breeds stigma (shame

and disgrace); and stigma and prejudice, in turn, fuel additional discriminatory policies. A vicious cycle of influence is clearly operative.

Familial. Goffman (1963) indicated that intimate contacts of stigmatized individuals are particularly likely to share stigma and stigmatization. Indeed, there is a sizable history of research on family-level reactions to mental disorder (see Dickens & Marsh, 1994; Hooley, 1985; Kreisman & Joy, 1974; Marsh & Johnson, 1997; Phelan, Bromet, & Link, 1998; Tessler & Gamache, 2000; Wahl & Harman, 1989; Wynne & Singer, 1964; Yarrow, Clausen, & Robbins, 1955). Amidst the variety of research methods and findings, it is clear that families experience a range of reactions to the mental disturbance of a family member, often in complex combination—fear, shame and guilt; revulsion; compassion; secrecy, withdrawal, and concealment; and frustration over service provision (or lack thereof)—and that families are clearly aware of stigma in society. For example, Wahl and Harman (1989) requested family members of a national self-help organization (National Alliance for the Mentally Ill; now just termed NAMI) to report on stigma. Participants overwhelmingly believed that stigma negatively influenced both the afflicted member and the family as a whole; importantly, over two thirds of the nearly 500 respondents affirmed that negative media coverage and societal jokes and insults were key contributors to stigma. Indeed, as discussed earlier, the reactions and coping of family members are bound to be shaped by predominant cultural and professional conceptualizations. Thus, when autism was viewed by its discoverers as the child's reaction to "emotional refrigeration" by parents (Bettelheim, 1967; Kanner, 1943; Rimland, 1964), parental guilt and humiliation were understandable reactions. More generally, when society discriminates against those with mental disorders and mandates silence and shame, we should not be surprised if family members do the same. Yet these are precisely the kinds of reactions that promote abdication of control and hope on the part of those suffering from mental disorder.

A key paradigm shift has taken place over

the past half-century: from being viewed as the unequivocal causal agents of a family member's mental illness, families are increasingly perceived as reactors and responders to the afflicted person's condition (Lefley, 1989, 1992; Kreisman & Joy, 1974; Wahl & Harman, 1989). For example, in families where one member is diagnosed with a mental disorder, decreased self-esteem is reported and tenuous relationships with other family members exist because of stigma. Moreover, the family members who do not have a mental disorder may become victims of a "courtesy stigma"—that is, being stigmatized because of their residing with a person who is diagnosed as having a serious mental illness (Goffman, 1963). Still lacking, however, is a truly integrative, transactional viewpoint from which family members and family interactions are seen neither as primary causes of mental disorders nor as passive responders to disturbed behavior but rather as interactional partners in a complex set of reciprocal processes.

We note also that mental disorder takes a toll on close family relationships: parents of disordered children are often highly stressed (Donenberg & Baker, 1993; Mash & Johnston, 1990); adults in close relationships with depressed or psychotic partners often have difficulty sustaining those relationships (Coyne, 1976; Coyne, Kessler, Tal, Turnbull, Worthman, & Greden, 1987; Hooley & Hahlweg, 1986; Lefley, 1992; Secunda, 1997); and families of individuals with severe mental disorder suffer from strain and grief, related to the sheer agony of symptoms, conflictual interaction, and lack of responsive intervention or rehabilitation (Kreisman & Joy, 1974; Wahl & Harman, 1989). Considerable research has shown that family-level differences in emotional response to mental disorder are influential in shaping the afflicted member's likelihood of relapse (see Hooley, 1985). Furthermore, children raised in the homes of parents with mental disorders are not only at high risk for maladjustment (Beardslee, Bemporad, Keller, & Klerman, 1983; Cicchetti & Toth, 1995, 1998) but also must contend with the unanswered questions as to why their parent is unavailable or shows periodic dyscontrol or absence (Beardslee, Versage, Salt, & Wright,

1999). In all, much remains to be learned about the operation of the familial context of stigmatization and shame regarding mental disorder.

Mental health professionals. We note that those entrusted with the care of individuals with mental disorders may themselves view their patients as flawed, shameful, and stigmatized (e.g., Lefley, 1992). One hint towards this conclusion comes from the survey by Wahl and Harman (1989) of family members (i.e., participants in the advocacy organization NAMI). In this report, families ranked “talking with mental health professionals” *last* as a perceived aid in coping with stigma, with a significant minority perceiving that teachings of mental health professionals actually contributed to stigma. Indeed, a major impetus for the formation of self-help and advocacy organizations has been distrust of and dissatisfaction with professional care, including the blaming of family members for the afflicted individual’s disorder (Wahl, 1999b). Within the fields of psychiatry and clinical psychology, patients are often treated differently than persons seeking other types of medical intervention. Clear boundaries are set between clinicians and patients, which, though often beneficial, contribute to a mindset of “us versus them.” Although such boundaries were originally established to prevent clinicians from exploiting their patients, this state of affairs may engender a more generalized perspective that psychiatric patients—unlike those receiving more conventional medical procedures—are fundamentally of lesser quality or humanness. Despite a lack of formal data in this domain, it is conceivable that one offshoot of the renewed focus on medical-model conceptions of mental disorder and on biological hegemony is a perpetuation of such “us versus them” attitudes on the part of professionals to their patients.

In this vein, we should ponder how the training of mental health professionals may influence their attitudes toward colleagues who may have a history or present episode of mental disorder. By and large, training programs do not mandate that trainees receive

psychotherapy; gross estimates of the percentages of trainees who do receive personal therapy range from half to three fourths (Macran, Stiles, & Smith, 1999). Whether personal therapy can help to diminish or eliminate stigma is unknown, but we conjecture that if a therapist has never experienced therapy himself or herself, then there may be a lack of empathy for the patient role. The qualitative analysis of Macran et al. (1999) revealed that personal therapy may powerfully enhance empathy, increase awareness of boundaries and power differentials, and promote deeper levels of understanding of client issues. Of course, it is also conceivable that personal therapy could unwittingly serve to promote stigmatization, if such therapy itself modeled or reinforced defensiveness or superiority or if it suggested (implicitly or explicitly) that more structured therapies for those with severe disorders were somehow inferior to insight-oriented treatments. Overall, we challenge training programs and accrediting agencies to consider socialization experiences that encourage respect and concern rather than condescension or derision.

Individual. In addition to the dynamics already discussed (e.g., shame, fear, isolation), an added burden is that the disordered individual must often devote considerable energy to hiding the “secret” of his or her mental disorder—whether withholding information on employment forms, wondering how to account for “missing” months or years of life, or debating how to tell family members as well as potential friends or partners (e.g., Goffman, 1963; Jamison, 1995; Wahl, 1999a, 1999b). Because the afflicted person must contend with living with what society has branded as shameful and repugnant, the implications for damaged self-image and self-esteem are clear (Markowitz, 1998). Compounding these issues are the practical battles that must be fought in order to obtain or maintain employment, fund coverage for medical and psychological interventions, and find the motivation to seek and remain in treatment (Wahl, 1999a, 1999b).

Fear of stigmatization also can directly in-

fluence the developmental course of mental illness. For example, if afflicted persons are ashamed and embarrassed by their psychiatric symptoms, then they may either delay or refrain from seeking treatment. Alternatively, for individuals with mental disorder currently in treatment, concerns about stigmatization may contribute to their becoming noncompliant with their existing treatment regimen. Delaying treatment or interrupting ongoing interventions may exacerbate the biological and psychological sequelae of mental disorder, thereby producing a poorer prognosis and increasing the likelihood of further stigmatization.

Another crucial concern regarding the personal level is the extent to which individuals with mental disorders may come to blame themselves for their difficulties, fueling self-doubt and self-denigration (Corrigan & Penn, 1999). Such tendencies may be expectable in conditions like depression, where negative self-evaluations are part of the core symptomatology. More generally, however, when an individual experiences strong, even terrifying emotional states and behaves irrationally—and when there is no clear explanation and even blaming or revulsion from family members, the community, or whatever service providers may be available—the person may understandably look inside for areas of the self to blame. Whereas such self-denigration clearly takes a toll on self-concept, it may be better, in an attributional sense, to have *some* explanation or anchor for such terrifying, disorganizing experiences rather than none at all, even if the explanation involves self-castigation.

To reiterate, the four “levels” under discussion—societal/community, familial, professional, and personal—comprise interrelated spheres of influence. Discrimination in schooling or employment may fuel personal humiliation and frustration; familial reactions both shape and are shaped by the response of the community and the reactions of the individual. The condescending or stigmatizing responses of professionals will negatively influence all other levels. The lesson is that we must appraise the effects of reform efforts to

reduce stigma and prejudice at multiple levels of “outcome.”

Developmental Perspectives on Stigmatization

Our coverage heretofore has not been explicitly developmental, an omission we now redress. We take up two related themes: (a) effects of mental disorder and stigma across the life span and (b) the implications of a developmental psychopathology perspective for the study of stigma, with particular reference to transactional models of causation and influence.

Stigma across the life span

Many of the most severe forms of psychopathology have their onset relatively early in development. Aside from disorders defined in the DSM as explicitly originating in childhood (e.g., pervasive developmental disorders, ADHD, disruptive disorders, learning disorders, communication disorders, separation anxiety disorder), obsessive-compulsive disorder often shows onset in late childhood or early adolescence; schizophrenia and bipolar disorder often show initial episodes during the teenage years; and evidence suggests that the age of onset of unipolar depression has decreased significantly in recent decades, with the mean age of onset in the 20s and with many episodes beginning in adolescence (American Psychiatric Association, 1994). Furthermore, even though overt symptomatology, in many of these instances, may not appear until late childhood or adolescence, risk factors and early developmental precursors are probably acting years in advance (e.g., Cicchetti, 1993; Cicchetti & Cannon, 1999a; Cornblatt, Obuchowski, Roberts, Pollack, & Erlenmeyer-Kimling, 1999; Sroufe, 1997; Sroufe & Rutter, 1984). Thus, a large proportion of serious mental illness begins during formative years of development. When aberrant behavior, disordered thinking and emotions, and extreme disorganization are compounded by prejudice, social rejection, blaming of families, and unavailable or (if

available) nonresponsive or punitive treatment during such periods, there are bound to be profound effects on one's perception of self and the world (see, e.g., Cicchetti & Toth, 1994).

In the next subsections, we discuss the impact of stigmatization when mental disturbance has its onset during childhood or adolescence. Although space limitations preclude our explicit discussion of adult-onset disorder, we note that (a) our case example shows long-lasting effects of stigma throughout the life span and (b) the Surgeon General's report notes the discrimination experienced by elderly individuals with mental disorder (U.S. Department of Health and Human Services, 1999).

Childhood onset. To take just one example, ADHD involves developmentally extreme, cross-situational, and impairing symptoms in the domains of inattention–disorganization, hyperactivity–impulsivity, or both (Hinshaw, 1994, 1999). More than the core symptomatology alone, however, such “secondary” features as poor peer relationships, discordant family interactions, and academic failure, all of which quite frequently accompany ADHD, are particularly predictive of a negative course (e.g., Hinshaw, 1999; Parker & Asher, 1987). Low self-esteem is also associated with ADHD (Treuting & Hinshaw, in press); prospective research by Slomkowski, Klein, and Mannuzza (1995) demonstrates that low self-concept in adolescence predicts adjustment difficulties in young adulthood. We therefore see evidence for a kind of “developmental cascade,” in which the core symptomatology of ADHD sets in motion a chain of discordant social interactions and lowered self-image, which, in turn, fuel negative outcomes. Yet, what if ADHD were less stigmatized at school? Or, what if parents could be led to understand that temperamental differences (such as those that presage ADHD) are not blameworthy or reflective of prior marital discord or ineffective parenting but rather deserving of renewed efforts towards more consistent, authoritative control at home (see Hinshaw, Zupan, Simmel, Nigg, & Melnick, 1997)? Our developmental sense is that some

of the worst long-term outcomes might be attenuated.

More generally, when a child feels different from his or her peers and when the difference is related to undesired behaviors and punitive home and school consequences, the potential for continuation of loneliness and self-denigration into the developmental trajectory is high. When difficulties are branded as mental disorder rather than “badness,” the hope is that benevolent attributions and ascriptions can be made, diminishing blame. Yet, as discussed above, when the behaviors are deviant and noxious, such diagnosis does not automatically lead to more benign attitudes; stigmatization may well occur.

Adolescent-onset and family disclosure. It is difficult to fathom the consequences for the development of self-worth and worldviews in general when dyscontrolled, markedly irrational, and (especially) psychotic behavior has its onset in adolescence. Relatively stable perceptions of the world that have been forming since childhood are likely to be shattered; identity consolidation will be at best interrupted and at worst permanently altered. As noted above, such conditions as bipolar disorder, schizophrenia, and in many cases major depression—which feature profoundly disturbing affect and cognition—often have their onset during the teenage years. Because adolescence is a crucial period for identity formation and consolidation and for widely expanding peer relationships, the interruption of this period by such disturbing and disorienting experiences and, moreover, by social reactions and “treatments” that are distancing and punitive may cascade across future development (Cicchetti & Toth, 1996; Feldman & Elliott, 1990; Harter, 1999).

To place such perspectives in more concrete terms, one of us (S.H.) has written about his father, a philosophy professor who grew up during the 1920s and 1930s in a religious, intellectually competitive household and who encountered major psychopathology initially during midadolescence and then recurrently throughout his life (Hinshaw, 2000). Misdiagnosis and maltreatment were also salient themes in his life. Although this brief summa-

tion necessarily omits many important themes and issues, we focus on the impact of severe mental disorder that originates in adolescence—and on institutional “treatment” during that phase of life—on identity formation and self-concept, highlighting developmental themes in relation to stigma.

Virgil Hinshaw, Jr., was born in 1919 outside of Chicago, the fourth of four boys. His father was chairman of the National Prohibition Party during the 1910s and 1920s, the time of the passage of the prohibition amendment, and his mother had been a missionary to Latin America. When he was 3 years old, his mother died following surgery for an ovarian tumor. He was inconsolable for a time, but his older brothers and his father supported him, and he soon adapted to his family’s moving out West, where they finally settled in southern California. His father remarried; and as the youngest of her four stepsons, Virgil was in a unique position to be disciplined by his stepmother, about which more will be noted later. He soon had two half-brothers, whom he helped to raise. A talented athlete and gifted student, his early years witnessed no psychological symptomatology, despite the family’s struggles with the Great Depression when he reached the age of 10 years. In fact, to help support the family, he and his older brothers found whatever jobs they could during adolescence. As a teenager, Virgil worked, for example, as an iceman’s assistant, carrying huge blocks of ice to residential iceboxes, for the wage of 17.5 cents per hour. It is noteworthy that, because of his father’s many years in Prohibition politics, foreign visitors often visited the family home, many telling ominous stories of the ascendancy of the Nazi Party and Hitler in Germany.

In 1936, at the age of 16 years, with a rather sudden onset during long, sleepless nights in the late summer, Virgil began to experience frightening, psychotic behavior:

Increasingly agitated and suspicious, and full of thoughts about the world situation, he did not sleep for a period of two days in early September, preoccupied with the specter of Hitler’s rise in Germany. On September 6, having been up the previous night walking the streets, he shed his clothes in the

morning while approaching the house, ascended to the porch roof, and jumped to the ground below. He had the delusion that he could fly; he was also attempting, he later recalled to me, to make a statement that Hitler must be stopped. Although physical injuries were apparently minor, police officers and a cousin (a woman physician) were called in, certifying his “insanity” and taking him, shackled, to the county hospital some miles away. (Hinshaw, 2000, p. 35)

A legal hearing occurred within 2 weeks, and he was subsequently transferred to a county facility. For the next 5 months, he was warehoused there, on a ward with extremely disturbed individuals with florid psychoses and severe mental retardation. There was no “therapy” except for being tied to the bed during agitated periods and rare visits by attending physicians. His lifelong recollection was of tormented screaming throughout the day and night.

Delusional, he believed that food was poisoned; his weight plummeted from 175 to approximately 120 pounds. His father, stepmother, and brothers were devastated by his drastic change of condition and feared for his life. Months dragged by, but little improvement was noted. He wished fervently that he could return home for Christmas, but his condition did not allow such release. The hopelessness of the institutional setting weighed upon him, as did his recurring agitation and delusions. By the late winter, however, the psychotic experiences rapidly cleared; he was sent home in March. Although no official records are available, the diagnosis that followed him upon release was schizophrenia.

With his sudden recouping of normal functioning, he was quite motivated to restart his life. He finished his academic requirements for 12th grade in less than a semester, rejoining the track and field team as well. No explanation of the behavior patterns and no follow-up treatment were provided to him or any family members by any hospital staff.

The chief reason for describing this harrowing episode is to set the stage for an incident that occurred 45 years later, when Virgil was in his early 60s. Brief tracking of the interim years is necessary to place the incident

in perspective: Following his initial hospitalization, he graduated from Stanford, received his doctorate from Princeton, became a faculty member at Ohio State University (with a reputation as a magnetic, exciting teacher), married, and had two children. Psychotic episodes recurred, however, during his graduate school years and particularly during the 1950s and 1960s, the time of new family and career consolidation. Grandiose, paranoid ideation; florid psychoses; and rash, poor judgment characterized these episodes, which were sometimes followed by periods of flatness, emptiness, and despair. Particularly severe episodes coincided with his wife's (S.H.'s mother's) pregnancies. Despite their nature and despite the long periods of normal functioning in between, the diagnosis continued to be schizophrenia, reflecting American psychiatry's tendency to brand any psychotic features as reflective of underlying schizophrenia rather than a mood disorder (Barondes, 1998; Hinshaw, 2000; Pope & Lipinski, 1978). Treatments included hospitalizations (one as long as 10 months, during S.H.'s entire third grade school year), high doses of neuroleptics like Thorazine and Mellaril during the early years of their use (followed by maintenance therapy with such agents for 20 years), a number of electroconvulsive therapy (ECT) treatments, and sporadic psychiatric counseling.

Throughout, the family somehow managed to hide the most florid of the psychotic episodes from the children. Furthermore, no mention of these episodes or the absences was ever made to S.H. or his sister. Doctors, in fact, cautioned Virgil not to speak with children about any such behavior or about mental illness at all. The legacy for the family was thus one of silence and denial around out-of-control behavior and around long, unexplained absences.

In one particularly harrowing incident, Virgil became entranced with a female television entertainer one night when S.H. and his sister, both preschoolers, were asleep. Through his ideas of reference, he believed that she was sending him personal messages. Determined to find her, he demanded to drive 100 miles to the transmitting television station in Cin-

cinnati. S.H.'s mother, terrified equally by the prospects of letting him drive off and of leaving the children behind, quickly decided to accompany him. They drove at frightfully high speeds on prefreeway roads, finally (and miraculously) finding the television station. Only after realizing that the station was locked up did he relent to drive back home, at nearly 90 miles per hour, where S.H.'s mother entered the house exhausted and shaking but relieved to find the children still asleep, in the wee hours of the morning.

During S.H.'s college years, Virgil noted his son's interest in psychology and cautiously began to discuss his life's legacy during holidays S.H. spent at the family home. These poignant conversations continued, several times per year, for the next 25 years, opening up worlds of silence for S.H. and further fueling his interest in psychology. By the end of college (mid-1970s), S.H. began to suspect that schizophrenia was not an accurate diagnosis and pushed for reconsideration. As a result of the prompting, and also as a function of a continuing education course taken by the treating psychiatrist, bipolar disorder was considered as a diagnosis and lithium was finally prescribed. This treatment led to a number of years of relatively stable mood.

The incident in question occurred during the early 1980s, when S.H. was a clinical psychology intern at UCLA's Neuropsychiatric Institute, supervised by Kay Redfield Jamison in the Affective Disorders Clinic. Jamison sponsored a major colloquium on bipolar disorders, featuring Frederick Goodwin and Mogens Schou. S.H. invited Virgil to come out from the Midwest, in order to provide further insight into manic-depressive illness and treatment advances. (Virgil had read extensively about bipolar disorder since the time of his rediagnosis approximately 6 years earlier.) A day or two after the conference, S.H. returned to his apartment one afternoon, where his father had spent the day walking on the beach and visiting some colorful local cafés. He described sitting near several "interesting characters" in one café and confided that he could immediately tell that some of them had been in mental hospitals. "When you've been

in hospitals as much as I have,” he explained to S.H., “you can spot the psychotics like yourself.”

I was floored by the juxtaposition of the erudite symposium he had just attended with this disclosure. Quite apparently, his largely successful treatment with lithium and his book knowledge of manic-depressive illness had failed to alter key portions of his underlying self-image—that of a “psychotic,” an inmate of hospitals. (Hinshaw, 2000, p. 97)

Terrifying, disorganized experiences that occur during adolescence—along with institutional care that engenders despair rather than hope and in the absence of explanation or follow-up care—clearly appear to outweigh later attempts at “education” and rational understanding of mental disorder. The primacy of the unexplained, identity-forming states is undoubted. Research efforts to understand the role of mental disorder and stigmatization on the development of self-esteem and self-image continue to be a priority.

A decade later—with Virgil now in his early 70s and showing increasing signs of cognitive deterioration from a combination of years of uncontrolled episodes, inappropriate treatments, and a growing syndrome resembling Parkinson’s disease—S.H. and Virgil had a poignant conversation outdoors, under the stars. Virgil said that he had longed, during his earlier psychoses and hospitalizations, for any evidence that his frightening, disorganizing, despairing feelings were “real” and not just “in his mind.” “How I wished for a physical cause of my problems!” he lamented, betraying the hope that his symptoms and experiences were somehow tangible. An unanswered question is the extent to which continuing advances into the psychobiological underpinnings of major mental disorder will provide such “reality” to patients and their families.

Again, we use this brief recounting to illustrate the deeply ingrained role of stigmatization when severe mental disorder originates during adolescence and to point out that effects may reverberate throughout the life

span, even into a person’s latter years. We return later to several other themes from Virgil’s life, to illustrate the varied biopsychosocial influences on etiology, the legacy of family silence on children of individuals with mental disorders, and the resilience displayed by him as well as countless other persons afflicted with mental illness.

Developmental psychopathology principles and transactional models of causation and influence

Now that we have defined stigma and stigmatization and discussed their impact across the life span, we direct our attention to the field of developmental psychopathology. We believe that this discipline has much to offer current attempts to understand the stigma associated with mental disorder. In this section we highlight the most salient themes and constructs from developmental psychopathology that pertain to stigmatization and prejudice, although many others could be offered as well.

Interplay of normal and abnormal. Developmental psychopathologists emphasize that the perspectives of normality and psychopathology are mutually enriching. Prior to the emergence of a mental disorder, certain pathways often signify adaptational failures in normal development that increase the odds of subsequent maladaptation and psychopathology (Cicchetti & Rogosch, 1996; Sroufe, 1989). Similarly, knowledge gleaned from the investigation of psychopathology can augment the comprehension of normal development (Cicchetti, 1984, 1990). Investigators and clinicians with a developmental psychopathology perspective are interested not only in the differences between individuals with and without mental disorders but also in their similarities (Cicchetti, 1993; Zigler & Glick, 1986).

Indeed, we cannot overemphasize the striking similarities between persons with mental disorders and their nondisordered counterparts. Individuals with mental disorders experience a range of feelings, possess a need for relatedness and belonging with others, seek a

sense of order in their worlds, and attempt to find meaning in their experiences. Despite the scientific and clinical need to categorize mental disorder and find similarities among those who fit a given diagnostic category, there are as many varieties of schizophrenia, bipolar illness, depression, or ADHD as there are people who meet DSM criteria; diagnosed individuals share universal desires, needs, and traits.

Development and mental illness are not static processes. Individuals with mental illnesses typically shift from phases of normality to psychopathology and back (Cicchetti, 1993; Zigler & Glick, 1986). They are therefore not either “ill” or “well”; rather, nearly all such individuals experience stages and phases of remission and relapse across the life course. This life-span developmental perspective alerts us to the fact that mental health and mental illness—and the biological, psychological, and social factors that interact and transact to create individual development—are dynamic phenomena (Cicchetti & Cannon, 1999b; Cicchetti & Tucker, 1994; Kandel, 1998, 1999; U.S. Department of Health and Human Services, 1999).

Based on such a developmental conceptualization, as well as on humanitarian grounds, individuals with mental disorders should not be reduced to their psychiatric diagnoses (see also American Psychiatric Association, 1994, which warns against labeling the person rather than the disorder). In particular, those individuals who have been successfully treated, or those in remission, may be strikingly similar to nondisordered persons. A major determinant of how such remitted individuals continue to function lies in the responses of society, family members, and mental health professionals (see Lin & Kleinman, 1988, for a cultural perspective on recovery).

Diversity in process and outcome. Diversity in process and outcome related to mental disorder and to development in general are hallmarks of the developmental psychopathology perspective. In this regard, the principles of equifinality and multifinality, derived from general systems theory, are germane (von

Bertalanffy, 1968). Equifinality refers to the observation that a diversity of paths may eventuate in the same outcome, whereas multifinality refers to the finding that a given “initial condition” may lead to an array of outcomes (Cicchetti & Rogosch, 1996; Sroufe, 1989). Such “pathways” concepts possess relevance for the stigmatization of mental illness and its influence on development. For example, persons with the same psychiatric disorder may experience different reactions from family members, teachers, and peers. As a consequence, they may develop different patterns of self-image and self-concept, fueling either vicious or virtuous cycles of influence on behavioral and emotional development. Their different long-term of outcomes, in this scenario, will depend, in part, on the context in which they are immersed, including familial reactions and social openness versus closedness.

Cultural and contextual influences. Developmental psychopathologists are devoting increasing attention to cultural and contextual issues related to development (see Boyce, Frank, Jensen, Kessler, Nelson, & Steinberg, 1998; Cicchetti & Aber, 1998). Nonetheless, our understanding of the ways in which culture and cultural processes influence development is in its infancy (Garcia Coll et al., 2000; Weisz, 1989). One important finding is that the societal understanding of and response to mental illness may contribute to the prognosis of serious mental disorder, independent of medical treatment (Littlewood, 1998). As discussed earlier, the World Health Organization International Pilot Study of Schizophrenia revealed that a higher percentage of patients with schizophrenia in the developing world experience positive outcomes than in the developed world (Cooper & Sartorius, 1977; Lin & Kleinman, 1988). Different levels of social support, of social expectations for deviant roles, and of employment opportunities following periods of disturbed behavior may be the relevant explanatory factors. Better understanding of such sociocultural factors could lead to preventive means of minimizing stigmatization in the lives of persons with mental illness.

Despite the growing awareness that contextual factors play an important role in defining phenomena as “psychopathological” (e.g., Richters & Cicchetti, 1993), there are major differences in how the contexts for human development are conceptualized. Garcia Coll, Lamberty, Jenkins, McAdoo, Crnic, Wasik, and Vázquez Garcia (1996) have proposed an integrative model for the investigation of developmental competencies in ethnic minority children, in which major social position variables such as prejudice, discrimination, oppression, and segregation are accorded prominent status as potential contributors to developmental outcomes. Likewise, we believe that research into the etiology of mental disorder must increasingly examine such social position variables as part of the array of contributors to the course and sequelae of serious mental illness.

Resilience. Resilience refers to a dynamic developmental process encompassing positive adaptation within the context of significant adversity (Luthar, Cicchetti, & Becker, 2000). In order for individuals to be resilient, there must be exposure to significant threat or severe adversity and positive adaptation in the face of these major assaults on developmental processes (Luthar et al., 2000; Masten, Best, & Garmezy, 1990). A growing literature documents that persons with serious mental disorders and their offspring can function in resilient fashion (Cicchetti & Garmezy, 1993; Luthar et al., in press; Masten et al., 1990), though far more remains to be learned about the developmental processes that facilitate such resilience.

In early writings on the topic of resilience, individuals who manifested positive adaptation despite experiencing multiple adversities were termed “invulnerable” (Anthony, 1974). Because this term implied that evasion of maladaptation was absolute and unchanging (Luthar et al., 2000), it was replaced by “resilience,” a term more accurate in its characterization that the attainment of competence in the presence of adversity involves a developmental progression, wherein new vulnerabilities or strengths often emerge with changing life circumstances. Relevant research once

again indicates that persons with mental disorders are not “always flawed.” Rather, not only do many have periods of remission, but also an appreciable number manage to function in an adaptive fashion for prolonged periods of their lives.

Current views of mental disorder: “brain disorder” versus “transactional” models. In contrast with the viewpoint that mental illnesses are “brain disorders” or “brain diseases” (see Johnson, 1989), developmental psychopathologists conceptualize mental disorders in a more complex, dynamic fashion (see, e.g., Cicchetti & Cannon, 1999b; Cicchetti & Tucker, 1994; Kandel, 1998, 1999; Sroufe, 1997). That is, not only do genetic and biological factors influence psychological processes, but psychological and social experiences are also capable of modifying the structure, function, and organization of the brain (Cicchetti & Tucker, 1994; Eisenberg, 1995; Nelson & Bloom, 1997) as well as influencing the occurrence and timing of gene expression (Hyman, 2000; Kandel, 1998, 1999). Thus, epigenesis is conceptualized as probabilistic rather than as predetermined or preformational; the bidirectional and transactional nature of genetic, neurobiological, social, behavioral, and pre- and postnatal environmental influences over the life course captures the essence of such probabilistic epigenesis (Cicchetti & Cannon, 1999b).

Because developmentalists conceive of brain–behavior relations as multidimensional processes, no component, subsystem, or level of organization possesses causal privilege. That is, no single level of the system “causes” development, normal or pathological (Cicchetti & Cannon, 1999b; Gottlieb, Wahlsten, & Lickliter, 1998; Johnson, 1999). Across different conditions and disorders, of course, there may be “initial states” regarding neural development or capacity that severely constrain or direct future development (e.g., certain genetic or chromosomal abnormalities, marked prenatal influences, or extremely traumatic experiences in early childhood). Yet except perhaps in the most extreme examples, the constant interplay of intraindividual and environmental influence on neural develop-

ment and the plasticity of the brain should keep the field open to transactional influence (see, e.g., Rutter and the English and Romanian Adoptees [ERA] Study Team, 1998).

Stated somewhat differently, whereas the brain is clearly involved in all forms of mental disorder, many other systems contribute and transact with the brain in dynamic fashion over the life course to bring about experience-dependent brain development (Greenough, Black, & Wallace, 1987). Neural plasticity is possible throughout the life course, as revealed, for example, through evidence demonstrating that successful drug treatment and psychotherapy result in normalization of brain functioning in persons with such serious mental illnesses as obsessive-compulsive disorder, major depressive disorder, and schizophrenia (Cicchetti & Cannon, 1999b; Cicchetti & Tucker, 1994; Kandel, 1998, 1999). We understand that promotion of the view that mental disorders are “brain diseases” may help to reduce personal and familial blame for aberrant behavior and emotion (Johnson, 1989). It is necessary, however, that investigators convey scientific truth to the public regarding the complex and dynamic processes that undergird the development of psychopathology. Whereas we fully believe in strong psychobiologic predisposition to many forms of major mental disorder, the “brain disorder” term may connote primacy or exclusivity for the biology and fail to underscore transactional processes. A close reading of Johnson’s (1989) “brain disease” appellation for major mental disorder, in fact, reveals that he actually subscribes to the biopsychosocial model of Engel (1977), which supports the reciprocal, transactional interplay of biological-genetic, psychological-developmental, and social support-social systems influences.

Personal and family account revisited

In order to illustrate several of the points we have made regarding a developmental psychopathology perspective on mental disorder and stigma—particularly the value of considering transactional models of influence—we raise again the example of S.H.’s father.

Accurate diagnosis and appropriate treatment. As was the case with hundreds of thou-

sands of individuals in the United States during the majority of the last century, Virgil was given a diagnosis of schizophrenia because of the psychotic symptoms that accompanied his escalations into full-blown mania. The field recognizes today that mood disorders may well involve psychosis, if symptomatology becomes sufficiently severe (American Psychiatric Association, 1980, 1987, 1994; Carlson & Goodwin, 1973). Yet when (a) diagnostic accuracy is not valued and (b) no differential treatments for differential diagnoses are available (as was clearly the case during the early years of his life), there is little “press” to diagnose and classify with precision (Barondes, 1998). We contend that accuracy in classification and diagnosis is essential to scientific rigor and clinical decision making, despite the limitations of DSM-style diagnosis in terms of construct validity and lack of developmental perspective (Hinshaw, 1994; Richters & Cicchetti, 1993). In passing, it is impossible to know how much Virgil’s decline in cognitive functioning during his last years was attributable to his repeated cycles of mood disturbance, his inappropriate treatments (related to misdiagnosis), or both.

Transactional causation. In terms of etiology, strongly supportive evidence exists for the high heritability of bipolar disorder (Goodwin & Jamison, 1990). In addition, attempts to understand and treat this disorder with exclusively dynamic-psychosocial means have met with extremely limited success, as biological treatments appear mandatory (see Nathan & Gorman, 1998). The field’s rush to completely “biologize” severe mental disorder, however, is inaccurate at several levels. For one thing, even disorders with high heritability may involve genes with incomplete penetrance or variable expressivity (Barondes, 1998; Goldsmith, Gottesman, & Lemery, 1997; Rutter, 1991). For another, heritability pertains to individual differences in a trait or disorder that are related to genetic (vs. environmental) influence; the term does not in the least exclude the possibility of key environmental events shaping the individual’s expression of the genetic predisposition (e.g., see Cicchetti & Tucker, 1994; Goldsmith et al., 1997; Kandel, 1998, 1999; Rutter et al.,

1997). In the case of S.H.'s father, the family history was "loaded" with mood disorders and alcohol or substance abuse disorders, primarily on the paternal side, providing circumstantial evidence for the role that genetic factors played in the unfolding of his severe bipolar disorder. Although the precise genes predisposing to bipolar disorder await final confirmation, research laboratories are closing in, despite the preliminary misidentifications of the late 1980s (Barondes, 1998).

Recall, however, that Virgil's biological mother died when he was 3 years old. There was clearly potential for such early loss to have contributed to later vulnerability to loss experiences or to have compounded risk for later mood disturbance (cf. Bowlby, 1980). Virgil also experienced, later in childhood and early adolescence, severe punishment (with a sexually abusive flavor) at the hands of his stepmother (Hinshaw, 2000). Whereas we do not contend that such a pattern of abuse is itself causal of bipolar disorder, there is strong evidence from his writings and recollections that these early experiences, as well as the harsh "treatments" he received in institutional settings, shaped his belief that he must have been personally responsible for his otherwise inexplicable episodes and punitive hospitalizations. Indeed, in writing about a hospitalization in his 20s, when he was beaten by fellow inmates, he stated, "Immediately I sensed, as in a *déjà vu* of my (step)Mother's stern but loving routine with a razor strap, the sound thrashing I was about to undergo." Environmental trauma may therefore help to shape the expression and meaning of mentally disordered behavior that carries a strong psychobiologic predisposition, consistent with a transactional model of influence (see Cicchetti & Tucker, 1994; Kandel, 1998; Pollak, Cicchetti, & Klorman, 1998; Post, Weiss, Li, Smith, Zhang, Xing, Osuch, & McCann, 1998).

Communication to family members, especially children. As noted earlier, Virgil was instructed by psychiatrists never to discuss his episodes or hospitalizations with the children (indeed, S.H.'s mother was often excluded from diagnostic or treatment considerations, revealing the lack of concern with family sys-

tems in the legacy of much 20th-century care). Concerns for confidentiality of the patient mistakenly took priority over the clear need for family members and close relatives both to aid in the differential diagnostic picture and become core components of treatment and rehabilitation. Whereas young children should be spared details of irrationality and psychosis that they cannot comprehend, utter silence leaves a legacy of (a) mystification ("why is the world so unpredictable?"), (b) internalization ("was it my fault that my parent acted out or disappeared for months on end?"), and (c) strong yearnings to maintain control over unexplained and out-of-control experiences.

Crucially, in an empirically supported, developmentally based approach to treatment of families where a parent has experienced depression, Beardslee and colleagues (e.g., Beardslee et al., 1999) explicitly encourage parents to create a narrative through which they can begin to explain the depression to the child in terms that are understandable. This approach has shown both short- and longer term success in terms of aiding familial adjustment and preventing depressive symptomatology in the offspring. When S.H. met William Beardslee at the Rochester Symposium on Developmental Psychopathology in 1996 and first learned of this approach, his initial reaction was one of disbelief: The legacy of silence in his family was so strong that he could not comprehend that conceptually informed interventions would explicitly target a family's communication with children about mental disorder. The potential for sensitive, developmentally appropriate communication about mental disorder with family members is far reaching, as it may prevent the aura of shame and mystification from expanding to later generations and may carry over into wider societal attitudes espousing openness rather than silence.

Resilience and strength. Despite his frightening and disorganizing experiences, his misdiagnosis and maltreatment, his multiple hospitalizations, and his diminished capacities in his latter years, Virgil was a respected professor and sensitive father, showing particular compassion during times of crisis for S.H. as a child, adolescent, and young adult. In addi-

tion, several years before he died, Virgil remarked to his son that he would never have traded any of his life experiences, despite their frightening nature (see also Jamison, 1995, who would not have traded her life with bipolar disorder despite its episodic terror and suicidal depressions). How do we explain such positive outcomes and strengths in the face of extreme adversity? As noted above, constructs of risk, protection, and resilience have spurred important conceptualization and empirical research in the field (e.g., Cicchetti & Garnezy, 1993; Luthar et al., 2000; Masten et al., 1990; Masten & Coatsworth, 1998); yet developmental psychopathology still has much to learn about the factors that predict healthy functioning “against the odds” (Werner & Smith, 1992). The value of personal and family narrative is that it can help us to formulate the nature of the processes underlying strength and resilience in a powerful, uncensored manner and to connect the still nascent field of resilience research with the raw phenomena of interest.

Investigating and Reducing Stigma: Research Evidence and Issues

We now shift to the key questions of the article: Can stigma be reduced? What means show the most empirical support for effecting such reductions? How would the field go about measuring beneficial effects of attempts at stigma reduction? At the outset, we note that although research on this topic is becoming increasingly sophisticated and systematic (Corrigan & Penn, 1999), the field still has a considerable distance to travel in terms of discovering the best approaches to prevention and intervention and the most valid means of evaluating their success.

At the outset, and in keeping with our view of the cyclic nature of history in the field, we highlight that an initial wave of public education about mental disorder took place in the 1950s and 1960s, in parallel with the onset of the community mental health and deinstitutionalization movements (e.g., Cowen, 1973; Cumming & Cumming, 1957). Such efforts were based, in many instances, on inculcating the public that severely aberrant behavior is

the product of mental illness rather than depravity or weakness. In a critical review of these efforts, Sarbin and Manusco (1970) contended that they were fundamentally misguided: From their perspective, the medical model was wholly inaccurate and the public was justified not to “buy” such a model fully. Because psychobiologic and medical models have evolved considerably in the last 30 years, public acceptance of the terms “mental illness” and “mental disorder” may well have improved incrementally, despite a backdrop of fear and castigation. Yet, in our opinion, neither classic medical views nor extreme anti-mental-illness perspectives are likely to lead to increased public acceptance. Indeed, as argued in the section above on transactional models, the public needs to hear a more complex (but “real”) message as to the dynamic interplay of psychobiologic risk with environmental stressors underlying serious mental disorders.

Intervention efforts

Corrigan and Penn (1999) provide an extremely scholarly and useful categorization of three types of educational, political, and intervention-related efforts to reduce stigma. We cannot recapitulate the thoroughness of their review, but we provide a distillation of its major points and strongly recommend to interested readers that they read it in full.

Protests against prejudice. Protests against prejudice constitute a growing class of attempts at destigmatization. Examples include advocacy groups’ organized campaigns against blatantly stereotypic portrayals of individuals with mental disorders in the media (e.g., advertisements for films that cast aspersions on the mentally ill) or the provision of “media watch kits” to local television network affiliates by NAMI (see Wahl, 1999b). A key problem is that extremely little research has been performed on such efforts. Furthermore, Corrigan and Penn (1999) voice the important concern that protests may engender the opposite effects to those intended if they, in fact, lead to the phenomenon of suppression (Wegner, 1997)—in which effort made to suppress

an emotion or stereotype may paradoxically increase the emotion or stereotype intended to be downplayed (the so-called rebound phenomenon). On the other hand, Wahl (1995) argues that protest efforts may have a long-term benefit of diminishing the number of media stereotypic messages in the future, thereby enhancing the public's positive attitudes in the long run. We would concur that the possible short-term and unintended effects of suppression of stereotypes are bound to be outweighed in the long run by a reduction of insulting, demeaning, prejudice-laden media presentations.

More subtly, media (especially film and television) portrayals of therapists and the mental health profession may provide both denigrating and overidealized images of such professionals, shaping not only the general public's attitudes and perceptions but also the expectations of trainees in the field and potential patients (Gabbard & Gabbard, 1992). Indeed, Gabbard and Gabbard uncover 10 common stereotypes of mental health professionals (e.g., "eccentric buffoon," "evil mind doctor," "dramatic healer"), pointing to the wide influence in the culture of such stereotyped roles.

Public education. Public education efforts have been better investigated (see the early review of Sarbin & Mancuso, 1970; for an updated review, see Corrigan & Penn, 1999). These include activities ranging from various forms of print media (brochures, booklets), visual media (slide presentations, featured television shows), workshops, and longer courses. Web sites must now be included in this category. Many such programs are based on findings suggesting that key components of more favorable attitudes towards mental disorder relate to (a) higher levels of general education, (b) knowledge of mental disorder, and (c) information about the contexts surrounding mental disorder—for example, the types of community placements into which previously institutionalized persons will be placed (Brockington et al., 1993; Penn et al., 1994).

In a key example of a relatively lengthy intervention, Holmes et al. (1999) investi-

gated the effects of a semester-long community college course designed to foster accurate perceptions of mental illness. Beneficial effects on attitudes were noted, and these were attributed to the discussion and interaction (as opposed to strict lecture) format. Yet (a) effect sizes were not large and (b) those community college participants who had reported higher levels of prior knowledge of severe mental disorder showed larger benefits than those with little prior knowledge. In a shorter program, Penn, Kommana, Mansfield, and Link (1999) found that providing information about the actual levels of dangerousness of persons with schizophrenia (relative to those with substance abuse disorders) did reduce stigmatic attitudes regarding schizophrenia. The potential downside, however, was that this effect may have merely been one of "substitution"—that is, promoting more fears and stereotypes about the alternative condition (i.e., substance abuse). Furthermore, extremely short informational inserts or additions to media presentations do not appear to be of much benefit (see review in Corrigan & Penn, 1999).

Overall, some short-term benefits have been recorded from educational interventions, chiefly in the realm of attitude change. Lecturing and informational brochures are not as likely to yield meaningful effects as are more interactive types of education. Furthermore, there is reason to believe that many stereotypes (e.g., those associated with race or gender as well as those related to mental disorder) are "automatic" in nature, not fully modifiable by information-based interventions alone—and perhaps even sufficiently "consistency-enhancing" to resist informational disconfirmation (Stangor & McMillan, 1992). Thus, challenges exist in the creation of powerful educational interventions; it may be that actual contact (more than education alone) is necessary to influence attitudes and behavior.

Behavioral contact. Behavioral contact is therefore the third category of antistigma efforts. Several states have formally introduced means for having persons with mental illness interact directly with mental health professionals in order to foster interaction and pro-

vide direct information about the disability that can attend to mental disorder (Corrigan & Penn, 1999). In addition, a formal meta-analysis by Kolodziej and Johnson (1996) revealed that contact with individuals suffering from mental disorder—usually exposure to mental health professionals or students, in institutional settings—was, in fact, associated with improved attitudes. Interestingly, the length of contact was not related to attitude change, and reduction of negative attitudes was more pronounced, overall, than enhancement of positive attitudes. Larger effects were also noted for personal contact-related interventions when used with college students than with mental health employees, showing the distance still needed to travel to overcome professional and staff-related stigma.

Corrigan and Penn (1999) provide a useful summary of those factors that should enhance the effectiveness of contact-related interventions, including (a) equal status and close contact among contact participants, (b) use of cooperative tasks during interaction, (c) institutional support for the contacts, and (d) contacts with persons with mental illness who do not greatly deviate from the stereotypes of mental disorder. This last point is intriguing: if members of the community have contact with an individual who is markedly different from the prevailing stereotype (e.g., a “model” person with mental disorder), then the stereotype may paradoxically be reinforced, as the individual is “subtyped” as atypical of members of the group (Kunda & Oleson, 1995). Thus, close interactions with persons who only mildly disconfirm the stereotype may be optimal for pervasive attitude change. Overall, contact with persons with mental disorders can be a powerful means of fostering attitude change, so long as the contact is not primarily focused on visits to or tours of mental facilities (which often promote distancing rather than real contact) or the encountering of erratic behavior on the street.

To the three types of “interventions” discussed by Corrigan and Penn (1999), we add a fourth, which is a corollary of the third (behavioral contact): disclosures of personal or familial mental disorder by influential people

in society. Several examples of such disclosure and exposure have abounded in recent years: first, books for the lay public (e.g., Jamison, 1995; Styron, 1990); second, television exposure (cf. the appearance of Naomi Judd, Mike Wallace, Art Buchwald, and Kay Jamison on *Larry King Live*, all of whom openly discussed their histories of mental disorder); third, disclosure by political figures (e.g., Tipper Gore’s magazine and newspaper stories regarding her experiences with depression); fourth, worldwide scientific acclaim (cf. the Nobel Prize awarded to game theorist John Nash, despite his long history of schizophrenia—see subsequent discussion); and fifth, disclosures by athletes (e.g., those with ADHD or Tourette’s disorder). Through all of these, the general population is exposed to persons of stature for whom mental illness is a fact of life. Our examples here are, of course, quite selective, as such disclosures are far more commonplace than in the past. In fact, prior disclosures of a “forced” variety have been disastrous: Vice Presidential candidate Thomas Eagleton was forced to withdraw in 1972 upon revelation of a history of alcohol abuse, depression, and treatment with ECT.

Indeed, one of our objectives for this article is to normalize even further the presence and disclosure of severe mood disorder in family members, as witnessed by S.H.’s excerpted discussion of his father. At another level, many physical illnesses receive increased recognition and funding when “stars” are attached to their cause (Kalb, 2000)—for example, at the time of the writing of this article, the actor Michael J. Fox has become public about his decade-long affliction with Parkinson’s disease; Muhammed Ali has also been a spokesperson. Although we do not necessarily advocate the finding of “stars” for all mental disorders (see discussion in Wahl, 1999b), an increasing atmosphere of disclosure, normalization, and positive publicity can only help to facilitate general attitudinal shifts. “Coming out of the closet” certainly incurs risks, but its application to mental disorders may provide increasing benefit in future years. We look forward to the point in time when such disclosures will no longer be pro-

vocative or newsworthy—which would be a clear sign of greater openness and acceptance.

Assessment of stigma

Space permits only brief notation of issues regarding the measurement and assessment of stigmatization, which are crucial to the evaluation of effective intervention and destigmatization programs. For one thing, most of the extant research utilizes self-report of attitudes toward the mentally ill as the primary or sole outcome measure. It is noteworthy that factor analyses of attitude scales tend to reveal several core dimensions of relevant attitudes: fear and exclusion of the mentally ill, benevolence, and authoritarianism and control (Brockington et al., 1993; Holmes et al., 1999). Informational programs have yielded reductions of the authoritarian components of attitudes but not, to the same extent, increases of benevolence.

Key problems exist, however, with self-report as the sole outcome indicator of stigma reduction programs. For one thing, social desirability is likely to plague such self-report (see Link & Cullen, 1983, for excellent research demonstrating such influences). The investigation of Page (1995), cited earlier in this article, is particularly instructive in this regard. Rather than relying on survey reports of public attitudes towards mental disorder, Page conducted a randomized experiment, in which those who had advertised rooms or apartments for rent (in the United States and in Canada) were phoned, either without elaboration or with the additional phrase that the caller was receiving mental health treatment in a hospital but would soon need a room upon release. Significantly fewer rooms were described as “available” in the latter, experimental condition. Page contrasted his findings with results from several surveys that appear to reveal a reduction of stigmatization of mental disorder. The relevant point, again, is the critical nature of how stigma and discrimination are assessed. Dovidio and Gaertner (2000) emphasize this issue with respect to the assessment of racism: although overt expressions have decreased in recent years, sub-

tle yet pernicious discrimination still persists in terms of such indicators as job selection.

In addition, to the extent that stigma and stereotyping are automatic processes, it may be that answering verbal or written questions is too far downstream in the process, utilizing an overly “cognitive” assessment means for processes that are quick and unconscious. The field may do well to consider use of measures from research on racial or gender prejudice that incorporate reaction times and other processes that circumvent verbal or written responses (see Dovidio & Gaertner, 2000).

There is no guarantee that even veridical attitude change will translate into behavioral indicators of reduced stigma. Indeed, associations between attitude change and behavior change are modest to moderate (Krauss, 1995), revealing their partial independence. A major need for subsequent research efforts is the utilization of ecologically valid behavioral measures to supplement attitude change (e.g., the telephone responses of renters from Page, 1995, and the interpersonal interactions of stigmatized and nonstigmatized individuals from Farina et al., 1968, 1971). Furthermore, although evaluations of long-term attitude or behavioral change following intervention are nearly nonexistent in extant research, they are clearly needed to ascertain any protracted benefits of antistigma interventions.

We indicated earlier that families experiencing mental illness need to be included as participants in research on stigma (e.g., Tessler & Gamache, 2000; Wahl, 1999b; Wahl & Harman, 1989), as do individuals with mental disorders themselves. Family members are uniquely attuned to the exclusions and slights endured as a function of mental disorder (Wahl & Harman, 1989) and to related stresses and strains on family functioning. In addition, to the extent that stigma has some of its most devastating consequences on the initiative, self-image, and self-esteem of persons suffering from mental disorders (Corrigan & Penn, 1999), measures of personal motivation or of change in self-perceptions are needed to evaluate the effects of stigma reduction (Wahl, 1999b). It may be difficult to disentangle the effects, for such measures, of interventions intended to treat the disorder per

se from efforts designed to reduce stigmatization by health professionals or the community at large. Indeed, the symptoms of many disorders are related to motivation, initiative, and self-image, which also are influenced by societal prejudice and reactions. One of the ultimate benefits of successful programs for stigma reduction may be to augment the gains yielded from individual and family-level treatments.

Finally, at a policy level, outcomes need to transcend individual-level measures of attitudes and behavior. For example, quality of care in treatment settings is presumably related (negatively) to stigma. We posit that the extent to which intervention programs and participating staff are respectful, responsive, and effective is a potentially important measure of stigma and of its reduction. In addition, access to mental health care is disturbingly low (U.S. Department of Health and Human Services, 1999); greater access to such care in the future may well be one of the most important indicators regarding reduction of stigma in terms of health-care policy, insurance coverage, and the like. In all, policy-level interventions mandate broader measures of stigma reduction than outcomes focused solely on individuals or families.

Policy Initiatives

In the past decade, a number of policy initiatives have been proposed or implemented, with the goal of increasing service availability and decreasing the stigma associated with mental illness. We selectively describe some of the most important and promising legislative policies aimed at reducing the stigma commonly associated with mental disorders.

In 1990, the Americans with Disabilities Act (ADA) was enacted, a key provision of which was to provide equal access to jobs, housing, public transportation, telecommunication, etc., for persons with physical or mental illness. Subsequently, in 1997 the Equal Opportunity Employment Commission (EOEC) was formed to extend and spell out in more specific fashion the rights of persons with mental illnesses as originally described in the ADA. Both the ADA and EOEC make it clear

that discrimination against persons with mental disorders is not acceptable or tolerable. Although it is not always evident precisely how to enact relevant accommodations in the workplace, the EOEC's charge of enforcing the ADA has led to greater awareness among employers and presumably greater ability for employees with mental disorders to keep their positions.

In the early 1990s, the United States' Senate Committee on Appropriations commissioned the National Advisory Mental Health Council (abbreviated herein as Council) to prepare a report on the cost of insurance coverage for medical treatment of persons with severe mental illness. The goal was to develop an insurance plan that would be commensurate with the coverage of other illnesses. In 1993, a special article was published in the *American Journal of Psychiatry* entitled "Health Care Reform for Americans with Severe Mental Illnesses: Report of the National Advisory Mental Health Council" (National Advisory Mental Health Council, 1993).

This report stated that, despite the existence of efficacious treatments, (a) many persons with severe mental disorders in this country cannot gain access to insurance coverage and (b) the extant coverage of those who do have access is typically insufficient and inequitable. For example, Council noted that private inpatient hospitalization was often limited to 30–60 days per year, whereas coverage of physical illnesses ranged from 120 days to unlimited days of inpatient care. Furthermore, persons with mental disorders who are on Medicare are required to make 50% co-payment for outpatient treatment, but Medicare recipients co-pay only 20% for other nonpsychiatric medical treatment. Council concluded that such insurance inequities for persons with mental illnesses constitute discrimination and that, with sound health care reforms, the nation could provide insurance coverage for children and adults with severe mental disorders that is commensurate with that for other nonpsychiatric disorders. Finally, Council contended that the economic benefits resulting from the increased productivity of persons with serious mental illness would more than offset the cost of providing such commensu-

rate coverage, even having the potential to generate an estimated \$2.2 billion in annual economic benefit for the United States.

In 1996, the Domenici–Wellstone Mental Health Parity Act (MHPA) became a first step in national legislation designed to acknowledge and redress the discriminating practices that exist in health care practices for the mentally ill. In particular, the MHPA strove to eliminate all annual and lifetime financial caps that are often invoked to deny persons with mental disorders the insurance coverage to obtain necessary treatments.

Despite the impressive efforts of the MHPA, key compromises were made to ensure its passage. For example, the number of inpatient hospital days and outpatient visits continues to be restricted, without regard to the seriousness of the patient's mental disorder. Likewise, the high copayments for all services related to mental illnesses remain burdensome, and the provisions of the act do not pertain to companies with fewer than 50 employees. Disturbingly, recent revelations by the General Accounting Office (GAO) document that thousands of employers are explicitly violating this legislation (Pear, 2000). Specifically, 14% of the employers surveyed by the GAO continued to set lifetime limits on mental health services that were lower than those for medical and surgical benefits. Furthermore, even among the employers who were complying with the letter of the law, many were still violating its spirit, by restricting such items as the number of visits or the length of hospital stays (even if they were complying with the overall requirement for equal dollar amounts of benefits). Such non-compliance again demonstrates the considerable distance that still needs to be traveled in order to reduce discrimination and stigma at the level of policy.

We contend that equal access to care must be made available to all individuals, regardless of their stage in the life cycle. Elderly citizens in this country have high rates of untreated mood disorders, a large number of children residing in poverty are Medicaid recipients, and persons with physical disabilities frequently are unable to receive necessary treatments for their mental health problems

(U.S. Department of Health and Human Services, 1999). In sum, it is essential that discriminatory practices in the insurance coverage of persons suffering from mental illnesses be abolished.

Encouragingly, efforts are underway in the Congress to expand the MHPA to reach full parity for persons with mental illness. The Mental Health Equitable Treatment Act (MHETA), introduced in 1999 by Senators Domenici and Wellstone, proposes full parity for the most severe and disabling mental disorders and partial parity (i.e., identical provisions except for the limits on treatment duration) for all mental disorders. The passage of MHETA could ensure that persons with mental illnesses will not need to receive disability benefits for large portions of their lives or be forced to live in public institutions because of a lack of adequate insurance coverage for mental illnesses. Even with passage, however, great efforts will need to be made to ensure compliance with its features, as highlighted for existing legislation by Pear (2000).

For the past several decades, the National Institute of Mental Health (NIMH) has appropriated enhanced funding for research on mental health services and their delivery. The NIMH and its Council have written several documents calling for parity of insurance coverage between mental disorders and general medical disorders (see the NIMH home page at <http://www.nimh.gov/publist/984332.htm>). The current NIMH Director, Dr. Steven Hyman, has been a strong advocate for mental health insurance parity.

A key concern is that such parity may be restricted to individuals with the most serious mental disorders, such as schizophrenia, manic–depressive illness, and other so-called “brain disorders.” As discussed earlier, we believe that the depiction of serious mental disorders as brain disorders is potentially misleading. Moreover, we fear that in order to obtain insurance coverage, patients with mental illnesses not designated as brain disorders may either be denied treatment or seek such a diagnosis in order to receive insurance coverage. As indicated earlier, equating serious mental illness with brain disorder could result in the public's developing stereotyped beliefs

that persons with mental illness have diseased brains, reminiscent of ancient times. Thus, such terminology may engender stereotypes about persons with mental illness that are unsupported by data. Despite the laudable goals held by proponents of such designations in terms of reducing shame, guilt, and self-blame, the concept of mental illness as brain disorder may unwittingly lead to the incorrect belief that the brain is an unchanging organ and (because patients with "diseased brains" are so different from others) result in additional stigmatization, discrimination, and a lack of access to care. We underscore that all mental disorders should receive parity with nonmental disorders in terms of insurance coverage.

In late 1999, Kendra's Law went into effect in New York, wherein patients with mental illness can be ordered to enter treatment before they inflict harm on themselves or others. According to this law, persons with mental disorders can be taken to court if they fail to comply with their medications or if they do not show up for their outpatient appointments. If they persist in refusing treatment, then they can be hospitalized against their will.

The legislation was named for a woman from upstate New York who died when she was pushed in front of a subway train by a patient who had a diagnosed serious mental disorder (and who, in fact, had pleaded to be hospitalized and had been placed on a number of waiting lists for supervised housing and a case manager). Its clear intent is to prevent persons with mental disorders from engaging in acts that would further contribute to their stigmatization. Some have feared, however, that under Kendra's Law persons with mental disorders could lose their right to choose their own form of therapy or to remain out of hospital settings.

Brief historical perspective is necessary in evaluating such contentions. Indeed, Kendra's Law provides a recent example of the cyclic debates between (a) individual versus societal rights and (b) voluntary versus involuntary treatment for mental disturbance. Before the 1960s, it took little effort in the United States (other than obtaining a judge's signature) to institutionalize an individual with an alleged

mental disorder for indeterminate lengths of time. Such practices were clear evidence of the fear of mental illness, its stigmatization, and the lack of civil rights of persons with mental disorders. In the wake of the civil rights movements for racial and sexual equality, legislation was enacted in the 1960s and 1970s that severely restricted the circumstances under which civil commitment could be made. Yet many advocates, including those promoting Kendra's Law, contended that such "civil rights" could be quite stigmatizing, when many of the most severely disturbed individuals in society (whose paranoia and lack of reason precludes their realization of a desperate need for treatment) are allowed to live on the streets in squalor, revealing to the general public the worst aspects of serious mental disorder. Another perspective, of course, is that Kendra's Law can be viewed as protective of society, at the expense of civil liberties. It will be important to track whether legislation such as Kendra's Law, designed to ease restrictions on commitment procedures, will in fact reduce stigmatization.

The federal Compassionate Care Act of 1999 amends an earlier Public Health Service Act requiring hospitals and other care facilities that are recipients of any form of federal assistance to protect the rights of their patients and residents, including ensuring freedom from physical abuse or mental abuse, corporal punishment, involuntary seclusion, and physical or chemical restraints utilized for punishment or convenience. Given the legacy of warehousing, maltreatment, and even frank abuse in institutional "care" for mentally disordered individuals (see earlier portions of this article; see also Mora, 1992), it is essential that such legislation be enforced and carefully monitored.

Exemplifying international initiatives, the Royal College of Psychiatrists in the United Kingdom (in collaboration with the World Psychiatric Association) launched a national, 5-year antistigma campaign in 1998 (see www.rcpsych.ac.uk). Its formal name is "Changing Minds: Every Family in the Land," with the goals of increasing public and professional understanding of mental disorder, decreasing stigma and discrimination, and closing the

gap between professional and public knowledge. The relevant Web sites and brochures are vivid, written in clear and direct language. In the United States, the National Institute of Mental Health has informational Web sites (e.g., <http://www.nimh.nih.gov/publicat/index.cfm>), with considerable focus on child mental disorders, in the wake of substantial media attention to school-based violence and controversies over medication treatment for young children. Despite the promise of such initiatives and the high quality of the materials that have been made available, we reiterate that it still may take (a) productive behavioral contact and (b) the public visibility of noteworthy individuals who disclose mental disorder—over and above educational materials alone—to put a significant dent into stigmatization.

Commentary

First, an important cautionary note is raised by Campbell and Heginbotham (1991), who assert that legislation designed to improve services and decrease stigmatization specifically for persons with mental disorder may backfire. They contend that such policies will, by definition, single out mental disorders as deserving of special status or “special treatment,” further fueling potential stigmatization. Although their full argument is too detailed to recapitulate herein, its main thrust is that discrimination against persons with mental disorder should be fought under the guise of general social principles of equity and responsibility rather than through disorder-specific laws. Although we do not agree fully with their argument, it provocatively raises the issue of potentially harmful effects of even the best-intended policies and legislation.

Second, we raise the more general issue of whether legislation in and of itself can fundamentally change attitudes and prejudice. A key argument raised in the 1960s regarding the historic civil rights legislation that was enacted was that one cannot “legislate morality.” Although such arguments were typically invoked as an excuse for legislative inaction, it is naive to imagine that laws alone can or should alter fundamental human attitudes to-

wards outgroups or typical victims of bias and discrimination. Furthermore, backlash can certainly occur without preparation for legislated equality (as just one example, witness the strong protests against mandated school busing to achieve racial equity in schools). Thus, we raise the question of how best to integrate “hard” procedures (e.g., legislated equal access to insurance, mandates for humane treatment) with “softer” initiatives designed to promote empathy, compassion, and acceptance. Fundamental change doubtless requires a dual strategy of (a) protests, mandates, and legislation plus (b) education, behavioral exposure, and disclosure.

Societal and Ethical Issues for the Present and Future

We comment on two broad issues raised by the topic of stigma and mental disorder: tolerance of nonconformity and genetic screening or engineering. These issues are of great importance for society in general, thus exemplifying a basic tenet of developmental psychopathology—the dynamic interplay between “normal” and “abnormal” (Cicchetti & Cannon, 1999b; Cicchetti & Cohen, 1995). In parallel, we contend that investigation of stigma and mental disorder (a) both informs and is informed by general research on social cognition and social perception, prejudice, and discrimination (e.g., Corrigan & Penn, 1999) and (b) potentially illuminates crucial issues for society at large, transcending mental illness *per se*.

Tolerance for diversity

First, like the stigma and prejudice associated with such individual differences as ethnic–racial identity, sexual orientation, and gender, the negative stereotyping of and discrimination towards persons with mental disorder raises fundamental questions about the levels of diversity that a given society is willing to tolerate (Allen & Grobman, 1996; Garcia Coll et al., 2000; Spencer, 1995; Spencer & Dupree, 1996). All social groups exert some pressure for conformity and rule-following—indeed, these are processes that underlie

group cohesion and social control—yet societies differ markedly in terms of tolerance for diversity versus pressure for conformity. Particularly in large, multicultural societies, placement on this continuum may have great relevance for an individual's civil rights. Pertinent questions include the following: What degree of conformity to social and behavioral norms do we expect from members of a given society? What kinds of deviance are branded as acceptable, and what kinds are potentially considered as both qualitatively distinct and, in a Western, technological society, as products of a putative mental disorder? To what extent is the tendency for all social units to form in-groups and out-groups “natural” and expected—and to what extent can humans learn to transcend tendencies to scapegoat, stereotype, and punish those different from the norm? Will our continually evolving conceptions of significant psychobiologic underpinnings for many forms of severe psychopathology reduce bias and stigmatization, or, rather, will they invoke notions of biological inferiority for persons with severe forms of behavioral deviance?

Such global, philosophical questions resist easy answers. At a concrete level, we might ask how well our society has done in terms of accepting racial and ethnic diversity over the past several generations. Although clear evidence of improvement exists, fueled in the 1960s by civil rights legislation, persistent prejudice has not been eliminated (see Dovidio & Gaertner, 2000). In addition, the genocidal tendencies in multiple cultures on earth (e.g., Serbia–Croatia; Rwanda) serve as warning against easy reassurances of fundamental human change in this regard. Invoking a parallel argument, and reflecting on the previous section, how much can antidiscrimination policy and legislation foster changes in the lives of individuals with mental disorders? How much additional work—for example, in terms of attitude change—will be required at individual, familial, and community levels to supplement general policies related to discrimination and mass education?

To paint an optimistic scenario: We know that the unpredictability, deviance, and lack of accountability of behavior patterns associated

with mental disorder appear to be the qualities most disturbing to the general public (Rabkin, 1974) and that, from most prior research, merely ascribing such behavior patterns to “mental disorder” does not automatically eliminate stigma. Yet as (a) overtly moralistic attitudes diminish, (b) our society becomes more heterogeneous in many respects (e.g., ethnically, religiously, behaviorally), (c) public disclosures of mental disorder become accepted, and (d) more education takes place regarding the existence of psychobiologically based (but environmentally influenced) “mental disorders” that may underlie the propensity towards extreme aberrations of behavior, we can envision greater tolerance and even compassion. Indeed, given the extent to which serious mental disorder affects a huge percentage of families, past tendencies towards silencing and distancing have served to isolate rather than unite a huge proportion of society who might otherwise welcome the relief of disclosure, shared pain, and renewed hope.

As an example, Nasar's (1998) biography of the game theorist and economist John Nash shows how the Nobel Prize committee in Stockholm fought to overcome prejudice and finally give him the award, despite his having suffered for decades from paranoid schizophrenia. This influential committee actively debated whether the prize would be tarnished by being received from a stigmatized, aberrant individual. Its final decision is clearly a positive sign. More telling, and more relevant for far greater numbers of individuals, will be the allowance to pursue meaningful employment or housing and the chance to integrate into society. For families, tolerance for diversity (related to mental disorder) should help to overcome pervasive isolation and shame. Again, however, to the extent that codes of acceptable behavior and lifestyle are narrowly defined, many forms of mental disorder will continue to be a salient example of the kinds of behavior that are castigated.

Genetic screening and engineering

Second, and in many ways related to the points just made about tolerance for diversity, fast-growing molecular genetic technology is

confronting society with the potential for detection of risk for mental disorder. It is not unreasonable to envision that, in the relatively near future, prospective parents could obtain a genetic map containing percentages of risk for major psychopathology in their offspring. Presumably, families might be more likely to elect to abort the fetus if risks were ascertained to be sufficiently high or if disorders were deemed to be sufficiently severe or stigmatized—schizophrenia and bipolar disorder come most readily to mind. Furthermore, with the potential for advanced genetic engineering not far behind, what sorts of interventions might society allow in terms of predetermining physical, mental, or emotional characteristics of unborn children? How much would pressure grow to engineer socially desirable traits, perhaps at the expense of limiting the genetic diversity of the entire human gene pool? In other words, how much would the desire to eliminate the real suffering and tragedy of serious mental disorder lead to (a) substantially reducing diversity and (b) potentially eliminating the adaptive qualities that may be associated with subthreshold (or even above-threshold) expressions of genetic risk (cf. Jamison, 1993)?

Given the lack of evidence to date for any single-locus origins of most psychiatric conditions (including those as heritable as bipolar disorder, schizophrenia, autism, and ADHD), such screening information would necessarily include ranges of risk rather than absolute “certainties.” But how would unknown environmental potentiation or reduction of genetic risk be factored in? We sense that even modest levels of presumed risk could become sufficient to have families choose abortion as an option. Take the example of bipolar disorder: risk to the offspring of an afflicted parent is around 8%, nearly 10 times the population risk but still quite low (Cicchetti & Toth, 1995; Goodwin & Jamison, 1990). Genetic screening might give more precision to that risk estimate for a given individual, but in the absence of knowledge of what life experiences may potentiate or diminish the actual risk. Furthermore, given the efficacy of mood stabilizing medications at present—with potential for large improvements as psychophar-

macology realizes intentional drug design rather than accidental discovery—how much concern should a family or society at large have about risk for this disorder? At a specific level, how would the potential for creative expression be weighed against the potential for suicidal depression?

Full exploration of this large and potentially explosive topic is obviously beyond the scope of this article. We can do no better than to quote Lander and Weinberg (2000), who authoritatively reviewed the past and future of genetics and genomics (the study and potential manipulation of complete genetic sequences) for the prestigious journal *Science* at the beginning of the year 2000:

The prospects for 21st century biology are surely breathtaking. At the same time, we must confront this new world soberly and with trepidation. The genetic diagnostics that can empower patients to seek personalized medical attention may also fuel genetic discrimination. . . . So the most serious impact of genomics may well be on how we choose to view ourselves and each other. Meeting these challenges, some quite insidious, will require our constant vigilance, lest we lose sight of why we are here, who we are, and what we wish to become. (p. 1782)

Conclusion

This article has been a “call” for several themes: reflection, pursuit of better science related to stigma and stigmatization, clarification of values, and action. The topic of stigma and mental disorder raises a host of historical, cultural, scientific, and ethical issues, with enormous implications for policy and policy change and for human interactions in general. Our hope is that the material we have covered will enlighten and motivate action on a number of research and policy fronts.

A pessimistic appraisal is that extreme social deviance, whether or not branded as mental disorder, will continue to receive extreme stigma and discrimination during the new millennium—the human legacy of demonizing and even annihilating outgroups is simply too entrenched. More optimistically, we posit that an important and needed “virtuous cycle” is beginning to take shape with regard to mental disorder and its stigmatization. That is, im-

proved scientific understanding is leading to better knowledge of fundamental mechanisms, spurring advances in treatment and care that, though still insufficient, are showing signs of real progress. An important by-product will be, we hope, improved training in and awareness of mental health and its stigmatization by scientists, professionals, and treatment staff. With better treatments and more tolerant and compassionate staff, greater levels of adaptive functioning and integration into the community can be attained, which should in turn foster more egalitarian contacts (the most powerful means of attitude change) and thus increased acceptance by the general public. As the public becomes better educated about the nature of mental disorder and in an atmosphere of normalized disclosures, another by-product may be the freedom to reflect on its and its own families' struggles with mental disorder with tolerance and acceptance rather than shame and fear as the backdrop. Defensive ascriptions of "us" versus "them" thinking may thus diminish.

Eventually, increases in funding levels for basic and applied research should lead to even greater knowledge and more sensitive care and to the attraction of top scientific minds and professionals to the field. Indeed, mental disorder is at the forefront of what is perhaps the ultimate intellectual challenge for the next millennium: the integration of mind, brain, consciousness, and human nature (cf. Cicchetti & Cannon, 1999b; Hyman, 2000; Kandel, 1998). The cycle of increased knowledge, enhanced care, greater public acceptance, and support for even more advances in knowledge could thus begin anew.

Is this too optimistic a picture? Will fear and intolerance prevail? If history serves as a guide, then we are bound to see (both over

time and across cultures) cycles rather than linear progress. Yet we believe that the trajectory is on a progressive, if uneven, rise. We emphasize that the essential element will be to promote, at all costs, the judgment and value that even the most severely disordered individuals are fully human. As we have seen, once behavior patterns, and then persons and subgroups, are branded as less than human, tendencies toward exclusion and extermination are not far behind.

Sontag's (1978/1989) words on AIDS, and the "baggage" that this illness carries, can serve as an epilogue for our discussion of mental illness and stigma:

... it is highly desirable for a specific dreaded illness to come to seem ordinary. Even the disease most fraught with meaning can become just an illness. . . . The age-old, seemingly inexorable process whereby diseases acquire meanings (by coming to stand for the deepest fears) and inflict stigma is also worth challenging, and it does seem to have more limited credibility in the modern world, among people willing to be modern—the process is under surveillance now. . . . But the metaphors cannot be distanced just by abstaining from them. They have to be exposed, criticized, belabored, used up. (pp. 181–182)

The challenge is great, however, when the subject is mental disorder, in that the afflicted organ is the brain and the symptoms of the (mental) illness are behaviors and emotions. Perhaps mental disorder will never be entirely shed of metaphor regarding evil, lack of control, and less-than-human qualities. Yet sensitive, aggressive policy change—and an equally sensitive and aggressive response by scientists and professionals to counter prejudice, subjugation, and superiority—are well worth the effort.

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