The Stigma of Mental Illness

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Stigma surrounding major mental illness creates many barriers. People who experience mental illness face discrimination and prejudice when renting homes, applying for jobs, and accessing mental health services. The authors review the current literature regarding stigma and mental illness. They define stigma and review theories that explain its impact. Counselor training is a peak time to identify and begin to mitigate stigma related to people with mental illness. Implications for counselor training are addressed.

"People suffering from mental illness and other mental health problems are among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of our society" (Johnstone, 2001, p. 201). Negative connotations and false assumptions connected with mental illness may be as harmful as the disease itself. Schizophrenia may evoke visions of violence and inability to care for oneself. Depression may conjure thoughts of laziness and substance abuse. Societal stigma significantly limits opportunities that are available for people with serious mental illnesses (Johnstone, 2001). In 1999, the Surgeon General's report pointed to stigma as a key variable in understanding the course of illness and outcomes for people who have been given a psychiatric diagnoses (Corrigan, Green, Lundin, Kubiak, & Penn, 2001). In this article, we first review the definitions of mental illness and stigma and then review the literature about the theories of stigma and the impact that stigma has on people with mental illnesses. Using current research as our basis, we suggest ways that counselors can work to mitigate the stigma of mental illness. We conclude with suggestions for dispelling the stigmatizing beliefs that counselors hold.

Defining Mental Illness and Stigma

Concepts about mental illness can be subjective, and it can be difficult to define. One of the definitions listed for mental illness in the *Merriam-Webster Dictionary* (1990) is "mentally disordered, mad, or crazy" (p. 506). During the Middle Ages, people with mental illness were considered to be living examples of the weakness of humankind. The common belief was that mental illness was a result of being unable to remain morally strong. People with mental illnesses were jailed as criminals and, on some occasions, put to death (Corrigan, 2002). In 1974, Thomas Szasz wrote about the "myth" of mental illness. He stated that physicians used anatomical and pathological methods to help identify physical illness. There was proof that these illnesses existed because of how they altered the physical body. Szasz's belief was that medical illnesses were being discovered, whereas psychiatric illnesses were being invented. According to Szasz, psychiatrists were inventing diseases based on groups of common symptoms. Most of the symptoms that accompany mental illness are invisible, leading people who experience these symptoms to doubt their reality and to experience isolation within that reality (Glass, 1989).

A broader and more current definition of mental illness refers to the spectrum of cognitions, emotions, and behaviors that interfere with interpersonal relationships as well as functions required for work, at home, and in school (Johnstone, 2001). This definition takes into account a myriad of different functions and how they affect a person's ability to perform the tasks necessary for daily living. This definition is also present in the current psychiatric diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; American Psychiatric Association, 1994). Most of the diagnostic categories take into consideration the degree to which the symptoms of a mental illness impede a person's daily functioning when identifying the severity of the diagnosis. With this definition as a criterion, Hardcastle and Hardcastle (2003) found that 30% of all general practitioner consultations involved a mental illness. They also reported that one in four people has a mental illness at some time in her or his life.

As is the case with major mental illness, stigma is also a difficult concept to define. Historically, *stigma* comes from the Greek word *stigmata*, which refers to "a mark of shame or discredit; a stain, or an identifying mark or characteristic" (*Merriam-Webster Dictionary*, 1990, p. 506). Stigma, when it is used in reference to mental illness, is a multifaceted construct that involves feelings, attitudes, and behaviors (Penn & Martin, 1998). There are several current theories about the construct of stigma and how it might be deconstructed and defined. These theories include *social identity, self-stigma,* and *structural stigma*.

Theories of Stigma

Social identity theory considers how people use social constructs to judge or label someone who is different or disfavored. Societies, or large groups within societies, evaluate

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people to determine if they fit the social norms. Social identity is a concept first written about by Goffman (1963). He discussed how stigmatized people form a *virtual social identity* when they become disfavored or dishonored in the eyes of society, and then they become outcasts. This applies to people with mental illness because, historically, mental illness has been viewed as a character or moral flaw. The term *spoiled collective identity* was also coined by Goffman to describe people who were stigmatized and whose identity as a whole was brought into question. Individuals who are not stigmatized are also judged by society. People with mental illness are often judged by their behaviors, but this does not reflect their whole being. With spoiled collective identity, the stigmatized person is reduced in the minds of others from a whole and normal person to a tainted, discounted one. Crawford and Brown (2002) agreed that stigma arises when an actual social identity falls short of a societally defined ideal identity.

The second theory of stigma is self-stigma. Self-stigma is an internal evaluation process whereby people judge themselves. This judgment could be a result of messages received from societal norms, but ultimately it is the individual who is creating the judgment toward himself or herself. This judgment decreases self-esteem as a person tells him- or herself that he or she does not fit in or is not good enough to live up to the expectations that others impose on a person and his or her environment (Blankertz, 2001). Self-efficacy has an impact on the belief that one can perform, and, consequently, confidence in one's future is greatly reduced when self-efficacy is poor (Blankertz, 2001; Corrigan, 2004). Individuals may internalize an identity that dehumanizes them. When individuals do not live up to the social norms regarding their identity, they have feelings of inferiority, self-hate, and shame (Lenhardt, 2004). Corrigan (2002) described self-stigma as a private shame that diminishes self-esteem and causes self-doubt regarding whether one can live independently, hold a job, earn a livelihood, and find a life mate.

Structural stigma is similar to Goffman's (1963) spoiled collective identity because it is an external evaluation of a person that is based on societal norms. This theory looks more in depth at the process of stigma throughout a culture and how stigma works as a system. The theory of structural stigma depicts the tangible barriers created for people who have mental illness. According to Johnstone (2001), one third of all states restrict the rights of people with a mental health diagnosis to hold elective offices or sit on juries, and one half of all states restrict the child custody rights of someone with a mental health diagnosis. Structural stigma describes a process that works to deny people with a mental illness their entitlement to things that people who are considered "normal" take for granted. People with a mental illness may have difficulty finding their function or a sense of place in the intersubjective world (Johnstone, 2001). They might also be challenged in the effort to find empathetic and supportive relationships with others, happiness, participatory citizenship, and peace of mind.

The Stigma Process

According to Corrigan (2004), structural stigma is a process. The process involves (a) the recognition of cues that a person has a mental illness, (b) activation of stereotypes, and (c) prejudice or discrimination against that person.

Cues. A cue is a social cognitive process of recognizing that something is different about a person. A cue may take several forms. A cue may be something physical or observable, for instance, a psychiatric symptom, a deficit in social skills, or a difference in physical appearance. A label or psychiatric diagnosis may also work as a cue, including a nonspecific label. In many cases, it does not matter what the diagnosis is as long as it involves a mental and not a physical aspect of a person; the diagnosis itself works as a cue (Corrigan, 2004). Other research shows that some psychiatric diagnoses work as a stronger cue than others. For example, psychotic diagnoses have more stigma associated with them than diagnoses of mood disorders (Granello & Wheaton, 2001). It is unclear if this is because mood disorders are more prevalent and acceptable in our culture or because psychotic symptoms are often feared and are further from the norm for acceptable behavior.

Stereotypes. After a person has been cued that there is something different about an individual, stereotypes are activated within that person's thought process. Stereotypes are defined as knowledge structures that are learned by most members of a social group (Corrigan, 2004; Lenhardt, 2004). According to research, stereotypes are collectively agreed-upon notions about a group of persons that are used to categorize these people (Krueger, 1996). Even though someone may hold stereotypes about a group of people, they may not believe them or endorse these ideals. When someone sanctions a negative stereotype, he or she is generating what is called *prejudice*.

Prejudice. Prejudice is a result of cognitive and affective responses to stereotypes. One common affective response is reflexive disgust, which is considered a defensive emotion. Often disgust is accompanied by a fear of contamination by or an overwhelming wish to avoid what is judged as unacceptable or offensive (Brockington, Hall, Levings, & Murphy, 1993; Corrigan et al., 2001). After the initial reflexive reaction, a cognitive and rule-based process takes over (Pryor, Reeder, Yeadon, & Hesson-McInnis, 2004). The rule-based process is based on rules that emerge from expected social interactions. The rule-based system allows the individual to make adjustments to his or her reflexive and subsequent reactions. This process can be turned off and on and may replace the initial response of disgust with one of pity or courtesy. People who have a strong internal motivation to control prejudice that is paired with weak external motivations to control it demonstrate less race bias on implicit measures (Pryor et al., 2004). If the rule-based system does not engage, more emotions are created as a result of prejudice. Statements such as "I hate them" or "they are dangerous and I'm afraid of them" are common examples of strong emotion toward a targeted group. Prejudice then leads to discrimination.

Discrimination. Discrimination is a behavioral response to the emotions and beliefs generated by prejudice. There is an emotional reaction that comes from attaching stigma to someone or something. Fear, for example, is a strong emotion, and this reaction leads to a behavioral response. For instance, social distancing is a common response to fear (Corrigan et al., 2001).

Among the underpinnings that support discrimination against mental illness are that belief systems are deeply ingrained and often structurally reinforced by societal attitudes of fear, ignorance, and intolerance (Johnstone, 2001). The belief systems that society holds about mental illness are so deep-seated that when someone has an interaction with a mentally ill person, their cognitive processes often distort the social relationship, leading to conscious and unconscious behaviors. The lens that people are looking through makes it both easier to see and to ignore certain conditions (Lenhardt, 2004).

Discrimination involves different aspects for the majority group and for the stigmatized group. Behaviors exhibited by the majority group result in negative action toward the stigmatized group and positive action for the majority group. Often, the positive action simply reinforces beliefs and stereotypes that were previously held by the majority group, thus creating barriers between the groups. *Avoidance* is a common action that a majority group can take. With avoidance, the stigmatized group becomes the out-group (Blankertz, 2001).

Avoidance is often defined as being attributive—the act or practice of keeping away from or withdrawing from something undesirable (*Merriam Webster Dictionary*, 1990). Avoidance may be an instinctual reaction triggered by stigma (Pryor et al., 2004). In 2001, Kurzban and Leary suggested that avoidance might serve several different functions, including social exchange, maintenance, and contagion.

Social exchange is based on the idea that people get something positive out of social interactions. If people are cued that someone with a mental illness is different or is perceived as beneath them in social status, they are less likely to interact with that person. They might be concerned that they are being cheated in the social exchange and use avoidance with someone who they perceive will offer them little or no social gain.

Maintenance of an ideal identity is another reason that avoidance may be used with someone with a mental illness. Establishing a social identity or group identity is important in establishing a social power structure. The question of stigma arises when a person's actual social identity falls short of some societally defined ideal identity (Crawford & Brown, 2002). Maintaining an ideal identity is also important to reinforce group norms and beliefs. Distancing allows the group with power to exploit subordinate groups and maintain their ideal identity as a group. Avoidance has a basis in blame, and someone who is being avoided is often being blamed for his or her own social situation (Alicke, 2000; Crandall & Eshleman, 2003).

The last reason that Kurzban and Leary (2001) have identified as a justification for using avoidance is concern about contagion. One of the many myths of mental illness is that mental illness is contagious. People often act as if physical contact with or even proximity to the stigmatized person can result in some sort of contagion (Pryor et al., 2004). Even though there is no research to support the idea that mental illness might be communicable, many people still perceive the idea as a truth. Avoidance is useful in dealing with the social consequence that being associated or socializing with a stigmatized person may influence one's social standing. The person socializing with someone with mental illness may be susceptible to the "contagion" of falling into the social group of the mentally ill (Sadow, Ryder, & Webster, 2002).

Avoidance is a common behavior that results from prejudice. However, the desire to avoid guilt may also be a motivating force in controlling prejudicial behavior (Pryor et al., 2004). People who are motivated to control initial prejudicial behaviors display more approach behavior toward the people they have stigmatized after they have had time to process. However, there are times when, even after reflection, people still choose avoidance. Avoidance is more common when the stigma is related to criminal activity.

Discrimination, or specific behaviors of prejudice, has a long history in the context of mental health. During the 19th century when people arrived at Ellis Island, officials were given a few seconds to decide if immigrants exhibited signs of insanity. If the immigrants were thought to be "insane," they were subjected to tests based on an illustrated guide to "signs" of insanity. These signs included behaviors such as acting like an Irish person, when in fact the individual was French. Individuals who were determined to be insane were sent back to their country of origin (Sayce, 1998). Discrimination is one of the primary elements that has an impact on people with mental illnesses.

Effects of Stigma

The process of stigma producing prejudicial behavior contributes to structural stigma. Specifically as a culture, it is normative behavior to perceive people with mental illness as dangerous and violent. There are many areas in which this cultural norm for prejudicial behavior results in prejudice against people with mental illness.The following areas are examples of the way in which structural stigma has an impact on people with mental illness: lack of employment opportunities; limitations on finding adequate shelter; barriers to obtaining treatment services, including negative attitudes of mental health professionals; and the role of the media in perpetuating the negative image of people with mental illness.

Citizens are less likely to hire people who are labeled *mentally ill* (Bordieri & Drehmer, 1986). Employers often assume that people with a mental illness may be more likely to be absent, dangerous, or unpredictable (Green, Hayes, Dickinson, Whittaker, & Gilheany, 2003). As a sort of self-fulfilling prophecy, it is not uncommon for people who experience such stigma to also experience more somatic symptoms.

It is more acceptable to talk about stomachaches and fatigue than one's mental problems (Wolport, 2001). Anticipation of negative responses from employers and fellow employees can also result in people with mental illness withdrawing from or limiting their social or occupational functioning (Alexander & Link, 2003). Researchers have found that once people have been labeled *mentally ill,* they are more likely to be underemployed and to earn less than people with the same psychiatric difficulties but who have not been identified as having them. This research shows that labeling alone can affect employment opportunities without taking into account a person's ability, knowledge, education, or qualifications for a particular job (Link, 1987).

Landlords may respond to people with mental illness in a way that is similar to the attitude and behavior of employers. They are less likely to lease apartments to someone who has been labeled *mentally ill* (Page, 1995). *Controllability,* as defined by Corrigan, Watson, and Ottati (2003), may be the key to acts of discrimination toward people with mental illness. Controllability is defined as the amount of volition one has in a situation. For example, a landlord may perceive a mental illness as something a person has control over or a result of negative behavior. The landlord may believe that the mental illness comes from something internal, such as poor moral character, and be less likely to agree to a lease.

Another way that stigma affects people with a mental illness is the barriers they face in obtaining treatment services. The most common barriers include financial challenges regarding paying for treatment, entry into treatment, and negative attitudes of mental health professional attitudes toward people with a mental illness (Simmons, 2001).

Financial barriers can make access to services difficult. As previously mentioned, if an individual has a mental illness, he or she might have a difficult time getting a job because of the stigma imposed on them by employers. They might also have challenges related to their symptoms that make it difficult to hold a job. Moreover, lack of resources and continued budget cuts can make it almost impossible for a person to receive comprehensive services. Such financial constraints also mean that mental health centers are often understaffed and underpaid, so that frustrations trickle down and can sometimes be reflected in the attitudes of those providing the services that are being offered to community members.

Entering into treatment can also be a barrier to services. Less than 30% of people with a mental health diagnosis actually seek treatment, and approximately 40% of people who had a serious diagnosis (e.g., schizophrenia) and who attempted to get treatment, failed to obtain treatment (Martin, Pescosolida, & Tuch, 2000). Schumacher, Corrigan, and Dejong (2003) found that stigmatized people who had an attribute that was easily concealed from others (e.g., gay men, someone from a minority faith community, or people with mental illness) could avoid negative attitudes by concealing the attribute and choosing not to seek support services. They may even choose to deny this attribute or group status by not seeking help through institutions that identify the attribute in the first place, like a community mental health center (Corrigan, 2004).

If a person with mental illness is able to reach out and seek services, the effects of stigma have been shown to influence the efficacy of his or her treatment (Sadow et al., 2002). People who are using services and perceive their own devaluation or rejection from society have been shown to have poor treatment outcomes (Jorm, Korten, Jacomb, Christensen, & Henderson, 1999). People with mental illnesses may have a difficult time accessing and using services. They may perceive support as minimal both from providers and from other support systems such as family and friends. This perceived lack of support often results in increased symptoms of depression (Mickelson, 2001).

Mental health professionals' attitudes toward someone with a mental illness can both perpetuate stigma and create new barriers to receiving treatment. Stigma can originate from the very people in the mental health field who are expected to offer help to persons with a mental illness. Most well-trained professionals in the mental health disciplines subscribe to the same stereotypes about mental illness as the general public (Corrigan, 2002). Historically, this has not changed much in the mental health field. The concepts reflected in the way that professionals talk about clients and conceptualize cases is very similar to the negative ideas that have characterized clients over the last 2 centuries. Patients are often thought to be incompetent. This attitude is similar to historical attitudes about psychiatric patients (Crawford & Brown, 2002). Cook, Jonikas, and Razzano (1995) actually found that the general public held more optimistic opinions about treatment outcomes for people with mental illnesses than were held by mental health professionals. Jorm et al. (1999) suggested that attitudes held by mental health professionals were influenced by the professionals' personal work experiences with clients and by prevailing attitudes of the profession and the professionals with whom they worked. Professional contact may improve general attitudes about mental illness, but such contact was not helpful in changing negative attitudes about predicting prognosis and long-term outcomes (Cook et al., 1995). Sadly, these negative attitudes may be conveyed to clients and their families and have an influence on their expectations of outcomes (Hugo, 2001). Fear is the most prevalent emotion reported by mental health professionals regarding this population. Some other secondary emotions include dislike, neglect, and anger (Penn & Martin, 1998). Fear is such a strong emotion that it may perpetuate stigma by creating more labels that influence clients' behaviors and symptoms.

One way in which structural stigma is learned and perpetuated is through the media. The media are reportedly the public's most important source of information about mental illness (Wilson, Nairn, Coverdale, & Panapa, 1999a, 1999b). In research by Corrigan, River, et al. (2001), 90% of survey respondents reported that they had learned about mental

illness from the mass media. The media contributes to structural stigma because it depicts characters with mental illness as being two-dimensional. The audience cannot relate to the character other than through the limited information that is presented. Most media representations of mental illness conjure up the image of a dangerous, violent individual who is almost always a potential killer (Sieff, 2003). Characters with mental illnesses are also portrayed in the media as being simple and childlike. Not only are the majority of characters with mental illness portrayed as physically violent (Wilson et al., 1999b), but they are also portrayed as unpredictable, failures, asocial, incompetent, untrustworthy, and often as being social outcasts. Television viewers find characterizations of individuals with mental illnesses in televised dramas to be more compelling than information from factual sources (Wilson et al., 1999b). Characters with a mental illness are depicted with an appearance, sounds, and reactions from other characters to signify danger and unpredictability. Camera shots and compare/contrast techniques (e.g., highlighting dangerous characters with lighting) are also used to underscore the differences between characters who experience mental illness and those who do not. Viewers are often not even aware of the influences that these techniques have on them (Wilson et al., 1999b).

Another area of the media in which mental illness is portrayed negatively is in children's media. In 2003, Wahl reviewed different forms of children's media, including television, films, and cartoons. Wahl determined that the common images of people with mental illness in these formats directed to children were consistent with such images in adult media. Mental illness is shown to be unattractive, violent, and criminal. Scheff (1999), one of the early pioneers in studying stigma, suggested that attitudes of stigma are fairly well set up by early childhood. In fact, he proposed that children probably understand the literal meaning of *crazy* as early as first grade. Some of the other messages that children's media conveys are that people with mental illnesses fail in life, are ridiculed by others, are unattractive, and seldom benefit from treatment (Wahl, 2003).

Impact of Stigma on Individuals With Mental Illnesses

The barriers to and negative attitudes toward people with mental illness that result from the stigma process affect them greatly. They are often compromised in dealing with daily activities. After hearing negative feedback and experiencing an onslaught of negative actions, they begin to see themselves in a negative light. People who have been diagnosed with a mental illness often find that their self-image and confidence are sacrificed by living under the pressure and negative expectations generated by stigma.

In 2001, Thesen discovered three attitude themes in conversations with clients and practitioners. The first theme that both clients and mental health workers noticed was that the language shifted. Clients and practitioners referred to clients as *cases* instead of *persons*. Such language is founded in a history of oppressing and dehumanizing people with mental illness. The second theme that Thesen found was lack of love. People referred to loneliness and feeling unaccepted. When they were asked to identify these feelings, people with mental illnesses described wanting love in their life and reported that they did not feel or experience this. The last theme that Thesen found for people with mental illnesses was that they felt like they lacked a life of their own. They felt that others were making choices and setting goals for them. These themes reflect an underlying attitude that contributes to a lack of self-efficacy for people with mental illness.

Self-efficacy can be defined as people's beliefs about their capability to achieve designated levels of performance. Self-efficacy is influenced by negative cognitions and low self-esteem (Blankertz, 2001). When people with a mental illness perceive that they do not have a support system and that they are dehumanized, they have a lower level of self-efficacy. When people with a mental illness perceive that people who constitute their support systems are judging them, this also affects their feelings of mastery and makes assessment of functioning difficult. Stigma imposed by others creates the expectation that people with mental illnesses are unable to live up to the responsibilities that are part of everyday living (Corrigan & Watson, 2002).

Self-esteem is another area that is affected by stigma. Self-esteem is often confused with self-efficacy. *Self-esteem* is defined as a person's appraisal of himself or herself at an emotional level. Stigma can be detrimental to self-esteem. Negative stereotypes associated with the stigma of mental illness can have a serious impact on self-esteem (Blankertz, 2001). Stereotypes are an important part of an underlying belief system, so they endure across many different settings. This influences recovery as well as other areas of one's life (Sadow et al., 2002).

Ways to Mitigate Stigma

Mitigating stigma related to people with mental illness is a difficult mission. Reducing the stereotypes about and the prejudicial behavior toward this group could create many opportunities for them. There are three areas of involvement that stigma researchers have suggested could foster change to help reduce stigma related to people with mental illness: protest, education, and contact.

Protest is defined as a complaint or an objection (*Merriam-Webster Dictionary*, 1990, p. 418). Through protest, an attempt is made to suppress stigmatizing attitudes by directly instructing individuals not to think about or consider negative stereotypes. Protest is used to dispute ingrained beliefs by proposing arguments or facts that dispel the belief system. Protest is often an attempt to appeal to moral indignation (Corrigan, 2002). Protest may be used in a public campaign

or in individual dialogue. The research of Couture and Penn (2003) indicated that the attempt to suppress stereotypes through protest can often result in a rebound effect and generally does not have an effect on stigma. According to these researchers, the very attempt to keep unwanted thoughts out of the mind might make these thoughts more insistent. In 1999, Corrigan and Penn found that protest might backfire. They conducted a study in which participants were instructed not to think about sex and found that these participants showed the same elevations of physiological arousal as participants who concentrated on sex. People are more likely to be sensitive to stereotype-confirming information when they are distracted by other cognitive tasks or if psychophysiological arousal diminishes their cognitive processes. Protest, which attempts to suppress negative stereotypes about mental illness, may actually be priming these stereotypes (Corrigan & Penn, 1999).

Education is another method that has been used to attempt to mitigate stigma. Education is the means of conveying factual information to specific populations. Often, education is used directly to contradict myths with facts. Couture and Penn (2003) found that education is helpful for changing attitudes but has little effect on subsequent behaviors. Education may help to mitigate stigma slightly but does not endure over time. Belief systems are so well ingrained that education may be too limited to reduce resilient stigmatizing attitudes (Devine, 1995).

Contact or direct interaction is an additional way to mitigate stigma. There is an extensive body of research that shows that interpersonal contact with someone with a mental illness is far more effective at mitigating stigma than either protest or education. Unlike education, which changes attitudes and not behaviors, contact has the capacity to change both.

The more personal contact a person has with a stigmatized group, the fewer stigmatizing attitudes he or she will have (Ingamells, Goodwin, & John, 1996). As total contact increases, the perception of danger and attempts to keep a social distance decrease (Alexander & Link, 2003). Research does support that even minimal contact with someone with a mental illness can change stigmatizing beliefs. Alexander and Link found that even very minimal contact, either professionally or personally, will reduce stigma. As little contact as a 15-minute video can dispel myths about mental illness. People begin to see someone with a diagnosis of mental illness as an individual who is not unlike them. Alexander and Link also found that a combination of personal contact, education, and cooperative contact, such as working with someone toward a common goal, could reduce stigma. Link and Cullen (1986) found that there was no significant difference between voluntary contact and involuntary contact in reducing stigmatizing attitudes.

Specifically, contact with the stigmatized group minimizes the perception of group differences. When people have contact with someone with a mental illness and this person is perceived to have equal status, either professionally or personally, then such contact mitigates stigma (Couture & Penn, 2003). One-on-one contact or more intimate intrapersonal contact also enables contact to work more effectively. Cooperative contacts are also important because as people work together toward common goals, stereotypes are more easily displaced (Corrigan & Penn, 1999). Interaction with someone with a mental illness can change cognitive structures and classification from a perception of *them* to that of *us* (Corrigan et al., 2001).

It is possible for a person to come into contact with someone with a mental illness who is considered "typical" of a stereotype or whose behavior somehow reinforces a stereotype. In this case, instead of mitigating stigma, contact reinforces it. Stigmatizing beliefs will continue and possibly become worse (Reinke, Corrigan, Leanhard, Lundin, & Kubiak, 2004). Mental health professionals may specifically struggle with this because they often see clients who are considered typical of a stereotype, and deep-seated beliefs about mental illness are reinforced. Clinicians are asked to examine their own values about mental health. Corrigan (2004) recommended that counselors use empowering treatment to counteract self-stigma in clients. If clinicians listen to their clients and empathize with their individual experiences with mental health challenges and if they watch their language and avoid belittling words like *compliance* and *resistance,* they may be able to counteract the client's self-stigma.

Improving Clinician Training to Minimize Stigma

As our research suggests, mental health practitioners are not immune to stigmatizing beliefs. Corrigan (2002) reported that most mental health professionals subscribe to stereotypes about mental illness, and Hugo (2001) found that the general public had more optimistic expectations for individuals with mental illness than mental health professionals did. In fact, the way that practitioners respond to their clients who are mentally ill may contribute to stigma (Penn & Martin, 1998) or make clients' symptoms worse (Sadow et al., 2002). Therefore, it is imperative to address stigma in the mental health field and work to decrease the stigmatizing beliefs that practitioners hold to be true. We suggest that counselors receive education about stigma and its impact on individuals with mental illness, that educators in counselor training programs work to increase their students' capacity for cognitive complexity, and that counselors find opportunities for developing egalitarian relationships with individuals having a mental illness.

Bieri (1955) described *cognitive complexity* as the degree of differentiation among the personal constructs of an individual. In the mental health field, Spengler and Strohmer (1994) reported that counselors with higher levels of cognitive complexity were less prone to biases in clinical judgment than were counselors with lower levels of cognitive complexity. These biases could also encompass the stigmatizing beliefs with which we are concerned

(Stoltenberg, 1981). Stoltenberg, McNeill, and Delworth (1998) similarly found that counselors with a higher level of cognitive complexity were better at case conceptualization, had a higher level of accurate empathy, and had better skills of attending to multicultural dynamics. This supports the findings of Fong, Borders, Ethington, and Pitts (1997) regarding cognitive complexity: Counselors with higher levels of cognitive complexity had higher levels of empathy and were less often judgmental about people with mental illness. Couture and Penn (2003) suggested that individual variables like trait empathy and openness to experience may influence how contact can minimize stigmatizing beliefs. Cognitive complexity is a vital element in counselors who want to avoid stigma.

Although counseling requires a high level of cognitive complexity (Reeve & Heggestad, 2004), most counselor training programs do not focus on the acquisition of cognitive skill development (Fong et al., 1997), and students often show minimal gains in cognitive functioning over the course of their master's-level training program. Whiston and Coker (2000) suggested that counselor educators should help students to think more complexly and process information more quickly. They even suggested that the curriculum in counselor training programs should be more demanding to increase students' level of cognitive complexity or that only students with high levels of cognitive complexity be admitted to counselor training programs.

Individuals achieve a higher level of cognitive complexity as they acquire experience in interpreting and anticipating diverse patterns of behavior in social situations (Adams-Webber, 2003). Thus, education should help students to achieve a higher level of cognitive complexity because they are exposed to diverse patterns of behavior and social situations through higher education. Stoltenberg (1981) outlined the developmental stages, in their increasing complexity, that counselors pass through, and he suggested different supervisory methods at each stage that are designed to assist students increase their levels of cognitive complexity. He suggested that counselor supervisors use discrimination skills to determine which environments are most suited to a particular student's level of development. Through the interactions with the supervisor, the students move through the developmental stages to progress from a stage of dependency, in which they are almost totally dependent on the supervisor to offer a didactic situation with lots of structure, to eventually reach a stage of autonomy, wherein supervisors are able to support them and encourage them to think critically about situations. Finally, students may reach a stage of mastery within the counseling field (Stoltenberg, 1981).

Duys and Hedstrom (2000) also encouraged early basic skills training to enhance cognitive complexity. This early basic skills training could also challenge stigmatizing beliefs or provide students with the opportunity for increased contact on an equal basis with an individual with mental illness. Sodowsky, Taffe, and Gutkin (1991) found that increased contact with a culturally different person correlated with higher levels of self-reported multicultural competence, and we suggest that the same could be true with mental illness. Martin (1990) suggested that skills training alone does not provide counselors with sufficient knowledge concerning purpose, conditions, and context associated with effective counseling. Curriculum could be created to require students to volunteer or intern either at a mental health facility or in other less formal settings where they have the opportunity for contact with people who have a mental illness. This contact could help mitigate stigmatizing attitudes and work as a preventative program for counselors who are entering the field of mental health.

Finally, people with mental illnesses could be conceptualized as a multicultural population. In the late 1980s and early 1990s, it was common for training programs to add multicultural classes into the curriculum (Hollis & Wantz, 1990). These courses offered specific information on working with minority populations, including ethnic minorities, gay and lesbian populations, and people of different ages. The stigma and prejudice experienced by individuals in such populations are also experienced by people who have a mental illness. Counselor educators could advance standards of care for clients with mental illness by defining this population as having multicultural issues. Educators could integrate information into existing classes to train counselors more effectively. Even if curricula already touch on these issues, counselor educators are challenged to review and expand on existing curricula because these practices are imperative in helping to reduce stigma in the classroom.

Conclusion

Stigma is debilitating for people with mental illness. It has an impact on their options for life, their beliefs about themselves, and even the course of their illnesses. We have reviewed the literature and reported the process of stigma and suggested ways of mitigating stigma for clients who are experiencing a mental illness. Finally, we have suggested ways that clinicians can develop awareness about their own stigmatizing beliefs and how clinicians can be trained differently to minimize the development of stigmatizing beliefs. We recognize that more research is necessary to validate the suggested changes. However, we also recognize that change is necessary if mental health professionals are to address the issue of stigma related to mental illness.

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