FROM WHENCE COMES MENTAL ILLNESS STIGMA?

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ABSTRACT

Background: This paper seeks to answer two fundamental questions: What is the basis of the current form of mental illness stigma? and Why do western cultures stereotype people with mental illness as dangerous, incompetent and blameworthy, rather than something else?

Material and discussion: We argue that a motivational model called system-justification offers several benefits for answering these questions. System-justification portrays stigma as a way of making sense of economic and political differences between the majority and stigmatized subgroups. We contrast system-justification with two cognitive models of stigma that seem to have strong support from naïve psychology: mental illness stigma results as the normal perception of a group of people who are dangerous and/or blameworthy and there is a kernel of truth to the stigmatizing attitudes about people with mental illness. Although research supporting the latter two models is mixed, there are significant limitations to the models, as well as concerns that normal perception and kernel of truth might actually promote stigma.

Conclusions: As an alternative, system-justification combines three paradigms that suggest its worthiness for future research: 1) a review of historical and economic forces that influence social phenomena; 2) the need of humankind to understand these forces and organize them into a unitary framework; and 3) the cognitive mechanisms that are essential for this comprehension. Implications of this model for stigma change are discussed.

Many persons with serious mental illness suffer the impact of stigma. They encounter landlords who refuse to rent them apartments, employers who fail to hire them, mental health professionals who inappropriately hospitalize them, primary care providers who withhold needed services and/or police officers who respond with unnecessary force; in many cases not because of the ways people with mental illness act but rather because of prejudicial beliefs about them. What does research suggest about why this state of affairs persists? Survey research of western cultures describes this kind of prejudice as based on beliefs about dangerousness (people with mental illness are violent), competence (people with mental illness cannot care for themselves) and responsibility (mental illness results from a character flaw) (Corrigan, 1998). Social psychologists have expanded on this descriptive work by explaining the relationship between these stigmatizing beliefs and discriminatory behavior (Crocker et al., 1998). Our paper seeks to answer a third, and more basic, set of questions: from whence come these beliefs? Why does the public continue to view people with mental illness
as dangerous and incompetent rather than lazy, deceitful or some other characteristic? From an even broader perspective, how come some groups are stigmatized (e.g. people of color, or those who are obese, have AIDS or have mental illness) while others may escape such harsh judgment (e.g. people who are tall or blue-eyed)?

We examine answers to these questions based on justification of the status quo, psychological processes that contribute to the preservation of existing personal and social arrangements and yield stigma as a product (Jost & Banaji, 1994). Psychological justification offers a motivational model of the processes that comprise stigma; namely, that stereotypes, prejudice and discrimination serve individual, group or social goals. We make sense of motivational models by contrasting them with two cognitive paradigms for understanding stigma that have strong support as naive psychologies. 1) What is called mental illness stigma is actually a normal perception of the bizarre behavior of people with psychiatric disabilities. 2) The cognitive processes that yield stigma result from a kernel of truth. Both cognitive paradigms have some limitations that suggest the need for the motivational approach we proffer.

Before discussing each of these research areas, the nature and impact of mental illness stigma is described. This review includes a social cognitive model of stigma that will serve as the basis of the remainder of the paper. We then summarize the strengths and limitations of normal perception and kernel of truth models; despite some empirical support, we also conclude that these naive psychologies may actually promote some stigmas. We contrast these views with system-justification which combines three paradigms for answering questions about the genesis of stigma; the historical and economic forces that create social phenomena; the motivational forces that compel individuals to understand these forces and the cognitive mechanisms that influence this comprehension process.

**COMPONENTS OF A SOCIAL COGNITIVE MODEL OF STIGMA**

Viewed as a social cognitive process, stigma comprises three components: stereotypes, prejudice and discrimination. Social psychologists view stereotypes as knowledge structures that are learned by most members of a social group (Judd & Park, 1993; Esses et al., 1994; Augustinos et al., 1995; Hilton & von Hippel, 1996; Krueger, 1996; Mullen et al., 1996). Stereotypes are especially efficient means of categorizing information about social groups. Stereotypes are considered 'social' because they represent collectively agreed upon notions of groups of persons. They are 'efficient' because people can quickly generate impressions and expectations of individuals who belong to a stereotyped group (Hamilton & Sherman, 1994).

Just because most people have knowledge of a set of stereotypes does not imply that they agree with them (Jussim et al., 1995). For example, many persons are able to recall stereotypes about different racial groups but do not agree that the stereotypes are valid. People who are prejudiced, on the other hand, endorse these negative stereotypes ("That's right; all persons with mental illness are violent!") and generate negative emotional reactions as a result ("They all scare me!", 'I hate them") (Devine, 1988, 1989, 1995; Hilton & von Hippel, 1996; Krueger, 1996). Prejudice leads to discrimination, the behavioral reaction (Crocker et al., 1998). Research has documented the behavioral impact (or discrimination) that results from the stigma of mental illness. Citizens are less likely to hire persons who are labeled
mentally ill (Olishansky et al., 1960; Farina & Felner, 1973; Bordieri & Drehmer, 1986; Link, 1987), less likely to lease them apartments (Page, 1977, 1983, 1995) and more likely to falsely press criminal charges against them (Sosowsky, 1980; Steadman, 1981).

**STRENGTHS AND WEAKNESSES OF TWO COGNITIVE MODELS**

From whence does this chain of stereotypes, prejudice and discrimination come? Two cognitive models have attempted to answer this question. First, what is called mental illness stigma is actually a normal cognitive reaction to perceptions of the bizarre behavior of people with psychiatric disabilities. The second model is a subtler extrapolation of the first; namely, mental illness stigma represents a kernel of truth (Allport, 1979 [1954]). Although all people with psychiatric disability are not dangerous, incompetent or blame worthy, there may be objective aspects to mental illness in general that serve as the origin of these beliefs. Let us consider the strengths and limitations of both models briefly here.

**Stigma as the normal perception of bizarre behavior**

Stigma as normal response echoes earlier arguments of Walter Gove (1970, 1975) who said societal reactions to individuals with mental illness are the natural response to psychiatric symptoms rather than biased expectations activated by some other source of stigma like labels. While Gove does not deny that labels generate negative reactions, he discounts their importance in the 'causation' and persistence of psychiatric stigma. Link and colleagues (1987) reviewed 12 published labeling studies that assessed the relative effect of deviant behavior versus labeling on social rejection. Ten of the 12 studies concluded that aberrant behavior on the part of the confederate had a statistically significant and more potent effect than labels on subsequent prejudice and discrimination. Four of the 12 studies failed to find any significant effect for labeling. These findings suggest that what some people call stigma may actually be the accurate perception of the public.

While the above mentioned studies suggest that behavior is more important in determining rejection than label, Link and colleagues (1987) note a growing body of experiential and empirical data that imply people with mental illness will experience discrimination regardless of their behavior. The researchers attempted to understand this discrepancy in their own study of the relative influence of labeling and behavior in determining social rejection and acceptance (Link et al., 1987). Although Link and colleagues found objectionable behavior explained a significant portion of variance, the authors also noted that perceptions of dangerousness activated by the mental illness label were as important as behavior in determining rejection. Additionally, they found that research participants who endorsed beliefs that individuals with mental illness are dangerous were more rejecting of labeled than non-labeled persons. Subsequent studies further seemed to support the egregious effects of labeling (Socall & Holtgraves, 1992; Aubrey et al., 1995; Cormack & Furnham, 1998; Link & Phelan, 1999; Pescosolido et al., 1999).

**Stigma represents a kernel of truth**

Evidence on the 'normal' reaction to perceiving bizarre behavior seems mixed with several studies showing stigmatizing responses resulting from the symptomatic behaviors of vignettes
while other prejudices arose solely from the label. How might mixed findings on the ‘normal response’ hypothesis be explained? Viewing the prejudice and discrimination as a normal cognitive response is reminiscent of social psychological research that suggests stereotypes contain a kernel of truth. The tendency for stereotypes to contain a ‘kernel’ (Allport, 1979 [1954]) or ‘grain’ (Campbell, 1967) of truth seems obvious to some researchers given the anthropological and sociological assumption that groups do in fact differ. From this perspective, stereotypes function as rational categories that ‘grow up from a kernel of truth’ (Allport, 1979 [1954], p. 22). Hence, if people with mental illness are, in fact, more bizarre, dangerous, incompetent and irresponsible than the general population, it is reasonable that these traits are attributed to the category of mental illness. Assessment of the kernel of truth hypothesis, therefore, is a matter of assessing ‘stereotype accuracy’.

Examples of ‘stereotype accuracy’ are apparent in people’s perceptions of a variety of social groups. For example, professional basketball players are stereotyped as tall, and objective measures confirm that the average basketball professional is indeed taller than most people. Nor is stereotype accuracy limited to physical attributes of social groups (Ashmore & Longo, 1995). More than half a century ago, Vinacke (1949) uncovered evidence of stereotype accuracy in students’ perceptions of Japanese, Chinese, White, Korean, Filipino, Hawaiian, Samoan and African American students at the University of Hawaii. Analagous findings have been obtained when examining trait impressions of other ethnic groups (Balk, 1965; Abate & Berrien, 1967; Triandis & Vassiliou, 1967; McCauley & Stitt, 1978; Bond, 1986; McCauley, 1995).

Perhaps the same is true when considering stereotypic perceptions of mental illness. That is, perhaps people with mental illness really do possess the traits commonly attributed to them. If this is indeed the case, evidence should reveal that people with mental illness are at least slightly more dangerous, dirty, homicidal, incompetent, rebellious, irresponsible, unable to care for themselves and lacking in moral fortitude than the general population (Nunnally, 1981; Gabbard & Gabbard, 1992; Monahan, 1992; Wahl, 1995; Hayward & Bright, 1997; Farina, 1998; Link & Phelan, 1999; Corrigan, 2000; Corrigan & Watson, in press; Corrigan et al., 2002). There are, of course, reasons to question the accuracy of these stereotyped perceptions. History is filled with examples of inaccurate stereotyping that has served to justify pernicious forms of prejudice and discrimination. Old-fashioned racist attitudes toward Blacks were bolstered by a belief in their intellectual inferiority. Early Armenian laborers in southern California were stereotyped as ‘dishonest’, ‘deceitful’ and ‘trouble makers’. In all of these instances, however, more objective assessments of group characteristics failed to confirm the validity of these stereotypes. For example, La Piere (1936) found that Armenians in southern California appeared less often in legal cases and possessed credit ratings that rivaled those of other ethnic groups. Moreover, performance of Blacks on standardized achievement tests matches that of similar White Americans when Blacks take these tests under conditions that minimize stereotype threat and its concomitant evaluation apprehension (Steele & Aronson, 1995). Thus, although some stereotypes contain a component of accuracy, it is clear that other stereotypes may possess a significant component of inaccuracy.

Are stereotypes of people with mental illness accurate?
Stereotypes of a group are often conceptualized as beliefs about the average group member
(Ottati & Lee, 1995). Moreover, stereotypic characterizations of a social group are inherently comparative. Thus, the belief that ‘schizophrenics are dangerous’ implies that people with schizophrenia are, on average, more dangerous than the mainstream population. What is the accuracy of this assertion? Several studies suggest that people with severe mental illness are more likely to be violent than people without these disorders (Swanson et al., 1990; Cirincione et al., 1992; Monahan, 1992; Mulvey, 1994; Torrey, 1994; Grossman et al., 1995; Eronen et al., 1996; Hodgkins et al., 1996). However, the increased risk of violence associated with mental disorder is modest and comparable to that which is associated with age, education, gender and previous history of violence in populations that are not labeled mentally ill (Swanson et al., 1990; Link et al., 1992). Additionally, this risk seems to be limited to individuals experiencing a specific subset of psychotic symptoms – termed ‘threat/control-override’ symptoms – which influence the person’s definition of a situation (Link & Phelan, 1999). These symptoms may cause an individual to define a seemingly benign situation as threatening and respond in a self-protective manner, as though a real threat exists. Co-occurring substance abuse disorders also seem to predict violence (Steadman et al., 1998). Given this evidence, the extreme fear associated with mental illness stereotype per se, and its broad application to all persons with mental illness, seems exaggerated. If we choose to avoid all persons with similar odds-ratios for violence, we would have to stay away from teenagers, males and grade school graduates (Link & Phelan, 1999).

**Inaccuracies that resort from perceptual biases**

There are undoubtedly multiple factors that contribute to inaccurate stereotyping. Errors that result from kernel of truth may be explained in terms of perceptual biases, processes that are solely related to cognitive mechanisms and not the truth value of the evidence (Stangor & Crandall, 2000). Chapman (1967) first labeled this phenomenon *illusory correlation* based on his basic cognitive research. He found research participants in an observational learning task reported a correlation in two classes of events that in reality were either not correlated or associated to an extent far below reported levels. Hamilton and colleagues (1976, 1981) extended this research to social cognition; they found that negative attributes are ascribed to minority groups solely based on group size and characteristics. In particular, minority groups and negative traits will (erroneously) appear related because they occur less frequently. This result explains the association between people with mental illness and such negative qualities as dangerousness, incompetence and blame.

Accentuation theories offer another model for explaining how cognitive biases lead to stereotypes (Ford & Stangor, 1992; Fyock & Stangor, 1994). According to this view, actual or misperceived differences are exaggerated through cognitive and/or perceptual biases. These theories do not account for the initial genesis of stigma, but rather how group differences are perceptually exaggerated (and hence, maintained) because individuals seek meaning in these differences. For example, people with mental illness are seen as dangerous because they are locked away in institutions. Cognitive models like these suggest that the cause of inaccuracies that lead to stereotypes results from perceptual biases. As a result, these models expand our understanding of stereotypes as well as providing a broad methodology for testing many of the hypotheses that emerge from this understanding. Unfortunately, these models are still unable to answer the fundamental question of this paper; why is mental illness in THIS form and not THAT one? How come the western world frames mental illness in
terms of dangerousness, blame and incompetence rather than some other constructs? Alternately, why are people with mental illness viewed as dangerous while other groups with similar violence rates are not? As argued below, the answer to these questions lies in better understanding the motivational role of stigma, an issue of psychological justification.

**STIGMA REPRESENTS PSYCHOLOGICAL JUSTIFICATION**

In this section we review justification models that base the ontogenesis of stereotypes and prejudice on foundations other than cognition. The specific focus here is on the origins of stigma as contemporaneously perceived. These approaches do not surmise the truth value on which specific stereotypes are formed. There is no assumption, for example, that mental illness stigma developed out of accurate perceptions of bizarre and dangerous behavior. Instead, justification models describe the motivations that are served by stereotypes.

Three such motivations have emerged in the literature: ego-justification, group-justification and system-justification (Jost & Banaji, 1994). Ego-justification suggests that stereotypes and prejudice develop to protect actions of the self (Katz & Braly, 1935; Adorno et al., 1950). According to group-justification, stereotypes protect the status of the social group as a whole, not just the individual (Tajfel, 1981). Both views, however, have significant difficulties answering a key question of this paper; why do these stereotypes (dangerousness, blame, incompetence) about mental illness currently emerge and not others? System-justification is proposed as an alternative to explain the social functions of stereotypes (Sidanius & Pratto, 1993; Jost & Banaji, 1994; Jost & Burgess, 2000). Before describing the benefits of system-justification, ego- and group-justifications are described more fully.

**Ego-justification theories**

Psychoanalysts were among the first to write about ego-justification; namely, the self is protected when internal conflicts are projected onto stigmatized groups (Freud, 1946; Bettelheim & Janowitz, 1964). In this way, people are able to shield their self-esteem. Social psychologists expanded the ego-justification idea beyond personal defense mechanisms to include any function that protects ideas, images or behaviors that negatively reflect the self by projecting these negative conceptualizations and actions on others (Lipmann, 1922; Katz & Braly, 1935). Despite its intellectual appeal and omnipresence in the clinical literature, little empirical evidence has been found to support ego-justification (Sherif & Cantril, 1966 [1947]). There have been a few studies that provided macro-level support to ego-based hypotheses. For example, one study showed people of higher socio-economic status were likely to stereotype poor people as lazy (Ashmore & McConahay, 1975). A second study showed soldiers were likely to dehumanize (or stigmatize) the enemy as savage and satanic (Bar-Tal, 1989, 1990). Noticeably absent, however, was research at the person level – e.g. examining whether the individual’s perception of ego threat directly leads to stereotypes. The absence of this kind of data is ironic given the individual-level of analysis inherent in ego-justification models. In part, little data supporting ego-justification may reflect the psychodynamic psychologist’s disinterest in the research enterprise, at least as framed by experimental social psychologists.
Group-justification models
Tajfel (1981; Tajfel & Turner, 1979, 1986) argued that the group, and not the individual, is the appropriate level of analysis for social phenomena. The motivation for group-justification is to support the goals of one’s in-group. For example, specific stereotypes about a minority out-group serve to frame the majority in a positive light. All members of the majority are hard-working; out-group minorities are lazy! Individuals endorse stereotypes as a way of justifying the actions of others with whom they closely identify. There is substantial research that supports these assertions (Hogg & Abrams, 1988). Consider, for example, the results of a meta-analysis of 137 studies on the in-group bias hypothesis (Mullen et al., 1992). In-group bias is significantly stronger when in-group membership is salient. Moreover, higher status groups seem to show more in-group bias on relevant attributes (i.e. those characteristics most important to the group) while lower status groups exhibit more in-group bias on less relevant attributes.

Using group-justification as an explanation for mental illness stigma is a bit problematic, however. What exactly is the in-group against which people with mental illness are contrasted? The ‘normal’ in-group is a default category that only gains definition in the absence of mental illness. Hence, there is no readily apparent source of in-group motivation to drive group-justification.

Additional limits to ego- and group-justification
Ego- and group-justification describe the motivations that are sated by stereotypes. However, there are several conceptual problems with these models that fail to address the central question of this paper. Implicit in ego- and group-justification is the idea that stereotypes and prejudice develop against an out-group, not because of any special qualities of that out-group, but rather because of individual or in-group need. Hence, ego- and group-justification do not explain why an individual or in-group would stigmatize people with mental illness, rather than, for example, people with blue eyes or blond hair. Given that mental illness is somewhat of a hidden stigma (i.e. an individual may not know a peer has mental illness unless that peer says so (Corrigan, 2000)), it is unlikely that individuals or in-groups select mental illness as a justified group because it is convenient.

Ego- and group-justification also fails to explain the form of mental illness stigma. Researchers have shown some consensus among the public about the nature of mental illness stigma (Taylor & Dear, 1981; Brockington et al., 1993); i.e. persons with mental illness are dangerous (and should be avoided) or incompetent and should have an authority make decisions for them. Nothing about ego- or group-justification suggests why dangerousness and incompetence are identified commonly as core stereotypes while statements about laziness and sloth are not.

System-justification
Jost and colleagues (1994, 1999; Stangor & Jost, 1997) have identified an even broader target for justification (beyond the self or group) arguing that stereotypes and prejudice develop to confirm the system. Once a set of events produces specific social relationships, whether by historical accident, biological derivation, public policy or individual intention, the resulting arrangements are explained and justified simply because they exist. These justifications
seem to evolve over time as the result of historic, economic or social pressures. System-justification has historical roots in classic theories of Marx, Weber and Durkheim on the need for social systems to seek legitimization. It also parallels more recent theories such as self-categorization (Turner et al., 1987), just world hypothesis (Lerner, 1980), conservatism (Wilson, 1973) and social dominance (Pratto et al., 1994; Rabinowitz, 1999; Guimond, 2000). System-justification is provocative as a paradigm because it bridges macro-level sociologic/historic variables with the kind of individual level variables defined by social cognition.

Jost and Banaji (1994) provide some interesting examples of system-justification. Because of historical events in the 16th and 17th centuries, Blacks were slaves and Whites were masters. The system explains this difference by stereotyping contemporary Blacks as less competent and industrious. Women are able to bear children; men are not. In western society, women are viewed as the caretakers and men the workers and business agents. This difference in the system leads women to being characterized as nurturing while men are viewed as autonomous (Eagly & Steffen, 1984).

How might system-justification account for mental illness stereotypes? During the Middle Ages, westerners locked away people with mental illness in prisons. Protection of the public from dangerous people was an implied theme. Beginning in the 19th century, prisons were replaced with asylums or state hospitals. People who require treatment and institutions are incompetent and need guardians. Since the deinstitutionalization movement that began in the 1960s, growing numbers of individuals with mental illness are again ending up in prisons and jails (Travis, 1997). This kind of historical trend leads to the popular notion that people with mental illness are dangerous and unable to care for themselves (Corrigan, 2000).

System-justification implies that a specific stereotype requires knowledge of past history. It suggests, for example, that people must recognize the historical role of institutionalization to systemically justify mental illness stereotypes. Does this mean the impact of system-justification is limited in people who lack historical knowledge? Not necessarily: system-justification probably has its greater impetus from contemporary social phenomena that reflect past history. System-justifications of African Americans are more likely to arise from contemporarily manifested social and economic injustices between the races; injustices that have their roots in slavery and its immediate aftermath. In a similar manner, justifications for mental illness may arise from the obvious institutions that suggest people with mental illness need to be controlled; e.g. state hospitals and prisons. Note in both cases that the news media and entertainment industry have a central role in informing the public about the status quo.

Research support for system-justification

Jost and Banaji (1994) have interpreted findings from a few past studies as supportive of system-justification. For example, Hoffman and Hurst (1990) came up with an ingenious way to examine the effects of perceptions of social roles on stereotypes. Research participants were asked to provide trait ratings of two fictional groups – the Orinthians and Ackmans – whose occupations were dominated by child raising and city work, respectively. Even this fictional social system led to gender stereotypes; the Orinthians were judged to be patient, kind and understanding while the Ackmans were confident and forceful. Stereotypes in no way reflected the objective personality traits of individual Ackmans and Orinthians. Instead they were based on systemic differences between the two groups reflected in their occupations.
Subsequent studies like this further support the assertions of system-justifications (Ross et al., 1977; Skrypnek & Snyder, 1982; Jost, 1997; Jost & Burgess, 2000).

Benefits of system-justification
The theory of system-justification overcomes many of the problems that resulted from ego- and group-justification models (Jost & Banaji, 1994). System-justification takes the essence of stereotypes beyond individual or in-group goals. Stereotypes do not necessarily arise as the result of a personal press; there is no external event requiring ego or in-group defenses in the form of stereotyping others. Looking to the system (instead of individual/in-group need) for the origin of specific stereotypes answers why the form of a specific stereotype is similar across the population. Stereotypes arise as explanations for the system-wide experience of in-group members. Note the important role of the news media and entertainment industry as purveyors of system-wide perceptions. Media analyses of film and print representations of mental illness have identified three common stereotypes: people with mental illness are homicidal maniacs who need to be feared; they have childlike perceptions of the world that should be marveled at; or they are rebellious, free spirits (Hyler et al., 1991; Gabbard & Gabbard, 1992; Mayer & Barry, 1992; Monahan, 1992; Wahl, 1995; Farina, 1998). These common representations reflect the systemic misperceptions of mental illness.

System-justification also resolves some of the problems that result from the idea of kernel of truth. System-justification does not rely on assumptions about the truth value of a stereotype. There is no assertion that persons with mental illness are dangerous or incompetent. Instead, these stereotypes are the natural explanation for institutions that control people with mental illness. Hence, system-justification does not reinforce public stereotypes in a fashion similar to kernel of truth or normal reality. It does not suggest that any aspect of a stereotype is valid.

Although system-justification provides a psychological explanation for mental illness stigma, it leaves the ultimate ‘from whence’ question unanswered. System-justification helps people to cognitively make sense of current differences among groups. However, the model makes no assumptions about the origins of the system that epistemically compels the person to create stigma. Questions that ultimately answer, ‘from whence comes stigma?’ are a matter of more macro social science: history, economics and political science. We briefly struggle with ways to combine these diverse methodologies with psychological approaches in the section below on changing mental illness stigma. Suffice it to say here that system-justification is adequate to resolve questions about the origin of a specific stigma when these questions are limited to the level of how individuals understand stigma in the contemporary world.

CHANGING THE STIGMA OF MENTAL ILLNESS

One of the reasons investigators seek to explain stigma is to better inform strategies for changing it. In earlier research, our group highlighted the impact of education and contact with people with mental illness on prejudicial attitudes (Corrigan & Penn, 1999; Corrigan et al., 2000; Corrigan et al., 2002). These seem to be appropriate strategies for challenging the misinformation about mental illness that poses as normal reactions or kernels of truth.
Education was found to yield mild to moderate changes in attitudes about mental illness. The effects of contact were stronger and broader. Members of the general public who interacted with a person with mental illness (who mildly disconfirmed the stereotype) exhibited large changes in stigmatizing attitudes. Moreover, they showed more positive processing of information about people with mental illness. Contact has also been shown to have positive effects on helping behavior. Research participants who had contact with people with mental illness were more likely to sign petitions against anti-stigma activities (Corrigan et al., 1999) and donate money to advocacy groups (Corrigan et al., 2002).

Some researchers believe that the kinds of challenges to discrete cognitions engendered in contact and education may not lead to lasting change in system-justifications (Jost & Banaji, 1994). Rather, the system itself must change to facilitate parallel justifications that reflect a less stigmatizing image (Jost & Banaji, 1994). Or, as other social psychologists have framed the task, the most effective way of changing stereotypes is to alter material reality (Eagly & Steffen, 1984; Haslam et al., 1992; Banaji & Greenwald, 1994). According to this perspective, changes in the political and economic relationships among social groups lead to improvements in corresponding labels and stereotypes.

This notion is historically evinced in the evolution of social relationships and stereotypes in key American groups. Consider, for example, how several historical events marked the changing place of African Americans in the United States: Lincoln’s emancipation proclamation (1863), repudiation of the Ku Klux Klan (1930), Johnson and Johnson establish successful business (1943), Jackie Robinson stars in the Major Leagues (1947), a quarter of a million Americans march on Washington for racial justice (1963), the Civil Rights Act passes (1964) and Toni Morrison wins the Pulitzer Prize (1988). In the process, attitudes about Blacks changed from one of slaves to passive sharecroppers to successful business people, athletes and authors. Although substantial prejudice and discrimination against African Americans persists, many of the barriers to education, employment, housing and prestige are crumbling.

Connecting these socio-economic events with change in attitudes and behavior is a methodological quagmire that requires the integration of sociological, psychological and historical strategies. Guimond (1995, 2000; Guimond & Palmer, 1996) has developed a research paradigm that seems to approach this integration. He has examined the change in a person’s values and attitudes as the individual passes through college or military training. In the process, social roles change as do perceptions of the system. For example, one study showed that values changed as participants became more socialized (Guimond, 1995). More compelling to the assertions about system-justification and stigma was a study on Canadian Francophones (the minority culture) and Anglophones (the majority) undergoing a four-year military training program. At the end of that time both the Anglophones and the Francophones were more likely to endorse the notion that the economic gap between the two cultures was legitimate (Guimond, 2000). Methodologists need to continue to examine ways to integrate diverse research paradigms to answer questions about system-justification.

As is evident in this political and economic evolution, policy makers have an important role in changing the system (and subsequent justifications). For example, the Civil Rights Act, along with the Voting Rights Act of 1965, had a major effect on racial roles. Consider the impact of the Americans with Disabilities Act (ADA) signed into law by George Bush in 1990. It has put employment practices for people with disabilities (including mental illness)
on the same playing field as considerations of race and gender. Namely, employers are learning that discrimination because of mental illness, like ethnicity, is heinous and will not be tolerated. Moreover, the ADA introduced the idea of reasonable accommodations; employers must consider restructuring their job practices so that people with mental illness can successfully meet the demands of the position. Future research needs to adopt the kind of socio-historical and psychological strategies discussed earlier to see if policies like the ADA (as well as the Fair Housing Act of 1968/1988, which has similar important implications for residential opportunities) lead to changes in stigmatizing attitudes and behaviors.

CONCLUSIONS

Both cognitive and motivational answers have been posed to the question, from whence comes mental illness stigma? The two cognitive models reviewed in this paper – normal reaction to perceived bizarre behavior and kernel of truth – were found empirically lacking in some regards and actually thought to promote stigma in others. We acknowledge that this is an incomplete picture of social cognitive models of stigma but selected these two because of their importance as a naïve psychology of stigma cognition; i.e. the way in which the average person might perceive how stigmas are understood. Given these limitations, we turned to motivational explanations that influence this naïve person’s cognition and found system-justification to provide a theoretically provocative and empirically supported model that helps us to understand why stigma is in this form for that population. System-justification integrates three social paradigms: 1) both past and current historical and economic forces that influence social phenomena; 2) the need of humankind to understand these forces and organize them into a tangible picture; and 3) the cognitive mechanisms that are essential for this comprehension. Note that system-justification combines motivational and cognitive approaches to this important social question.

System-justification provides an exciting heuristic with avenues for stigma research that diverge in several directions. Hence, further development of this paradigm will benefit from a variety of different theories and methods. Like other macro-theories of this sort however, system-justification also provides some significant challenges. For example, social science has not easily bridged the sociological processes suggested by historical and economic forces with the individual-level phenomena of psychology (Liska, 1990; Newman, 2001). Nor has research thus far used the breadth and depth of information on social cognition to better understand the justification of stigma. However, the mix of these three paradigms provides a conceivably fruitful avenue for understanding the origins of mental illness stigma in particular, and prejudice and discrimination in general.

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BOOK REVIEWS

OUT OF ITS MIND – PSYCHIATRY IN CRISIS: A CALL FOR REFORM
This is a passionate polemic borne out of the frustration of observing psychiatry sliding towards depersonalised pill pushing and the public health services banishing the mentally ill onto the streets and into prisons. Allan Hobson is a Professor of Psychiatry at Harvard Medical School and Director of the Laboratory of Neurophysiology at Massachusetts Mental Health Centre (MMHC) and has decades of clinical experience behind him. His co-author, Jonathan Leonard, is a freelance medical writer. Allan Hobson takes the reader on a grand tour of American psychiatry from the early icepick-wielding lobotomists and somnambulist Freemasons to present-day physiologists and pharmacologists. He thinks that the downfall of psychiatry was caused by the sharp paradigm shifts and the loss of confidence in treatment based on speculation rather than evidence. The book is sprinkled with anecdotes from his own practice and references to the history of the MMHC. He has a rare talent for making neurophysiology seem easy, as in a series of elegant tutorials. The chapters have catchy names such as 'The Master Magician and the Waterfall', 'Sleep and the Dawn of Dreams' and 'Mapping Inner Space – New Models of Mental Order and Disorder'. Having established the parameters he then focuses on the three main concerns in psychiatry: anxiety disorders, depression and schizophrenia. He sees the underlying causes as chemical imbalances. Schizophrenia is linked to a heightened sensitivity to dopamine, mania to acetylcholine and depression to lowering of serotonin levels. He concludes with a deceptively simple prescription for the alleviation of severe mental illness: continuity of care, integration of fragmented services, monitoring and reassessments to prevent relapse and a continuous dialogue and cross-fertilisation between psychiatrists, cognitive psychologists, neuropsychologists, social scientists and politicians. Allan Hobson offers a utopian blueprint to end the prevailing segregation and fragmentation of the mental health services and argues for a new evidence-based psychiatry, which can provide the rationale for early intervention and continued treatment and social care. This book is an accessible distillation of decades of clinical practice and is warmly recommended to mental health professionals and anybody who wishes to stay informed about advances in the thinking and treatment of major mental illnesses.

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AGE, NARRATIVE AND MIGRATION. THE LIFE COURSE AND LIFE HISTORIES OF BENGALI ELDERS IN LONDON
Katy Gardner.
This is Katy Gardner's second major work on the Sylheti Bangladeshi community. This time she concentrates on those Sylhetis who are resident in London and who arrived some time ago, mostly to seek work or in order to accompany relatives who sought work. These Sylhetis are now elders and have a unique outlook not only on the relationship between themselves and the indigenous white population, but also on their own lives. Gardner is an excellent ethnographer and she is able to go beyond trivial observations to show how different aspects of migrant lives interweave and how different emphases come to the fore at different times in individual life cycles. The life stories of elders are particularly interesting because they are able to tell stories which cover a life span. We hear about how the requirements of work have implicated processes of domestic change and the need for family help and support. We also learn about the role of gender in self-expression. For example the ethos of men is inextricably tied up with work, leaving elders who cannot work stripped of many possibilities for self-fulfilment. For women, on the other hand, expressions of care, love and suffering for loved ones are