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Rethinking theoretical approaches to stigma: A Framework Integrating Normative Influences on Stigma (FINIS)

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ABSTRACT

A resurgence of research and policy efforts on stigma both facilitates and forces a reconsideration of the levels and types of factors that shape reactions to persons with conditions that engender prejudice and discrimination. Focusing on the case of mental illness but drawing from theories and studies of stigma across the social sciences, we propose a framework that brings together theoretical insights from micro, meso and macro level research: Framework Integrating Normative Influences on Stigma (FINIS) starts with Goffman's notion that understanding stigma requires a language of social relationships, but acknowledges that individuals do not come to social interaction devoid of affect and motivation. Further, all social interactions take place in a context in which organizations, media and larger cultures structure normative expectations which create the possibility of marking "difference". Labelling theory, social network theory, the limited capacity model of media influence, the social psychology of prejudice and discrimination, and theories of the welfare state all contribute to an understanding of the complex web of expectations shaping stigma. FINIS offers the potential to build a broad-based scientific foundation based on understanding the effects of stigma on the lives of persons with mental illness, the resources devoted to the organizations and families who care for them, and policies and programs designed to combat stigma. We end by discussing the clear implications this framework holds for stigma reduction, even in the face of conflicting results.

Introduction

Stigma is a mark separating individuals from one another based on a socially conferred judgment that some persons or groups are tainted and "less than." Stigma often leads to negative beliefs (i.e., stereotypes), the endorsement of those negative stereotypes as real (i.e., prejudice), and a desire to avoid or exclude persons who hold stigmatized statuses (i.e., discrimination, Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Link & Phelan, 2001). There is no shortage of categories in health and medicine in which concerns of stigma have been applied directly (e.g., obesity, HIV-AIDS, leprosy). Further, concerns have been raised about how membership in other stigmatized categories (i.e., homosexuals, minority racial or ethnic groups) amplifies the negative effects of stigma associated with health problems.

Perhaps most clearly, however, socio-medical scientists turned their attention to analyses of the stigma associated with mental illness to understand and illustrate stigma's causes and consequences. Recent research continues to show that individuals fear and avoid persons with mental illness, even as psychiatry claims dramatic increases in effective treatments and social scientists document greater

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levels of public acceptance of medical theories about underlying biological and genetic causes of mental illness (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Martin, Pescosolido, & Tuch, 2000; Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999; Stuart & Arboleda-Florez, 2000). Moreover, negative attitudes and experiences of rejection and discrimination continue to affect the quality of life for persons with mental illness and their families (Katsching, 2000; Wahl, 1999). Stigma also occupies a central place in explanations of low service use, inadequate research funding and treatment infrastructures, and hindered progress toward recovery from mental illness (Estroff, 1981; Markowitz, 2001; Sartorius, 1998).

Yet, despite these findings on the pervasive existence and impact of stigma, coupled with a long tradition of research on mental illness, we know relatively little about the sources of stigmatizing attitudes. Given the recent research and policy resurgence in attention to stigma (e.g., see Keusch, Wilentz, & Kleinman, 2006), we propose that now is the time to rethink the contributions of the social sciences to better understand the underlying roots of stigma. Elsewhere, we proposed one step in that direction (Martin, Pescosolido, Olafsdottir, & McLeod, 2007; Pescosolido & Martin, 2007). But that attempt was designed to organize what we already know about the different factors (e.g., attributions, socio-demographic and illness characteristics) that influence the prejudice and discrimination associated with mental illness.

Here, we step back to offer a more general framework which looks across disciplines and different levels of society to bring together insights on stigma, prejudice and discrimination. Like Goffman (1963), we argue that stigma is defined in and enacted through social interaction. However, because stigma is socially constructed in and through social relationships, its essence lies in the "rules" which guide behaviour at particular points in time and place by defining it as acceptable, customary, "normal," or expected (Merton, 1957; Nisbet & Perrin, 1977). As such, the foundation for "differences" that become solidified in stigma are normative, and thus the organizing focus for our framework.

While social interactions take place at the individual level, theoretical advances over the last two decades have integrated insights across the social sciences to understand the myriad of forces exerted on individuals. Individuals do not come to social interaction devoid of affect, values and motivation; and, they exist in larger political, cultural and social contexts which shape their expectations on all of these issues (Coleman, 1990; Pescosolido, 1992). Further, social interactions take place in a context where organizations and institutions structure norms that create the possibility of marking and sharing notions of "difference." Concepts from labelling theory, social network theory, the limited capacity model of media influence, the social psychology of prejudice and discrimination, and theories of the welfare state, as well as theories of the micro–macro link, offer the opportunity to begin the development of a framework to unravel the complex web of expectations shaping stigma.

Such a framework is necessarily complicated and perhaps aspirational, but ignoring the complexity of stigma does not allow for appreciation of the textured understandings, policies, or interventions necessary to match the reality. An overall framework sensitizes researchers to the broad range of forces that might be in operation. As a theoretical frame, it would spin off multiple models, tailored to particular health and illness problems, to specify and operationalize substantive concerns, processes and issues (Pescosolido, 1992). Our long-term goal is two-fold: to further the understanding of the theoretical and empirical roots of stigma; and to help establish a broad science base to identify targets of intervention to decrease stigma.

Background: what we know about the stigma of mental illness

Classic studies conducted in the 1950s and 1970s documented a lack of understanding of mental illness and negative attitudes surrounding causes, treatments and outcomes (Gurin, Veroff, & Feld, 1960; Star, 1955; Veroff, Kulka, & Douvan, 1981). Subsequently, innovations in treatment, advances in scientific knowledge, the transfer of mental health care out of long-term institutions, and the establishment of a consumer advocacy movement were expected to, and even credited with, increased public knowledge and decreased community-based stigma (Garfinkle & Dorian, 2000; Hyman, 2000).

However, research in the 1990s targeted to public understanding and response to mental illness confronted these claims of progress with empirical data. For example, the MacArthur Foundation supported the 1996 General Social Survey's (GSS) "Problems in Modern Living" study, designed in part to replicate key elements of the 1950s and 1970s studies (Pescosolido et al., 2000). In the UK and Canada, pilot projects were designed for the World Psychiatric Association's "Global Campaign to Fight Stigma and Discrimination Because of Schizophrenia" (Crisp et al., 2000; Stuart & Arboleda-Florez, 2000).

The findings of these studies of public culture were remarkably consistent. First, American, British and Canadian publics display a high level of acceptance of scientific advances marking biological or genetic causes of mental health problems; an acknowledgement of, and differential response to, types of mental health problems (e.g., depression, schizophrenia); and a recognition of the existence and support for effective treatments (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Second, a majority of individuals indicate a personal familiarity; about half report knowing someone with a mental health problem or who had used some kind of treatment (Swindle, Heller, Pescosolido, & Kikuzawa, 2000). Third, however, a majority of Americans and Canadians reported an unwillingness to work alongside or have intimate connections with persons with mental illness; agreed with images of persons with mental illness as unpredictable and dangerous; and, in the American case, found a doubling (since the 1950s) in spontaneous mentions of violence as descriptive of persons with mental illness (Martin et al., 2000; Phelan, Link, Stueve, & Pescosolido, 2000). Finally, respondents were willing to use legal means to coerce individuals into treatment, especially when the spectre of danger was raised (Pescosolido et al., 1999).

Research on personal experiences of stigma and its outcomes also continued to present a consistent and distressing picture. Individuals with mental health problems, their families, and their providers reported deep and continuous experiences of stigma and discrimination. Criticism and rejection are commonplace, emanating from communities, families, churches, co-workers and caregivers (Chernomas, Clarke, & Chisholm, 2000; Hinshaw & Cicchetti, 2000). Studies also documented profound effects of stigma, including a lower quality of life and well-being (Markowitz, 1998; Mechanic, McAlpine, Rosenfield, & Davis, 1994), persistent stress (Wright, Gronfein, & Owens, 2000), low self-esteem (Penn & Martin, 1998), interference with recovery (Markowitz, 2001), loss of legal rights (Burton, 1999), discrimination in medical care (Bailey, 1998; Scholsberg, 1993), and shortened life span (Farnham, Zipple, Tyrell, & Chittinanda, 1999). Finally, studies comparing the health, health care, and life outcomes of individuals with mental illness to those with coronary disease, tuberculosis or cancer report a greater vulnerability to stigma and its negative effects (Ben Noun, 1996; Ohaeri, 2001).

Findings from individual- and community-level interventions have also been mixed, documenting unanticipated reactions and effects (Adams & Partee, 1998; Estroff, Penn, & Toporek, 2004; Link, Mirotznik, & Cullen, 1991). Not surprisingly, then, after reviewing recent scientific evidence, the U.S. Surgeon General's *Report* (U.S. Department of Health & Human Services, 1999: 8) concluded: "Stigma was expected to abate with increased knowledge of mental illness, but just the opposite occurred: stigma in some ways intensified over the past 40 years even though understanding improved."

Forces underlying stigma and its effects: drawing across disciplines and substantive cases

To date, there have been few attempts to consider influences shaping stigma, in part, because they are often conceptualized and measured at different levels of analysis, use different methods of analysis, and draw from different research traditions. For example, researchers have tried to locate critical ingredients that may exacerbate or moderate stigmatizing reactions. Some research points to underlying implicit attitudes held by individuals, or to motivations that individuals hold as central to understanding and reducing stigma (Bastian & Haslam, 2004; Crocker & Major, 1989; Dovidio, Major, & Crocker, 2000). Individual social skills also appear to be important, affecting others' ratings of attractiveness and moderating the influence of negative symptoms of schizophrenia (Penn, Kohlmaier, & Corrigan, 2000). In other studies, those who had some experience or personal contact with persons with mental illness appeared to have less negative reactions (Adams & Partee, 1998). Knowledge of symptoms associated with the acute phase of schizophrenia, however, increased negative reactions (Penn, Guynan, Daily, Spaulding, & Sullivan, 1994). Race, gender stereotyping, social class, all which tap into larger issues of social power, have also been examined (Link & Phelan, 2001). Often mentioned or implicated, but rarely conceptualized or directly operationalized, is the role of media in establishing predominantly negative societal templates for responses to persons with mental illness (Wahl, 1997). Similarly, at a higher level, the World Health Organization International Study of Schizophrenia (ISoS) concluded that a society's level of development may shape an accepting or rejecting climate for recovery from mental illness (Hopper & Wanderling, 2000).

We conceptualize all of these factors as contributing to the underlying roots of stigma because each helps shape the norms that mark differences. Indeed, if, as Goffman observed, stigma is embedded in social relationships, then what individuals bring to social interactions with persons with mental illness involves both individual and contextual influences. Fig. 1 depicts the Framework Integrating Normative Influences on Stigma (FINIS), which attempts to synthesize the variety of theoretical influences on stigma.

FINIS

In its most basic sense, like the response to illness and other social problems requiring action, stigma lies at the interface of community and individual factors (Pescosolido, 1992). While there may be many ways to document the multiplicity of forces at work in establishing and maintaining stigma, the FINIS framework focuses on the central theorem that several different levels of social life – micro or psychological and socio-cultural level or individual factors; meso or social network or organizational level factors; and macro or societal-wide factors – set the normative expectations that play out in the process of stigmatization. Curiously, but perhaps not unexpectedly, the factors toward the centre of the model represent those best understood and most studied. Those on the periphery represent newer areas of investigation.

The micro level

Social and illness characteristics

The left side of Fig. 1 contains concepts related to characteristics of persons with mental illness and how they might combine to predict stigmatizing responses. The inside section displays the most traditional understandings of factors shaping stigma. From Goffman's (1963) original sociological treatise, to Scheff's (1966) elaboration, to Allport's (1954) listing of conditions that produce prejudice, theorists have compiled a research base "to understand how persons construct categories and link these categories to stereotyped beliefs" (Link & Phelan, 2001: 364).

Briefly, social characteristics and illness characteristics combine to shape the evaluation of the person's behaviour as well as the probability that a person can be easily identified by a stranger as a person with mental illness. The greater the extent that the "target" person holds devalued statuses, the greater the likelihood that the "receiving" person will mark the problem as serious, label it as a mental illness, and endorse stigmatizing responses. To the extent that there is greater social differentiation between the target and the receiver (e.g., race/ethnicity differences, age differences), the more likely are negative responses (Loring & Powell, 1988). In addition, to the extent that the "problem" is perceived as serious, or as causing the person to behave

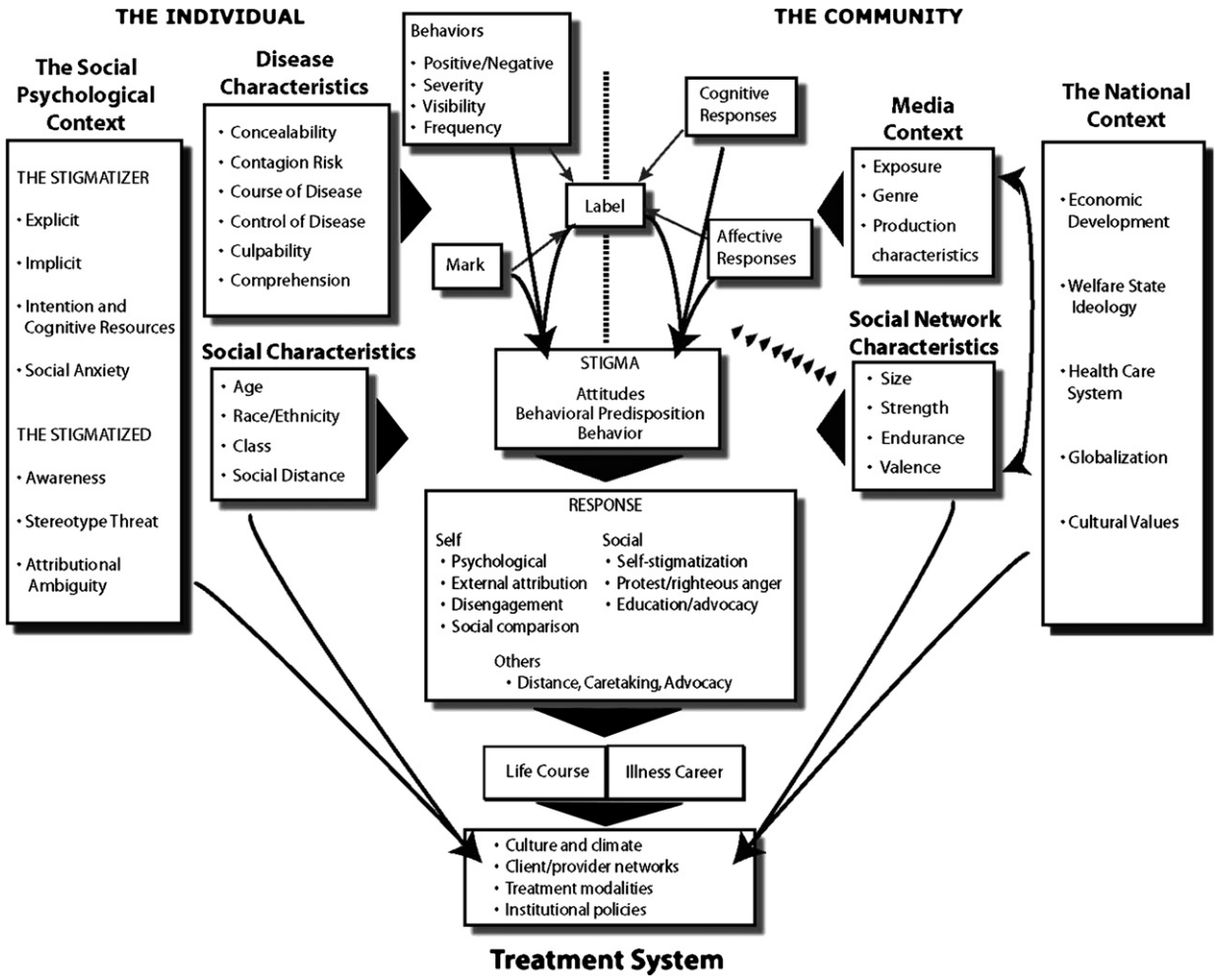

Fig. 1. Framework Integrating Normative Influence on Stigma (FINIS).

in ways outside of social norms, stigma increases. Finally, controlling for the nature of the behaviour or the assessment of a "mark," attaching the label of "mental illness" to a vignette describing a person has an independent negative effect on social rejection (Martin et al., 2000).

Recent social psychological and cognitive insights

A more recent line of inquiry, more general in character, and less targeted to the specific of mental illness or illness in general, comes from social psychology. That is, targeting any situation in which the self is threatened, social psychologists have looked at the intentions, motives, and emotions of those who may stigmatize as well as those who are potential targets of stigma. In its most radical version, this new social and cognitive psychology suggests that stigmatizing attitudes are implicit, hidden in motivation, and unrecognized by individuals (Banaji & Greenwald, 1994). However, for other social psychologists, conscious motivations and emotions drive stigma. For example, anxiety in dealing with persons with stigmatized conditions can occur in individuals who hold very prejudicial attitudes and in those attempting to override known social prejudices. In either case, the level of anxiety is likely to be expressed in words and actions (Haslam, 2006; Stephan & Stephan, 1985). Similarly, yet through a distinctive psychological process, individuals who feel an attributional ambiguity associated with others' behaviour toward them may experience negative self-stigma (Crocker, Cornwell, & Major, 1993). Further, the "target's" awareness of having a devalued social identity can also influence the perception and response to the social slights and to the acts of discrimination (Blaine & Crocker, 1993). Finally, understanding the pervasive nature of stereotypes held by others in society sets up a "stereotype threat" which, in turn, can negatively affect an individual's performance, particularly in situations where the stereotypes apply, reinforcing the stereotype, and the prejudice and discrimination that follow from it (Steele & Aronson, 1995).

The macro level

The right side of the FINIS model posits that stigma is embedded in a larger cultural context that shapes the

extent to which stereotyping exists, the nature of social cleavages that define "others," and the way that different groups accept, reject or modify dominant cultural beliefs. We focus on two critical elements of community context – the nature of media images which reify or counter popular stereotypes, and community-based social networks which function as a mechanism to alter larger cultural stereotypes and offer advice and assistance to individuals facing mental health problems.

Media images and influences

Research has suggested that media represent a powerful force in shaping the image of mental illness. For example, Angermeyer and Matschinger (1995) documented that violent attacks on public figures by persons identified by the media as "mentally ill" significantly increased prejudice. Research examining newspapers, movies, and television finds a largely consistent picture, indicating that individuals with mental illness are rarely portrayed in a positive light. Images of danger, unpredictability, and incompetence dominate (Diefenbach, 1997; Signorielli, 1989; Stout & Villegas, 2000; Wahl, 1997).

An underlying assumption of this research is that people's view of the world is, to some extent, both a mental and social construction (Hawkins & Pingree, 1982; Shapiro & Lang, 1991; Shrum, 1995). Mass media is constructed selectively (Gitlin, 2000) and allows for an "imagined" community culture (Calhoun, 1992). As people construct their view of what people and places are like, they may include information learned from media (Shapiro & Lang, 1991), particularly among heavy TV viewers whose social realities closely resemble the television world. Heavy viewers of violent programming are more fearful of becoming victims of crime, have more negative attitudes toward less powerful groups (Gerbner, Gross, Morgan, & Signorielli, 1980), and more positive attitudes toward powerful groups (Volgy & Schwartz, 1980).

Early research on media influence used a simple linear model incorporating two processes, learning and construction. Viewers pick up incidental information about the world while watching TV (the learning process) that is used subconsciously to make judgments about the real world. More recent approaches (Potter, 1991) suggest that two types of construction occur. In 1st order construction, individuals' estimates about frequencies and occurrences in the TV world influence their estimates about the real world. In 2nd order construction, individuals' beliefs about the TV world influence their beliefs about the real world. Generalization occurs when individuals use TV images to arrive at beliefs about the TV or real world. However, drawing from psychological theories of attention, not all sensory information garners individuals' attention (Harris, 1983).

While initial research suggested that the mechanism of selection might be an "attention filter" (Deutsch & Deutsch, 1963), later research suggested that selection might be based on various properties of the stimulus including sensory channel, features, and relevance (Shiffrin & Schneider, 1977). Eventually, limited capacity models of attention were developed, positing that attention occurs when a person allocates processing resources to a task/stimulus. Some tasks involve limited resources; other tasks can be performed using very few processing resources (Kahneman, 1973; Wickens, 1980). Further, emotional tone also significantly impacts processing, and how persuasive, attention getting, or memorable a message is (Basil, Schooler, & Reeves, 1991; Lang, 1991; Lang & Friestad, 1993). In any case, information about mental illness learned from a lifetime of media use will be a source of stereotypes, impacting judgments people make in their everyday life when they encounter situations related to mental illness, mental health care, or persons with mental illness.

The national context

While stigma is seen as "cross culturally ubiquitous" (Dovidio et al., 2000: 31), cultural and historical forces shape norms. The national context provides an overarching ideology by categorizing stigmatized groups and providing clues to appropriate responses toward them. The larger context embeds normative expectations in and through economic development, social organization, and cultural systems because each reflects access to social power. Context sets the stage for available resources, the acceptability of acting on cultural biases, and in the end, the likelihood of recovery.

Indeed, the International Study of Schizophrenia found that patients in lower income countries have a more favourable short- and medium-term course of the disease than those in high income countries (Sartorius, Gulbinat, Harrison, Laska, & Siegel, 1996). Researchers concluded that differences in stigma across "developing" and "developed" societies may be a critical mechanism explaining this finding (Hopper & Wanderling, 2000).

While the relationship of economic and cultural systems is debated, both have implications for stigma. Modernization theorists contend that economic development brings pervasive cultural change, while others from traditionalists to postmodernists suggest that cultural values are an enduring and autonomous influence on society. In a study of 65 countries, economic development appeared to produce a shift to values that were increasingly tolerant, trusting and participatory (Inglehart & Baker, 2000).

More generally, the social organization of a society reveals who is able to obtain power and shapes how citizens view themselves and others within society (Foucault, 1980; Parker & Aggleton, 2003). In particular, the nature of a nation's welfare state provides important clues as to inclusion and exclusion processes in developed nations (Drake, 2001; Esping-Andersen, 1990; O'Connor, Orloff, & Shaver, 1999). More universal health care systems may instil norms of entitlement for health care in its citizens, which in turn may make citizens more likely to view health problems that are included in the national health care system as legitimate, and therefore, less stigmatized. More specifically, it has the power to interfere in stratification processes, to enact specific policies that may reduce stigma, and it provides the overall cultural climate for normative behaviour and responses within a nation. Goodwin (1997) argues that mental health policy reflects the social organization of welfare. More specifically, mental health policy in liberal welfare states (e.g., the USA and Canada) reflects

market concerns; mirrors reaction and reliance on other organizational types in conservative regimes (e.g., Germany and Switzerland); and represents commitment to social rights and inclusion in social–democratic welfare states (e.g., Sweden and Iceland). In fact, on-going research on the cultural aspect of mental health norms conforms to welfare state expectations. An examination of printed media discourse reveals that the discourse in social democratic welfare states (i.e., Iceland and Germany) was most concerned with social inclusion and stigma, while the liberal welfare state (i.e., the USA) emphasized danger and criminality and moving these individuals out of the mainstream (Olafsdottir, 2007).

The meso level

Social networks

The notion of "contact" with persons with mental illness has long been thought to be a potential source of change and a basic force in human lives. Early theories of prejudice, deviance and inter-group relations drew from the "binding power of common experiences" (Calavita & Serron, 1992: 766). Particularly in the area of race relations, psychologists (Allport, 1954) and sociologists (Williams, 1947) focused on interactions as key to reducing discrimination and prejudice. In early studies in workplaces, neighbourhoods, and schools, there was wide support for the notion that increasing interaction between those "marked" and "unmarked" increases sentiments of "liking" (Caplow, 1964; Homans, 1951).

Not surprisingly, mentions of the positive effects of familiarity, experience or contact with persons with mental illness are prominent across the stigma literature (Penn & Martin, 1998). Swan (1999) contends that slow but steady progress is occurring to reduce stigma due to the greater proximity of persons with mental illness now living in the community. Training or other "educational" efforts that bring mental health consumers and students together have been documented to "break down barriers" (Adams & Partee, 1998; Estroff et al., 2004); to be important in dispelling myths about mental illness (Read & Law, 1999); and to decrease perceptions of persons with mental illness as dangerous (Iutcovich, Iutcovich, & Strikland, 1996; Link & Cullen, 1986).

Relevant research on this possibility is inconsistent. Penn et al. (1994) found that previous contact decreased negative response to a vignette; however, detailed knowledge of schizophrenia symptoms increased stigma. Increased contact was associated with lowering stigmatizing attitudes regarding dangerousness among white respondents, but not among African-Americans (Whaley, 1997). Other studies documented little or no support for the contact hypothesis (Damico & Sparks, 1986).

Half a century ago, Simmel (1955; Goffman, 1963) argued that the configuration of linkages and content in social groups have consequences for individuals inside and outside. Most relevant, Simmel theorized that "traditional" social networks offer members support and a common cultural orientation. However, such networks lead to low levels of tolerance and high levels of suspicion of outsiders (Pescosolido & Rubin, 2000). Networks described as "modern" offer less support but greater freedom to members. On the normative level, tolerance increases; suspicion of the "different" decreases; and prejudice is lowered. Further, only where contact is voluntary, equal, intensive and/or rewarding, prolonged, or where there are a number of people involved, did the contact hypothesis hold (Jackman & Crane, 1986; Weller & Grunes, 1988). Under these conditions, the "group" becomes more variable and less monolithic, making it difficult to uphold "global" stereotypes. But even this more sophisticated line of research does not offer consistent findings (Kolodziej & Johnson, 1996).

FINIS suggests that media exposure to images of MI and real-life exposure to persons known or perceived to have mental illness will interact to create physiological, cognitive, attitudinal and emotional responses. Real-life exposure to mental illness, combined with media exposure to images of mental illness, is expected to have direct effects on attributions, emotional and cognitive reactions, and stigma. Real world experience can function to confirm or disconfirm media information and images. Even a small amount of experience congruent with the TV message may significantly increase a message's effectiveness. Having contacts is likely to dilute the impact of negative media images only if the experiences were considered to be positive (Freidson, 1970; Pescosolido, 1991).

The treatment system

A theoretical framework of stigma would be incomplete without acknowledging both the dynamic nature of stigma and the role of organizations designed to deal with societal problems. These issues represent the newest foci of research; and, while that presents a challenge to laying out the forces at work, they cannot be ignored (see Basnett, 2001).

A variety of advocacy groups express continual concern about treatment, and self-labelled "psychiatric survivors" maintain that "official" psychiatry and its normative approach does more harm than good, or at minimum, does not help (Cresswell, 2005; Reidy, 1993). Others have been concerned that climate and culture of treatment settings often have unintended, stigmatized influences, including the absence of hopeful messages from providers (Crowley, 2000; Kelly, 2006; Pescosolido, 2006). Corrigan (2007) suggests that the very assignment of a diagnosis may have the unintentional consequence of triggering stereotypes, including the notion that people with mental illness cannot recover. Even for providers, the generalizations that help narrow decisions and discussions can all reflect a homogeneity that may not help providers or clients in the long run, in part, because they suggest stable and unchanging characteristics. While "institutionalized stigma" (Corrigan & Kleinlein, 2007) is not limited to the treatment system, organizational norms in the health care system that, even unintentionally, increase prejudice and discrimination are ironic and paradoxical at best.

Conclusion

We conclude with the observation that research on stigma is not "simply a matter of curiosity" but a "vital

component of the efforts to enable persons with serious mental illness to lead decent lives in the community'' (Attkisson et al., 1992: 619). Our current effort has sought to derive a theoretical framework of stigma that integrates insights from past theories and research, current theories of media effects, the moderating influence of personal experiences modelled from a social network perspective, and overlooked macro level factors.

FINIS provides a point of view, a set of assumptions and a conceptual map to understand this pervasive process. By its very nature, our framework is more general than a model, and several middle-range models can be drawn from it. As a general framework, FINIS may be applied to any stigmatizing condition, but would have to be tailored in substance and in hypotheses to be useful in empirical research and in substantive cases (Pescosolido, 1992). While it may not be possible to provide an overall empirical examination of FINIS, the framework sensitizes researchers to the possibility of other influences.

Implications for stigma reduction

Of what use can FINIS be with its complicated conceptualization and in the face of disconfirming, empirical evidence that will always appear for any programmatic attempt? We suggest that complexity offers an opportunity rather than a roadblock on two counts.

First, FINIS may help unravel why attempts at stigma reduction fail. It is fairly standard to get latent or unintended consequences from social policies (Waitzkin, 1971). For example, as described earlier, there is disconfirming evidence from experiments and observational studies that ''contact'' or ''advocacy'' may be useful. However, FINIS suggests that the contexts, from both inside and outside of the experimental or policy frame, may operate to thwart intended effects. Inside the experiment, FINIS suggests that it is the quality and nature of the interaction that matters. Only programs where social network ties are sustained, meaningful, interactive and positive are likely to have an influence that is not ephemeral. Further, outside the experiment, a subject's past experience with mental health issues, as a consumer, a family member, a person on the street can affect the reaction to a stimulus and to the effect of any experiment. Thus, the ''contact hypothesis'' although seemingly simple and straightforward, represents a complex set of possible configurations relative to stigma. At minimum, the effect of having contact (i.e., someone in the social network with a mental illness) can only be configured when the valence is considered. If the overall impact of social interactions is troubling, harmful or otherwise disturbing, then contact will likely have a negative impact. If interactions are rewarding and enriching, the effect of contact will be to reduce stigma (Pescosolido, Perry, Martin, McLeod, & Jensen, 2007).

Second, complexity and disconfirming evidence also leads to a baseline consideration of the limits of stigma reduction. While the overriding concern and hope lies in the belief that stigma can be eradicated, research on implicit attitudes described earlier as well as more general research on socialization and identity theory (Stryker, 1980) suggests there will always be a process of ''us'' and ''them'' at work in interaction. Subgroup identification, according to classic symbolic interaction theory, makes social interactions in a complex world possible. Further, all stereotypes are based on ''social fact'' whether that is real or constructed. For example, according to the body of research on the link between violence and mental illness, there is evidence to show that some symptoms of mental illness are associated with greater violence but the effect is small and exacerbated for individuals who are co-morbid for drugs and alcohol. In fact, according to the MacArthur Violence Risk Assessment Study, these are only two of a dozen factors that are associated with violence; and even with the full complement, the ability to predict violence is poor (Monahan et al., 2001). If we are to fear individuals with mental illness, we should be at least as concerned with men and, particularly, young men as a class of individuals; and given U.S. rates of incarceration, people of colour. However, these ''marks'' are either not stereotyped or they have been constructed as unacceptable social prejudices. The problem for stigma reduction in mental illness is that the negative behaviours of some individuals, because they are in a stigmatized group, become amplified, magnified and generalized to all members of the group.

Rather than abandoning hope, these insights lead to a direct consideration of why the macro level is so critical. Contemporary commentators on the stigma associated with race provide compelling evidence that over the years, it is only the manner in which racial prejudice is expressed that has changed, not the existence of racist ideologies per se. For example, while the public no longer endorses traditional ''Jim Crow'' racist notions, U.S. scholars of racial prejudice contend that Americans do continue to invoke negative stereotypes relative to a presumed inferiority of black cultural institutions, values, and norms that account for blacks' continuing disadvantaged status (see, for example, Bobo, Kluegel, & Smith, 1997). With regard to gender discrimination, Reskin (2003: 15) argues that the search for understanding and changing attitudes has produced only ''never-ending and unprofitable debate over the role of unobserved motives.'' She suggests two things: only intradisciplinary dialogue and collaboration, which include but are not limited to the individual level, are essential; and the focus needs to shift away from ''hearts and minds'' to allocation mechanism.

This insight returns us to FINIS' initial assumption regarding the role of norms. Norms can be informal; however, norms can also be enacted in the form of problems, policies and laws. Reskin (2003: 16) argues that allocation mechanisms are the ''engines of equality and inequality.'' If social systems, from welfare office to treatment clinics to political organizations, encode notions of civility, partnership, citizenship rights and concern, then it will likely lessen the stigma (Hemmens, Miller, Burton, & Milner, 2002).

If it is inevitable that we can only change ''hearts and minds'' around the edges, then any variation in prejudice and discrimination that we document across levels may reflect the critical importance of the macro level. In the USA, laws that limit the community system participation of individual in the judicial, political, medical and social arenas continue. There are exclusionary clauses regarding jury duty, voting, holding public office; there is a continual call for

parity for mental health insurance coverage; and there are concerns regarding the loss of parental rights for those with children with mental health problems but without the resources to afford care (Corrigan, 2005; Crowley, 2000; Hemmens et al., 2002; Kelly, 2006). If we cannot ask individuals to be totally free of the biases embedded in the cultural cleavages that exist in their society, we can prohibit them from acting on their prejudices, or to do so, with consequences from social institutions, including the legal system.

In sum, the advantage of looking across the spectrum of influences is that it is likely to improve our understanding of how any one factor is likely to operate.

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