

Confronting and Overcoming Stigma of Mental Health Challenges

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Table of Contents

<i>Abstract.....</i>	<i>3</i>
<i>Introduction.....</i>	<i>4</i>
<i>Defining Stigma of Mental Illness.....</i>	<i>5</i>
<i>Why do we Stigmatize.....</i>	<i>5</i>
<i>Evolutionary Origins of Mental Health Stigma.....</i>	<i>6</i>
<i>Cognitive Factors of Mental Health Stigma.....</i>	<i>9</i>
<i>Historical and Sociocultural Origins of Mental Health Stigma.....</i>	<i>11</i>
<i>Why is Stigma a Problem.....</i>	<i>13</i>
<i>Stigma Disclosure and Help Seeking.....</i>	<i>13</i>
<i>Stigma Reduction Efforts.....</i>	<i>15</i>
<i>Addressing Social Stigma.....</i>	<i>16</i>
<i>Protest Based Interventions.....</i>	<i>17</i>
<i>Contact Based Interventions.....</i>	<i>18</i>
<i>Educational and Persuasive Interventions.....</i>	<i>20</i>
<i>Linguistic considerations.....</i>	<i>22</i>
<i>Considerations of Control: Removing Blame and Drawing Equivalencies.....</i>	<i>23</i>
<i>Desire for Control.....</i>	<i>24</i>
<i>Removing Blame.....</i>	<i>26</i>
<i>Drawing Equivalencies.....</i>	<i>26</i>
<i>Interactional Methods of Stigma Confrontation.....</i>	<i>27</i>
<i>Addressing Self-Stigma.....</i>	<i>30</i>
<i>The Development of Self-stigma.....</i>	<i>31</i>
<i>Reducing Self-stigma in the Self.....</i>	<i>32</i>
<i>Reducing Self-stigma in Others.....</i>	<i>38</i>
<i>Conclusion.....</i>	<i>42</i>
<i>References.....</i>	<i>44</i>

Abstract

Mental health stigma remains a consistent and widespread barrier to mental health literacy, mental health treatment, and social equality. Due to the overarching effects of mental health stigma, many have formulated methods to reduce its prevalence and severity. However, many of the proposed reduction strategies are often focused on the sociological level, tackling large scale social institutions such as the healthcare industry, political policies, and mass media. While effective, many of these interventions exist on such a large scale that they leave many individuals with a sense of powerlessness, as most cannot hope to achieve large scale social or political change within a single lifetime. Thus, the purpose of this project was to locate, identify, and formulate possible mental health stigma reduction techniques that can be accessed and applied on the level of the individual within one's day-to-day interactions. The concept and process of mental health stigma is discussed and dissected in order to formulate and contextualize effective and relevant interventions. Interventional methods are primarily focused on interpersonal interactional style, language usage, effective psychoeducation, positive between-group contact, and mental reformulation. This knowledge may be used to further one's understanding of mental health stigma while guiding effective confrontational strategies.

Keywords: Psychology, Stigma, Mental health, Intervention, Reduction

Confronting and Overcoming Stigma of Mental Health Challenges

Mental health stigma has been a salient and recurring issue throughout my personal and professional life, as well as a frequent focus of study throughout my academic career. The challenge of mental health stigma is one that humans have struggled with across nearly all cultures and recorded historical periods, with a great many scholars throughout the years proposing solutions and methods to combat its effects. Unfortunately, discussions of mental health stigma confrontation and reduction often stray into the abstract, leaving those who are searching for concrete solutions feeling forlorn and inadequate. There is no denying that political structure, mass media, legal systems, and large-scale sociological factors all play a role in creating, perpetuating, and disseminating stigmatized views of mental illness throughout the population. However, when confronted with these behemoth challenges, individuals may feel overwhelmed and unable to find a clear and realistic solution, leading to a complete withdrawal from the discussion or the search for solutions. When the problem at hand seems so immense that even a great deal of effort on the part of the individual may be inadequate to properly address the issue, most individuals tend to view this endeavor as a waste of time and effort, opting instead to focus on something they can influence. Thus, the purpose of this review will be to look past the societal and political causes of stigmatization and ground the discussion of mental health stigma confrontation and reduction in the realm of the individual: the ordinary, busy, chronically stressed, politically powerless individual, who simply wants the easiest and most convenient way to address the issue within their own life as it affects them and those around them.

Defining Stigma of Mental Illness

Although stigma has been described and redefined by the countless scholars who have lent their hand to the discussion of stigma, it is Erving Goffman (1963) who is credited for formally defining the force of stigmatization as the possession of an “attribute that is deeply discrediting”, leading to the “situation of the individual who is disqualified from full social acceptance”. While many other definitions of stigma have emerged to fill in the blanks left by Goffman’s original work, most definitions now refer to stigma as a mark of disgrace associated with a particular circumstance, quality, or person, often resulting in negative cognitive and behavioral patterns such as stereotyping, prejudice, and discrimination against the stigmatized individual (Hinshaw, 2007). Ultimately, I am not interested in dissecting differing definitions of stigma and their connotations as a more colloquial understanding of stigma is all that is necessary in order to recognize and overcome its effects. Regardless of the way one formally defines stigma, most people can recognize it when they see it play out in an authentic setting. I will however posit that explicit and implicit stigma have significantly different functions and presentations, as implicit bias is much harder to detect and overcome, and its effects are also much less substantial.

Why Do We Stigmatize

In order to properly address stigmatization of mental illness and engineer an effective method for its disassembly, I feel it is important to understand why it is that stigma exists at all. After all, it is hard to locate a solution to a problem when one is unsure about the nature of the problem itself. The process of mental health stigma appears complex due to the multitude of situations in which it operates, and the many ways it can present itself. However, the cultural

ubiquity of stigma combined with specific cultural presentations of stigmatization provide clues as to the origins of stigmatizing thoughts and actions, and the methods through which stigma can be confronted and overcome.

Evolutionary Origins of Mental Health Stigma

Human culture is incredibly varied and diverse, so much so that it is nearly impossible for any one person to truly understand its complexity. This complexity leads to cascading effects on individual development, through patterns, personalities, preferences, behaviors, languages... the list goes on. And yet, stigma of mental illness—among many other forms of stigma—is one process that is observed in nearly all cultures studied across the globe (Rössler, 2016). Furthermore, stigma of mental health has been recorded throughout nearly all major time-periods of human history, with evidence dating as far back as ancient Greece (Hinshaw, 2007; Rössler, 2016). This cultural and temporal ubiquity provides evidence for a deeply ingrained biological explanation for stigmatizing behavior that may trace back to our species' evolutionary history. As is the case with most processes that appear throughout all subunits of human culture despite varying cultural influences, such as sexual desire, the cooking of food, or physical conflict, there seems to be something about stigmatization that causes it to occur “naturally” throughout our species.

However, just because something appears to be naturally selected for and possibly advantageous to our species in the past, does not mean that it should necessarily remain a salient factor within our species' psychobehavioral profile. The idea that something occurring naturally somehow justifies or endorses its existence is termed the naturalistic fallacy, due to the fact that the natural occurrence of a given phenomenon does not in and of itself justify its existence

(Geher, 2012). Just because something *does* happen, does not mean it *should* happen. Ultimately, naturalistic justification fails to account for changing circumstances and shifting environmental pressures. While something may have been naturally selected for in the past, does not mean it can or should be justified in the present or into the future, as the challenges our species faces in the present are distinctly different from the challenges we faced in the past, and cannot be solved using the same modalities. This line of reasoning encapsulates the concept of evolutionary mismatch, the process through which previously advantageous adaptations become deleterious due to shifting environmental (or in this case societal) pressures that render an evolved trait ineffective at solving novel challenges (Geher, 2012). While it may seem strange that a species could evolve something that would be disadvantageous in the future, this makes perfect sense when one recognizes the fact that evolution by natural selection is not a conscious force that plans for the future, but simply the result of historically relevant pressures on a species' ability to reproduce.

Ultimately, stigmatization of mental illness can be viewed as an evolutionary mismatch between the environment of evolutionary adaptiveness, for which both our bodies and minds have been naturally selected for across hundreds of thousands of years, and our modern, globalized and technologically advanced environment which has developed and changed much faster than our biology has been able to adapt to it. This has resulted in our "stone age brain" being forced to function in a very much not stone age environment. While the physiology of our central nervous system is highly adapted towards a nomadic, unindustrialized life within a small group of well-known individuals, this is far from the environment we tend to find ourselves in today. Unlike the environment for which our neurology, and thus our consciousness, is designed to function in, our modern environment contains highly advanced technology, media influences,

and most importantly, large groups of foreign individuals with diverse appearances, experiences, beliefs, and backgrounds interacting with one another on a constant basis. Ultimately, it is this relatively sudden influx of strangers that serve as the foundation for stigmatization and derision of individuals who we perceive to be members of “outgroups”. While these outgroups do not pose any inherent danger to us in our modern society, in the environment of our ancestors whose traits we have inherited, a foreign group of conspecifics would almost certainly pose a danger to one’s own survival and the survival of one’s in-group, due to the necessity for resource and mate competitions in a pre-agrarian and industrialized world.

However, stigma of mental illness (or any illness for that matter) faces an additional evolutionary challenge, that of our immune systems. Much like every other aspect of our beings, our immune system is the product of evolutionary pressures and consequent adaptations. While our immune system is chiefly composed of specialized networks of cells and transport systems within our bodies, we have also developed many cognitive adaptations that work in conjunction with our physiological immune system to keep us protected from possible pathogens. This cognitive aspect of our immune system is often referred to as our behavioral immune system, composed of a series of processes that allow us to identify individuals who are infected with possibly contagious diseases through a series of informational and behavioral cues so that we may avoid these individuals, thus protecting ourselves from the effects of illness or infection (Lund & Boggero, 2014). Although we have been made consciously aware that mental disorders are non-contagious through years of scientific advancement, our ancestors did not have access to this knowledge. Because of this, we are adapted to a “better safe than sorry” mentality, in which those with visible signs of illness (mental or physical) are actively avoided and disintegrated from our social groups as a physiological defense mechanism.

Cognitive Factors of Mental Health Stigma

The final evolutionary adaptation we must contend with in order to reduce the stigma of mental health is that of cognitive heuristics: the miraculous cognitive shorthand we use to break down complex concepts, phenomena, or patterns into simple and easily understandable chunks. The concept of cognitive heuristics has been a part of scientific research for quite some time, dating back to the 1950s when economist and cognitive psychologist Herbert A. Simon first discovered the concept at work in our financial decision making (Santos & Rosati, 2015). However, it was not until this concept was further investigated within the psychological community that the evolutionary advantage of cognitive heuristics was connected to characteristic based stereotyping (Santos & Rosati, 2015). The argument here is simple. Our nervous system uses 20-30% of all the calories we consume, making it an incredibly expensive resource to maintain in a world in which food sources are scarce. Most of these calories are spent thinking, therefore, reducing the amount of time we spend thinking will reduce the number of calories our brains require to function. Those who were able to function optimally with the least amount of wasted energy on frivolous thought processes were less likely to succumb to hunger, and thus more likely to pass down those traits to their offspring.

The problem with this seemingly effective adaptation is that, in the process of saving energy and processing power, we run the risk of rushing to conclusions that may be inaccurate. As it applies to mental illness, this is where stereotyping comes into play. It is certainly possible to think of mental health consumers as a large and diverse group of individuals who possess unique idiosyncrasies and experiences that make each person meaningfully different from the next. However, from a cognitive, energy saving standpoint, it is much easier to think of this group of others as homogenous and largely similar, ascribing a predetermined set of

characteristics to everyone rather than doing the work of ideographically understanding each individual. Furthermore, drawing back to the behavioral immune system and our “better safe than sorry” mentality, if some members of the group display possibly dangerous or unpredictable behavior patterns, it is mathematically easier and safer for us to conclude that all members of the group share these characteristics, even if this notion is fundamentally untrue when the available data is critically and systematically analyzed.

Mental health destigmatization is facing a trifecta of evolutionary mismatches: in-group/out-group bias, the behavioral immune system, and our cognitive heuristics designed to expedite our cognitive processes. These three factors combine to create a situation in which mental health consumers are viewed as a homogenous outgroup of possibly contagious or dangerous individuals. Although it should be obvious by now, I feel it is worth stating that none of these beliefs are true (mental health consumers are an outgroup to some, but outgroups are not inherently dangerous like they were in our past). The best weapon we have against an evolutionary mismatch—apart from literally evolving across generations to surmount a new adaptive hurdle—is education. Understanding the concepts of evolutionary mismatch has been shown to allow individuals to consciously recognize and overcome these largely unconscious influences on our cognitions and behaviors (Lund & Boggero, 2014). The caveat is that this process is effortful and difficult and requires far more active critical thought and meta-cognition than simply aligning our behaviors with our naturally selected and largely ubiquitous thought processes (Lund & Boggero, 2014). However, it is certainly possible, and is something I believe we are obligated to strive towards as a species that hopes to carry its progress into the future.

Historical and Sociocultural Origins of Mental Health Stigma

While the evolutionary explanation goes a long way in elucidating the mechanism of stigma, the picture is not yet complete, as there also exist socially constructed pressures that contribute to the development and perpetuation of mental health stigma. Most of the social pressures driving the stigma of mental illness stem from the historical treatment of those with mental illness, as well as the power dynamics involved in the treatment of mental health consumers. To spare too much detail for the sake of length, suffice it to say that mental illness has likely been stigmatized for as long as we have been capable of recognizing it, evidenced by a nearly unbroken historical record of mental health stigma appearing in many geographically and culturally disconnected regions, spanning from ancient Greece to the present (Hinshaw, 2007; Rössler, 2016). This historical influence has trickled down to an individual level, since regardless of where one is born and raised, they will nearly always be exposed to stigmatized views of mental illness throughout the course of their development, often starting at very young age during which attitudes and beliefs are highly plastic and subject to external influence.

In addition to the historical and cultural influence of stigmatized beliefs on individual cognitions, there exists a strong influence from those who hold power over mental health consumers (medical professionals, researchers, politicians, etc.) that contributes to the existence and prevalence of mental health stigma. Various misinterpretations of the causes, mechanisms, and symptoms of countless different mental illnesses has led to public confusion surrounding the topic. Although this misinformation is sometimes spread with malicious or defamatory intentions, for the most part misinformation is instead attributable to the iterative and often faulty process of scientific discovery. Many modern stigmatized beliefs—such as the notion that mental illness is the fault of one's parents, that mental illness can be genetically bred out of existence

through eugenics, or the idea that individuals are responsible for their illness and make conscious choices to remain ill—are but a few examples of the mischaracterized or downright false beliefs surrounding mental illness that have been created and spread by those in positions of medical, scientific, or legal power (Hinshaw, 2007). These social influences have led to a situation in which we are exposed—early and frequently—to negative stereotypes about mental health consumers that are often displayed to us by groups of individuals with which we identify, or who carry a significant degree of power. This process culminates in an internalization and incorporation of stigmatization towards mental health consumers that becomes very hard to shake due to the constant social influences that prompt us to continue holding stigmatized attitudes or justify the use of stigmatizing behaviors.

Suffice it to say, while we may be evolutionarily adapted towards certain kinds of stereotyping and stigmatizing thoughts and behaviors, the presence of these forces throughout our society, during our entire course of development leads the pre-existing tendencies towards stigmatization of mental illness to be actualized and expressed. These factors make it seem as though stigma of mental illness is, always has been, and always will be a ubiquitous and insurmountable challenge for our species. However, this leaves one important piece of the puzzle empty, our free will and metacognitive ability to recognize, contemplate, and even change our thoughts and behaviors. As we will see, it is this gift of free will, combined with our unmatched intellect and metacognitive ability that can allow for our species to take an active hand in recognizing, deconstructing, and reforming faulty patterns of thought such as mental health stigma that hamper our ability to function optimally within our modern world.

Why is Stigma a Problem

From this point, the next question that needs to be addressed is, why is stigma of mental illness a problem? Although this question may seem like it has an obvious answer, as most people have a fundamental distaste for social inequality, I nonetheless believe it is important to define why the forces of social and internal stigma are so damaging to individuals, as well as society as a whole. Because of stigma, mental illness acts as a double-edged sword to its victims. First, those who suffer from challenges to their mental wellbeing must contend with presenting symptoms. Although mental illness is a broad category containing a wide variety of conditions, symptoms may range from inconvenient or annoying to unbearable and even life-threatening, with certain disorders presenting chronic or recurring challenges for their victims. However, the difficulty does not end there, as victims must still contend with the second edge of the sword, social and personal stigma. In addition to the possibly debilitating symptoms, they are already forced to manage, individuals must learn how to exist in a social climate that is often deeply uncomfortable and intolerant towards those labeled as “mentally ill”. While the challenge of stigma is often established in social settings, persistent exposure to the stigmatized attitudes and behaviors of others can cause these beliefs to become internalized, establishing a paradigm in which individuals with mental health struggles may begin to consciously apply socially stigmatized opinions to themselves.

Stigma Disclosure and Help Seeking

The effects of stigma are easily observable throughout mental healthcare systems across the globe. While it is true that over 50% of people will experience mental illness at some point in their lives, with 1 in 5 people being diagnosed every year in the United States, this already

daunting data is does not capture the magnitude of the problem (National Institute of Mental Health, 2022). Chiefly concerning is the issue of disclosure, an essential step in the process of overcoming the challenges of mental illness and/or seeking help from professionals. While it is difficult to assess the true rate of disclosure of mental illness, due to the obvious fact that it is impossible to know what people will not tell you about themselves, it is estimated that up to 40% of those with diagnosed mental illness with conceal their diagnosis due to fear of the stigmatized reactions from others (Henderson et al., 2013). These statistics appear even more grim when one considers that statistics on disclosure only apply to those who have been formally diagnosed. Globally, it is estimated that more than 70% of those with diagnosable mental illness will receive no treatment or diagnosis from healthcare staff (Henderson et al., 2013). While these number owe some of their grandeur to systematic overpathologizing within the psychiatric community, there is no denying that many real mental disorders are represented here. Additionally, I argue that overpathologizing and under reporting balance out, leading to statistics that are fairly accurate. Either way, the data indicates that a mental illness is a ubiquitous and undeniable problem for many members of society.

The difference between the apparent, treated prevalence and true prevalence of mental disorders can be referred to as the treatment gap. While imperfect healthcare systems, financial inaccessibility, and physical proximity to a treatment center are all somewhat responsible for the existence of this gap, lack of knowledge of the features of mental illnesses or how to access treatment, and the fear of prejudice against people who have mental illness or an expectation of discrimination are the most significant factors driving the monumental disparity between those who do and do not seek treatment for mental illness (Henderson et al., 2013). I believe these

statistics alone present a solid argument that it is imperative to conquer the stigma of mental illness within society.

Stigma Reduction Efforts

On the bright side, there is strong evidence indicating that this treatment gap is not inevitable, and that mental health consumers need not suffer from the double-edged sword of mental illness and its accompanying stigma. There exists an increasingly large pool of data indicating that many different stigma reduction efforts can be highly effective in elevating the subjective quality of life of mental health consumers, reducing the treatment gap, and increasing meaningful disclosure (Henderson et al., 2013). Psychoeducational stigma reduction techniques can be especially effective in closing the treatment gap, as educational stigma reduction efforts can work not only to reduce the perceived shame of receiving mental healthcare, but also to increase knowledge regarding what conditions warrant treatment and how said treatment can be accessed (Henderson et al., 2013). Reducing or even eliminating the stigma of mental health is a proven possibility that undoubtedly increases treatment seeking, social outreach, and recovery.

Beyond the clinical argument for the reduction and prevention of mental health stigma due to its effects on mental health consumers, there exists a more personal and humanitarian argument for stigma elimination. Stigma itself is the product of faulty reasoning, overgeneralizations, misconceptions, and cognitive heuristics. To allow such a malformed and misguided pattern of reasoning to have a hand in controlling one's thoughts and actions is to allow the self to function at a suboptimal level. That is to say, holding stigmatized views is both a signal and a cause of close-minded and anti-intellectual cognitive structures that contribute to one's inability to become the most informed, intelligent, and compassionate version of oneself,

ultimately preventing self-actualization. Additionally, this burden also reflects on those who are subject to stigma, as the various social and personal pressures stigmatized individuals experience culminate in significant barriers to said individual's self-actualization. It is hard to be the best version of oneself when artificial shame and systemic discrimination stand in the way of total social acceptance, equality, and the development of a healthy self-concept. Therefore, if one wishes to be the best person they can be, while inspiring and assisting others to do the same, systematic recognition and prevention of mental health stigma is a prerequisite accomplishment.

Addressing Social Stigma

Given the previous description of the causes underlying the stigma of mental health, any intervention that is attempting to reduce stigma should thus be tailored to one or more of the aforementioned causes. Indeed, the most thoroughly supported and efficacious stigma reduction techniques often align with one or more of the recognized causes of stigma. The most widely supported interventions tend to center on contact, education, or public protest, with more therapeutic, cognitive-behavioral approaches being used to reduce self-stigma, as this process operates slightly differently than stigma towards others (Corrigan & O'Shaughnessy, 2007). Applying these interventions to our working model of stigmatization demonstrates that contact-based interventions work to break down in-group/out-group barriers, education works to overcome our misdirected cognitive heuristics and faulty behavioral immune tendencies, while protest works primarily to address the socially constructed causes and consequences of mental health stigma.

Protest Based Interventions

Protesting salient instances of mental health stigma may be used to reduce or eliminate specific instances of mental health stigma as they occur. Protest may be aimed at changing media portrayals of mental illness, reducing employment, and housing discrimination, lowering the incarceration rate of those with mental illness, the list goes on. However, due to the applied and individualized nature of this paper, large scale political activism such as protesting will not be emphasized. This is not because protest is ineffective at reducing stigma of mental health, particularly expressions of stigma such as media portrayals and legal policies, but simply because protesting extends beyond the scope of an individual's capabilities and draws instead on large-scale social congregation. Given the difficulty involved in organizing and staging large scale protests, as well as the variable accessibility to the attendance of such events, protest-based interventions will be de-emphasized within this review. That said, it is worth noting—for any who wish to organize or take part in protests aimed at increasing equality for mental health consumers—that protest can be effective when the goal is to change stigmatizing behavior, especially when large scale social pressures are used to threaten the profit margins of corporate entities that are displaying stigmatized media related to mental illness (Corrigan & Penn, 1999). However, while protest may be one of the more effective interventions when behavior change is the goal, it does not work as well as other interventions when core belief and attitude change is the goal; in fact, it may have counterproductive effects on the adjustment of stigmatized attitudes.

Ultimately, protest without a clear request for action must be done carefully, as the demand for someone to stop *thinking something*, such as a stigmatized attitude, can in fact cause those thoughts to become even more incessant (Corrigan & Penn, 1999). This is cleverly

illustrated by the famous pink elephant or white bear scenario. That is, if I demand that you *DO NOT* think about a pink elephant, chances are you will have pink elephants on your mind for the next few minutes. As one might have guessed, this effect is not unique to colorful wildlife, as statements that are designed to rebuke stigmatizing thought patterns have been shown to prime said thought patterns to flood the mind of individuals who possess them, increasing their frequency without achieving any meaningful reduction in the presence or magnitude of stigmatized content (Corrigan & Penn, 1999).

I do not say this to actively discourage the use of protest, but simply to ensure that, if such an approach is used, it should be done carefully and should focus on addressing a specific pattern of behavior that could be systematically identified and changed. Additionally, it is worth noting that many of these interventions are multimodal and overlapping, meaning that contact can also work as a form of education and social reconstruction, while education can also work to break down in-group/out-group barriers and call suspect social beliefs into question. Protest can also work in a multimodal fashion; however, the goal of protest is often to change the behavior of a specific group or entity rather than to further public education or facilitate between-group contact.

Contact Based Interventions

Outside of the context of protest, there are many interventions and stigma reduction techniques focusing on education and social contact that have demonstrated greater efficacy in relation to attitude change than protest. While these interventions may work to dismantle and reform stigmatized attitudes and beliefs that serve as the foundation of all instances of stigma-based stereotyping, prejudice, and discrimination towards mental health consumers, many interventions fail the test of everyday applicability. While many strategies for stigma

confrontation have a strong evidence base and a proven track record, much of this success only exists within the context of controlled experiments or social studies performed or facilitated by experts. While this is not a weakness in the methodology, as these interventions have proven highly effective, it could be difficult for an individual to operationalize and facilitate between-group contact in a realistic setting.

Obviously, if one attempts to facilitate positive contact in their day-to-day lives there will be no such team of experts, few controls on the environment in which the interaction takes place, and little to no informed consent on the part of the individual or group on which one is attempting to facilitate attitude reformation and behavioral change. If one hopes to utilize the lessons and strategies gleaned from psychological research within their own life, they must be prepared to improvise their own methodology within a non-controlled environment, with “participants” who most likely did not choose to enter an endeavor of attitude and behavioral reformation and may display a moderate to strong level of resistance. For this reason, I will focus less on the specific methodology and results of scientific studies on stigma reduction, instead highlight the conceptual frameworks underlying effective interventions that can be removed from the artificial context of academic or clinical research and readjusted to apply to non-controlled interactional situations.

Additionally, many contact based interventions will be excluded from consideration in daily application, even though contact-based interventions are one of the most effective destigmatization efforts possible (Corrigan et al., 2001). This is simply because the feasibility of facilitating contact in everyday situations is highly subjective to the individual in question. However, in instances in which groups of individuals with stigmatized attitudes are able to interact with mental health consumers in a positive and constructive manner, stigmatization

nearly always decreases (Corrigan et al., 2001; Corrigan & O'Shaughnessy, 2007; Lien et al., 2021). Yet, despite the long and prosperous track record of between-group contact decreasing stigma, the methods in which someone might facilitate such an intervention in an applied context are simply too variable to be concisely summarized. All that said, there still exists a strong history of the effectiveness of contact-based stigma reduction interventions. Depending on the context of the stigmatization, positive social contact may in fact be the most effective method for stigma confrontation (Corrigan et al., 2001). Thus, while it may be hard to practically facilitate and apply positive social contact scenarios, this should not preclude individuals from trying, or seizing an opportunity if it presents itself.

Educational and Persuasive Interventions

In addition to protest and contact-based interventions, there exists a litany of education-based interventions related to mental health stigma reduction and attitude reformation. However, many of these interventions are focused on the didactic model of structured lesson plans administered by experts to bodies of willing students. In most people's day-to-day lives this will not be practical or even possible, making nearly all educational interventions seemingly useless to the average person who wishes to decrease stigma within their community. However, the frameworks and strategies used to drive educational destigmatization can be disconnected from specific interventions and reapplied to one's everyday interactions. For instance, many educational interventions, while differing greatly in terms of their specific constructions share the commonalities of sharing information on the origins and causes of stigma, identifying the faulty heuristics and unconscious thought patterns that lead to stigma, critiquing flawed thought patterns, and working collaboratively to achieve meaningful attitude change (Corrigan et al., 2001; Waqas et al., 2020). Ultimately, it is these basic techniques that truly drive attitudinal

change, allowing for them to be disconnected from specific interventions and reapplied to everyday interaction.

Some of the basic methodologies shared by all educational interventions involve critiquing flawed techniques and faulty reasoning, as these approaches are often much more effective in changing the minds of individuals who hold objective misconceptions than simply telling someone that they are wrong without explanation. Mental health stigma can thrive and propagate through the avenues of logical fallacy and flawed reasoning techniques such as relying on unsubstantiated theories, cherry picking evidence, subscribing to the testimony of false experts, and engaging in stereotype-based reasoning. Rather than directly confronting individuals who engage in these practices and telling them without proper explanation that they are wrong and need to change their opinions and alter the way they are thinking, one should instead attempt to point out the ways in which certain cognitive processes and sources of evidence are ineffective or incorrect (Schmid & Betsch, 2019).

From there, one should explain how and why they are wrong, as well as how they could work to better their evidence gathering and attitude formation processes in the future. Although this methodology is far from perfect, it is better than telling someone at face value that their deeply held attitudes and beliefs are wrong without explanation. This type of direct and unexplained confrontation may appear to be an attack on the personality or intelligence of the individual in question or those whom they place their trust in, only leading to further entrenchment while perpetuating an *Us vs. Them* mentality (Schmid & Betsch, 2019). Ultimately, the key to changing the attitudes of others in relation to mental health stigma—as well as many other contexts—involves collaboration rather than competition, as competitive

debate often leads to entrenchment in one's original position rather than meaningful attitude reformation.

To apply this advice to one's own interactions, one must work to establish a sense of understanding and cooperation between separate sides of a debate and avoid turning the discussion of mental health stigma into an argument, as this will only work to radicalize both sides of the debate, leading to mass entrenchment and a sense of conflict rather than cooperation against a common enemy. As frustrating as it might be to converse with someone who holds a prejudicial or offensive attitude, one must avoid turning to a place of anger and derision, instead focusing on calm and reasonable debate that addresses the faulty patterns of reasoning underlying another's belief system rather than attacking specific beliefs at face value. Additionally, due to our heuristic thought processes, it is nearly always easier to passively maintain an existing ideal or attitude than actively dismantle or alter an established pattern of thought and effortfully replace it with a new and improved construction (Schmid & Betsch, 2019). For this reason, one must find a way to make this process as painless and agreeable as possible, while allowing individuals with mistaken beliefs to maintain their dignity and seamlessly incorporate new information into their minds with minimal resistance or effort.

Linguistic considerations. In addition to the tone and style of language one uses when discussing mental health stigma or confronting others to reduce stigmatized attitudes and behaviors, the words one uses to describe mental illness and the mental health consumer population can also have an influence on the magnitude of stigma reduction. Regardless of context, person-centered, individually-focused language is the most effective in preventing the development stigmatized attitudes as well as reducing existing mental health stigma (Mann & Himelein, 2008). For example, it is nearly always better to refer to an individual with

schizophrenia as, well, an *individual with schizophrenia*, rather than a *schizophrenic*. That said, if a specific mental health consumer prefers they be referred to using identity-focused language, it is certainly the case that the individual's preference should be recognized and respected and they should be referred to as such. However, in a neutral or educational context in which specific individuals and their preferences are not relevant, person-centered language has been shown to prevent the development of stigmatizing beliefs and reduce the impact of existing stigmatized attitudes (Mann & Himelein, 2008). This is because person-first language works to establish the individual as a human being who experiences a certain mental health challenge, rather than framing the individual's identity strictly in terms of the specific challenge they face. I believe this ultimately draws back to the concept of in-group/out-group bias, as person centered language establishes mental health consumers as fellow human beings, rather than some representation of a disorder with which we cannot identify.

Considerations of Control: Removing Blame and Drawing Equivalencies

In terms of specific strategies for destigmatization of mental health, two particularly effective techniques are removing blame from the stigmatized individual or group and drawing equivalencies between a stigmatizing in-group and a stigmatized out-group. Although this specific piece of research was tested on groups of individuals with racial minority status, obesity, or HIV, the methodology would more than likely extend to mental health consumers and the stigma that comes with the label of mental illness (Clair et al., 2016). The principle of removing blame is simple. In the case of mental illness, this involves altering the attributional style of those who believe that it is somehow the fault of the consumer that they suffer from any given mental illness or mental health challenge. Sadly, this relatively simple route to destigmatization faces

many obstacles. Chief among these obstacles, is the seemingly ubiquitous human tendency to attempt to “make sense” of situations with logical, causal attributions.

Desire for Control. Ultimately, people find comfort in the belief that they have free will and the capacity to dictate their thoughts and behaviors. People like to feel in control, they like to understand what is going on at any given moment, and they like to believe that their actions are under their own jurisdiction. Ultimately, this is understandable, as our ability to control the way we act and react to stimuli, avoid or reduce negative experiences, and pursue and achieve our goals is central to our identity as living beings. Since we are all equal in our status as human beings (at least on a biological level), assuming I am in control of my thoughts, actions, and ultimate destiny means that everyone else must also be in control of these factors as well. To assert that one individual has control of the trajectory of their life while another does not is inherently paradoxical, given of course that two individuals face similar environmental constraints. However, the science surrounding our notion of free will and personal autonomy is much less clear. While there are certainly many things within our lives that we can control, there also exist an array of variables that are completely out of our hands.

Returning to the concept of mental illness, our genetic lineages, our family systems, and the trauma that others bring upon us are the primary examples of factors that remain largely out of our hands. Although it is certainly not the case that all mental illness or psychological distress is the result of the aforementioned factors, there is no denying that genes, upbringing, and exposure to trauma play a significant role in the development of many psychological challenges. However, this notion brings into play yet another factor that may increase stigma surrounding mental illness, one’s attributional style. Although biogenetic, family systems, and trauma-based explanations for the development of mental illness and generalized psychological distress have

strong empirical support, these explanations may lead individuals to believe that, since one is unable to control whether they develop a mental illness, they are also unable to control their own ability to cope with and recover from said illness (Larkings & Brown, 2018). This view is highly damaging to the destigmatization effort, as it leads to the belief that mental health consumers lack any agency in their own recovery or wellbeing, further increasing the stigma surrounding the victimized and seemingly helpless individuals (Larkings & Brown, 2018). Again, progress is throttled by the craving for logical and consistent patterns of reality.

If one is unable to control the circumstances surrounding their psychological wellbeing, then how could they control their own recovery? On the other hand, if one can control their own recovery, doesn't that mean that they must have had a hand in the circumstances that led to their illness in the first place? Thoughts such as this are completely natural, as our minds are optimized to distill complex conundrums into simple syllogisms that can be solved with minimal cognitive effort. However, this is yet another example of our cognitive heuristics backfiring on us and distorting our perception of reality. Although it may seem contradictory and somewhat nonsensical at first, the idea that someone could be unable to control the circumstances of their illness yet still capable of controlling their outcome is perfectly possible (Clair et al., 2016). Something can happen to someone that is not their fault and that they had no control over, yet they can still take action to ameliorate the situation. It does not have to be all or nothing. It is possible for an individual to suffer from a psychological disorder that was not caused by the actions or beliefs of the individual in question, yet still be able to take certain actions and hold certain beliefs that will work to reduce the severity of the illness or overcome it all together. In short, effacing an individual's responsibility for the situation they find themselves in does not contravene their ability to extricate themselves from the situation. Additionally, it is important to

recognize the reciprocal scenario, in which an individual may have made a certain choice or taken a certain action that led to their own psychological distress yet is not fully capable of simply taking control and “stopping” their illness. Drug addiction serves as a perfect example here. While it may be true that an individual’s initial choice to use a certain drug could fall under the umbrella of their own responsibility, asking said individual to “just stop” is a hopelessly ineffective solution that overlooks both the social and neurological complexity of the situation.

Removing Blame. To properly remove blame from the individual with mental illness, one must recognize that the individual may have made a choice in the past that has led them to where they are now, while also recognizing that said choice does not define the entirety of this person’s existence, and that a simple choice to change one’s trajectory no longer exists. One must recognize that choices are not made in a vacuum, and that responsibility and autonomy can increase and decrease depending on time, situation, and context. Regardless of the situation, removing blame is much more easily said than done, as we possess a host of cognitive adaptations that are working against us in our goal to obtain an accurate perception of reality. Yet, this goal is far from unattainable. Using the previously mentioned strategies of respectful, cooperative debate with a focus on faulty logic or misconceptions and an absence of accusatory or divisive language, one can work to instill these beliefs in others, often leading to significant reductions in stigmatized attitudes (Clair et al., 2016). The goal of removing blame is to establish mental health consumers as fellow people who simply struggle with different challenges. Much like anyone else struggling to manage a difficult area of their life, they did not choose to struggle with these challenges, and they are certainly not at fault.

Drawing Equivalencies. Unlike the seemingly simple yet surprisingly sophisticated task of removing blame from mental health consumers, the act of drawing equivalencies is much

more straightforward, and possibly more effective due to its simplicity (Clair et al., 2016). This process is exactly as simple as it sounds, boiling down to three essential steps: 1) noticing an instance of stigmatized, between group language or behavior – e.g., “I just don’t get people with OCD, they should just control their impulses and behave normally like the rest of us.”, 2) confronting the individual and highlighting the use of stigmatized language – e.g., “The compulsions of OCD are not like the urges that someone without OCD experiences, they can’t be ignored in the same way.”, and 3) highlighting a commonality between the stigmatizing and the stigmatized individual – e.g., “haven’t you ever had a feeling or experience that you can’t explain or get across to others, but is still highly significant to your own subjective experience?”. While this is but one example, this paradigm can be extended across nearly all types of mental health stigma as it relates to many different disorders and individuals. Provided an effective and appropriate equivalency can be drawn, the sense of a boundary between *us* and *them* can be challenged and replaced by a more inclusive concept mental illness that defines mental health consumers as fellow members of an individual’s perceived in-group (Clair et al., 2016). Furthermore, the act of drawing equivalencies may further facilitate contact between mental health consumers and those with stigmatized beliefs, which remains one of the most effective destigmatization strategies.

Interactional Methods of Stigma Confrontation

Much like the processes of removing blame and drawing equivalencies, reframing and counter-framing strategies rely on the creative use of language to reduce public stigma towards mental health consumers. Redefining and describing mental health consumers as typical members of the public with equal status who are just like the rest of us, yet who face different

obstacles has been shown to reduce stigmatized attitudes and behaviors (Vyncke & Van Gorp, 2020). This works to reframe the stereotype of a mental health consumer in more realistic, diverse, and accommodating terms, thereby reducing the severity of previously held stigma, while preventing the development of stigmatized beliefs that are predicated upon the dehumanization of mental health consumers, and the cognitive disconnection of their population from the rest of society (Vyncke & Van Gorp, 2020). If one can learn to internalize and apply this type of language within their own conversations, and work to correct those who use mischaracterized or negatively framed descriptions of and references to mental health consumers, small yet significant seeds can be planted in the minds of those with stigmatized attitudes that may ultimately grow into long term reframing of mental health consumers in a more positive and inclusive light.

Finally, on the topic of confronting and ameliorating the stigmatized beliefs of others, I feel it is worth addressing the style in which information is presented, and the relevant interactional medium through which information is conveyed. In terms of the type of information that is presented, research findings strongly suggest that material meant to moderate stigma should be socially, culturally, and personally relevant to the individual in question (Rüsch et al., 2005; Fung et al., 2020). The more the messages of attitude change appear to be tailored to the target individual in question, the more receptive they will be to the message, leading to greater levels of understanding and identification with the messages of others, resulting in strong, long-lasting stigma reduction (Rüsch et al., 2005; Fung et al., 2020). This may be more easily said than done, as it is not always possible to know the details of another's experience and tailor one's language towards it. However, if it is possible to personalize one's destigmatization efforts, a

personal and relatable message will be the most significant in facilitating receptivity to counter-attitudinal views, thus increasing the effectiveness of arguments against mental health stigma.

Consideration of communication medium is also relevant to the process of mental health destigmatization. It comes as no surprise that face-to-face interactions are often the most meaningful in reducing stigmatized attitudes (Goh et al., 2021). However, stigma confrontation does not *need* to occur face-to-face, as virtual interventions and communication modalities have been effective at reducing mental health stigma (Goh et al., 2021; Lien et al., 2021). Although face-to-face communication is often preferable to virtual communication for many individuals, especially when discussing sensitive or important topics, it is not prerequisite for confrontation of mental health stigma and the facilitation of attitude reformation and behavioral change. In fact, the somewhat divisive nature of stigmatization within our society may in fact mean that virtual communication may be more effective, as it provides a degree of disconnection that allows individuals to express themselves while feeling as though they are not being judged as harshly by those around them (Lien et al., 2021). Furthermore, the effectiveness of online or virtual intervention has been demonstrated across many different populations, and in relation to many different forms of stigma (Goh et al., 2016; Lien et al., 2021). Thus, while there are many interpersonal contexts in which mental health stigma can be recognized and confronted, virtual intervention and discussion—such as texting, social media interaction, phone calls, email, etc.—is another viable option with relatively strong empirical support.

Ultimately, social stigma of mental illness is a complex process that occurs on multiple cognitive and societal levels. There exist many factors that stack upon each other, culminating in the emergence of discomfort, misunderstanding, prejudice, and discrimination towards those who have been diagnosed or are associated with mental illness. Although this process appears to

be deeply rooted within both human evolutionary history and our sociocultural history, there exists several methods through which this persistent challenge can be recognized and overcome. Much like any other form of attitude change, the process for addressing and reforming stigmatized attitudes involves changing the way we think about and discuss these attitudes, as well as recognizing the ways in which our mind can distort the information we perceive, leading to faulty or misconstrued beliefs. Confronting others who hold stigmatized beliefs surrounding mental illness, using effective, personally tailored strategies of persuasion and linguistic representation, and approaching the problem cooperatively rather than competitively can all lead to meaningful reductions in stigmatized attitudes. Contact with mental health consumers is particularly effective as it works to provide individuals who hold stigmatized ideals with incontrovertible evidence that their beliefs are inaccurate or misinformed through direct interaction. In the end, no one wants to be wrong; it is simply that some people see their misconceptions as truth due to a lack of conflicting evidence. If one can demonstrate that stigmatized attitudes are wrong, why they are wrong, and how they could be corrected, only the most stubborn and deeply entrenched individuals will refuse to reform their attitudes considering personal exposure to conflicting evidence.

Addressing Self-Stigma

So far, this review has been primarily focused on the social presentation of stigmatized attitudes towards mental illness as it occurs between different individuals or groups, as well as the methods through which this type of stigma can be addressed and rectified. However, there are two sides to the issue of mental health stigmatization: social stigma and self-stigma. While these processes may appear to be superficially similar, there are distinct differences between mechanisms of social stigmatization and the internalization and reflection of stigmatized

attitudes upon the self. Additionally, these processes require distinctly different methods of confrontation and reduction, as the process of applying stigmatized attitudes and beliefs to others is a qualitatively different process than the application of stigmatized beliefs to the self. While educating, persuading, and convincing others change their mindset can certainly pose a challenge, prompting this same reformation in the self can much less straightforward, especially when stigma has become entrenched and incorporated into one's self-concept over a long period of time.

The Development of Self-stigma

Unlike the processes of social stigma, self-stigma is a much more internalized and cognitively driven process in which social attitudes are recognized and assimilated into an individual's self-concept (Mittal et al., 2012). From this point, the individual in question begins to both identify and agree with stigmatizing attitudes about themselves, and display a pattern of behavioral and emotional congruence, leading many individuals to act out and over-represent the very thoughts and behaviors they are being stigmatized for, forming a cycle of self and social stigma that feed off each other with increased frequency and intensity (Mittal et al., 2012). Additionally, while social stigma can be present within and expressed by any individual, regardless of their personal status, self-stigma is distinctly a problem for those with mental health challenges, as it requires the presence of an existing disorder or diagnosis that serves as the target for external stigmatization. Much like the effects of social stigma on those with mental illness, the presence of self-stigmatizing attitudes has been strongly associated with a host of negative outcomes, such as reductions in self-esteem, subjective quality of life, self-efficacy, rates of disclosure, and treatment seeking behaviors, among other negative consequences (Corrigan et al., 2013; Yanos et al., 2015).

Much like the overarching process of social stigma, self-stigma likely stems from both innate and socialized cognitive and temperamental characteristics. The mechanism of self-stigma is typically described as a four-stage process: 1) awareness of a stigmatized attitude or stereotype, 2) agreement with a stigmatized attitude or belief, 3) application of the attitude or belief to oneself, 4) an accompanying barrage of negative or self-deprecating thoughts and behaviors (Corrigan et al., 2011). While the first step in this process is clear, the second and third steps are much less straightforward and often counterintuitive. Although there are an uncountable number of idiosyncratic reasons that an affected individual may begin to agree with negative stereotypes and apply them to the self, much of this is thought to be due to our nature to strive for group acceptance and conformity (Corrigan et al., 2011). As humans, we strive for social connection and group membership, two desires that are actively inhibited by stigmatization. In a sense, people who have been subject to high and persistent levels of stigma and social exclusion may feel so outcast from the rest of society that agreeing with stigmatized beliefs may be subconsciously perceived as a way to find common ground and build group connections (Corrigan et al., 2011). The takeaway from all this is that interventions aimed at reducing self-stigma should (and usually do) involve aspects of both positive social contact, as well as education aimed at cognitive restructuring and the unlearning of false, stigmatized beliefs.

Reducing self-stigma in the self

While certain aspects of self-stigma are similar to those of social stigma and can be addressed through similar interventions, there are several ways in which these processes differ from one another, and several interventional modalities that are better suited to one type of stigma or another. One notable pathway to self-stigma reduction that is not relevant in the

context of social stigmatization towards individuals with mental illness is the capacity for therapeutic interventions to address self-stigmatizing patterns of thought. This is more easily said than done, as one of the major mitigating factors in the reduction of self-stigma is the reluctance to seek treatment brought on by self-stigma. Thus, therapeutic interventions are only effective if one can find the strength to disclose their mental health challenges to someone else (professional or non-professional), and then follow up on this disclosure through frequent therapeutic sessions.

One possible way to mitigate the discomfort associated with disclosing and seeking help for a self-stigmatized condition is the presence of mutual help or peer support interventions (Corrigan et al., 2013). As the name suggests, mutual help programs are patient care and support systems run by mental health consumers. These programs have been effective in reducing self-stigma and increasing quality of life, as well as offering opportunities for group identity and mutual understanding in the treatment process (Corrigan et al., 2013). It is the process of group identification that drives the success of mutual treatment programs in reducing self-stigma, as it allows individuals to lower their initial inhibitions towards discussing their self-stigmatizing struggles with others whom they know will accept and understand them, rather than respond with confusion or further stigma. In addition to consumer-led mutual help programs, group therapy settings can also be effective in facilitating self-stigma re-evaluation and reduction. Like the consumer-led therapeutic context, group therapy environments can foster a similar sense of solidarity and social support that works to aid individuals in the process of disclosing their own self-stigmatizing thoughts and behaviors (Yanos et al., 2015). Regardless of the specifics of the group in question, finding non-stigmatizing social supports is a crucial ingredient in both preventing the development of self-stigma and reducing existing self-stigma.

Aside from the context in which self-stigma is addressed, certain therapeutic methodologies have been shown to be particularly effective in facilitating the personal re-evaluation and cognitive restructuring that facilitate the reduction of self-stigmatizing thought patterns. Acceptance Commitment Therapy (ACT) has demonstrated high efficacy in reducing self-stigmatizing tendencies while facilitating the development of a healthier, non-stigmatized self-concept (Fung et al., 2020). Furthermore, ACT can be especially useful for patients who are experiencing significant levels of self-stigma in conjunction with the management of active symptoms from an existing mental illness (Fung et al., 2020). ACT's focus on the use of acceptance and mindfulness strategies, commitment, and psycho-behavioral change allow for increased psychological flexibility, fostering stigma resistance and increased self-esteem (Fung et al., 2020). Due to a long history of empirical and clinical success, ACT is a commonly used therapeutic tactic that is employed by many practitioners, making it relatively easy to access if one is motivated and capable of seeking therapeutic self-stigma intervention.

Narrative Enhancement Cognitive Therapy (NECT) is another therapeutic methodology that has demonstrated significant success in reducing self-stigma within clinical contexts (Hansson & Yanos, 2016). NECT is a manualized group-based intervention that targets self-stigma through a combination of psychoeducation, cognitive restructuring, and narrative therapy (Hansson & Yanos, 2016). Within this model, psychoeducation works to help replace stigmatized views of mental illness and recovery with non-stigmatized, empirical findings, while cognitive restructuring and narrative therapy work to teach skills to challenge negative beliefs about the self while broadening and enriching one's ability to narrate one's life story (Hansson & Yanos, 2016; Yanos et al., 2012). The narrative therapy skills within this paradigm are particularly effective at instilling long lasting self-stigma reduction, while preventing the

development of further self-stigma in the future, as narrative based skills allow individuals to restructure the way they take in information and relate it to the self (Yanos et al., 2012).

NECT has been effective across the board in addressing self-stigma, demonstrating reductions self-stigmatizing thoughts, social avoidance, and avoidant coping, while increasing subjective quality of life and self-esteem (Hansson & Yanos, 2016; Yanos et al., 2012). This success can likely be attributed to the effects of psychoeducation and narrative enhancement combined with peer support, as this intervention also provides the benefits of group-based therapy that have been previously discussed. Additionally, the degree to which information is spread across multiple sessions appears to correlate directly with reported reductions in self-stigma (Yanos et al., 2012). This finding provides evidence that self-stigma is best confronted in a gradual but consistent manner, rather than attempting to dismantle a constellation of internalized stereotypes within a single, intense session.

Lastly, in the realm of therapeutic self-stigma intervention, there is evidence that self-stigma reduction efforts do not need to be externally guided for them to be effective. The self-guided use of virtual resources or therapeutic literature directed towards those with mental health challenges can work to reduce self-stigma, even when a professional therapist or clinician has no hand in the process (Mills et al., 2020). Self-guided programs, such as virtual or at-home educational materials and exercises have been effective in reducing all forms of stigma regarding mental illness yet have been particularly effective at addressing self-stigmatizing attitudes (Mills et al., 2020). Although there is no single format that is dedicated to use in self-administered therapeutic stigma interventions, most intervention plans follow an easily digestible cognitive-behavioral structure, often incorporating elements of psychoeducation and narrative restructuring common to both ACT and NECT.

There are several reasons for why this type of self-guided program is so well suited to self-stigma reduction. First, this type of intervention takes advantage of the intrinsic motivation to decrease self-stigma. Unlike social stigma, the presence of self-stigmatizing attitudes is nearly always detrimental to one's own wellbeing, rather than the wellbeing of an often abstract other. Because self-stigmatizing consumers are directly and negatively affected by their own self-stigmatizing attitudes, they may be more intrinsically motivated to reduce the presence of these negative or undesirable self-perceptions, leading to greater efficacy of self-driven stigma interventions (Mills et al., 2020). This is not meant to discount the effectiveness of professionally guided interventions or attempts to reduce stigmatized attitudes in others, but simply to bolster the idea that all forms of stigma reduction are most effective when relevant information is connected to the self in some meaningful way. While it would be a stretch to say that all humans are fundamentally selfish, there is some truth to the idea that we are more receptive to information that somehow affects ourselves as opposed to someone else. Thus, in the case of self-stigma reduction, the advantage is an immediately noticeable increase in one's own quality of life, leading to greater motivation to address self-stigma, thus leading to statistically greater efficacy of self-directed interventions.

Self-administered interventions also allow the trepidation surrounding disclosure of a mental illness to be tempered, or even avoided altogether (Mills et al., 2020). This may result in greater access to these types of interventions, especially among populations of individuals who experience high levels of both social and self-stigma, as the self-directed nature allows one to address their self-stigmatization without the need to include others who may judge or alienate them. Additionally, some of the success of self-directed and administered self-stigma

interventions may be due to the process of auto-application rather than the specific content of a given self-directed treatment approach.

Particularly within westernized cultures that place high value on independence, autonomy, and individual capability, the capacity to address one's own struggles rather than seek help may lead to increases in self-esteem and self-efficacy for self-stigmatizing individuals who hold respect for these "individualistic values" (Mills et al., 2020). Self-directed confrontation of one's own self-stigma may lead to greater reductions in reported self-stigma due to an increase in both self-esteem and self-efficacy that comes with solving one's own struggles without external assistance. Reductions in self-efficacy are a common side effect of self-stigma, as individuals may come to believe that they are incapable of driving their own recovery or being considered *normal*. However, self-efficacy is not only an important factor in determining one's subjective quality of life, but also one's capacity to make positive changes in the future, as people are often unlikely to attempt something that they do not believe they are capable of (Weinberg et al., 1979). Thus, the use of self-directed internalized stigma reduction programs may reduce self-stigma while providing a boost in self-efficacy that is necessary for an individual to seek further professional treatment for their disorder, breaking the barrier that self-stigma puts in the way of treatment seeking.

All that said, remote or self-guided interventions should be used only when other interventions are unfeasible, inaccessible, or highly uncomfortable for the consumer. While they have demonstrated strong efficacy in reducing self-stigma and increasing self-esteem and self-efficacy, they do not facilitate meaningful social support, and may in fact do the opposite, causing consumers to further withdraw from the larger population. The many findings regarding

the efficacy of group based or consumer led interventions provide conclusive evidence for the importance of a social support network in overcoming stigma. The more isolated an individual is, the easier it is for them to feel outcast or exiled from society, increasing their levels of self-stigmatization, not to mention the negative effects that social isolation can have on individuals with certain mental illnesses such as depression. Furthermore, this isolation may lead to a perpetuation and amplification of self-stigmatizing attitudes, as individuals feel that their isolation is a byproduct of their illness, and that they somehow deserve this treatment, leading to further entrenchment of self-stigmatizing views.

Reducing self-stigma in others

Outside the realm of therapeutic or formal psychoeducational approaches, there is almost no scientific literature aimed at reducing self-stigma in others. For the most part, this is to be expected, as the process of self-stigmatization is complex, confusing, and often accompanied by other mental health challenges and social struggles. Thus, it is typically not advised that the average, non-mental health professional attempt to formally remediate the psychological challenges of others, as botched or misguided attempts to do so may be harmful or counterproductive, given the difficulty involved in mental healthcare. However, there are a few ways in which the average person who neither a mental healthcare professional nor an active mental health consumer suffering from self-stigmatizing thought patterns can work to reduce perceived self-stigma in others.

Providing support to those who do experience mental health challenges and accompanying self-stigma can go a long way in enhancing the quality of life for these individuals. Particularly for those who suffer from serious and persistent mental illnesses such as

schizophrenia, bipolar disorder, or major depressive disorder, the presence of non-stigmatizing caregivers and social supports can be one of the most crucial factors in reducing existing self-stigma or preventing its development (Karaçar & Bademli, 2021). Even for consumers with less severe mental illnesses the presence of non-stigmatizing or counter-stigmatizing social supports can work to reduce self-stigma (Karaçar & Bademli, 2021). Caregivers and social supports can also work to provide consumers with psychoeducational information regarding the disease process as well as stigma coping and resistance. When this information comes from trusted social supports and is presented accurately and effectively, it is even more effective in reducing self-stigma than when the information comes from individuals who are relatively absent from the consumer's life (Karaçar & Bademli, 2021). Caregivers, family, friends, and any other members of a consumer's social network can work to provide non-stigmatized and informative support about the disease process of mental illness, leading to reductions in self-stigma and increases in hope about the future (Karaçar & Bademli, 2021). Ultimately, the implementation of Interventions that include caregivers and social supports in the fight against stigma is a powerful weapon against the force of self-stigmatization.

Providing accurate and meaningful information that works to increase the mental health literacy of self-stigmatizing individuals is another way in which individuals can work to reduce self-stigma in others. Overall metrics of mental health literacy appear to have a direct influence on attitudes regarding the process of self-stigmatization, especially when said attitudes are predicated upon self-blame and depreciation (Jung et al., 2017). While increasing mental health literacy may work to reduce existing self-stigma, the more significant effects are observed when mental health literacy is severely lacking. While increasing mental health literacy high levels may work to reduce self-stigmatization and increase help-seeking behaviors, severely low levels

of mental health literacy do correlate strongly with increases in self-stigmatization (Jung et al., 2017). Thus, while it may or may not be effective to help those with mental health challenges become experts in the facets of mental illness and healthcare, ensuring that consumers have at least some degree of mental health literacy may be effective in dampening the effects of self-stigmatization.

While discussing the process of self-stigmatization with sufferers of mental illness it is important to avoid placing blame on the individual for their own self-stigma. While it may be true that self-stigmatization occurs due to the internalization of publicly endorsed stigmatized attitudes and behaviors, it is not fair or productive to blame the consumer for internalizing these stimuli and applying them to oneself. In attempting to assist consumers in the process of overcoming self-stigma, advocates must be sure that they are not suggesting that self-stigmatizing attitudes or behaviors are the fault of the consumer (Corrigan & Rao, 2012). Enforcing the idea that self-stigma is not a flaw on the part of the individual experiencing it, but rather a societal injustice that has been unwillingly incorporated into the individual's self-concept is a crucial step in preventing the entrenchment of self-stigma (Corrigan & Rao, 2012). Similar to other psychiatric symptoms which the consumer is not directly responsible for yet must learn to manage and overcome, self-stigma is not the fault of the consumer, even if the burden is ultimately on them to handle it.

Additionally, it is important to understand that doing everything in one's power to confront and reduce instances of social stigma will ultimately work to reduce self-stigma for those with mental health challenges. While social stigma and self-stigma are two distinct processes, they are inextricably connected, as reducing one will work to reduce the other. In a sense, self-stigma can be thought of as a symptom of the larger issue of externalized mental

health stigma. Social stigma is the ultimate cause of self-stigma, as the process of self-stigmatization can only occur when social stigmatization is internalized and incorporated into one's psyche. This means that confronting social stigma will, in a roundabout way, work to reduce self-stigmatization and internalized negative self-perceptions for those with mental illness. Thus, even those who are not struggling with mental health challenges can work to reduce the effects of self-stigma by confronting instances of social stigma in others and preventing the development and proliferation of stigmatized ideology that may work its way into the self-concept of individuals with mental illness.

Ultimately, self-stigma is a complicated and counter-intuitive process that affects individuals suffering from mental health challenges uniquely, creating an additional challenge that this community must contend with to achieve a healthy and positive self-concept. The process of awareness of and agreement with stigmatized attitudes and the application of said attitudes to one's own self-concept and behavioral patterns constitutes the foundation of self-stigma, making this challenge highly subjective to the individual in question. The inherent idiosyncrasy of this process makes it a difficult one to confront, as there are many ways in which self-stigma could present itself. However, there are several ways in which this process can be addressed, confronted, and hopefully, eliminated. Therapeutic, psychoeducational, and support based interventions have all demonstrated merit in their ability to halt the process of self-stigmatization and reduce its severity and prevalence throughout various contexts. By providing information about mental illness and the disease process, expounding upon social and self-stigmatization, and teaching coping strategies designed to ameliorate the negative effects of self-stigmatizing cognitive processes, individuals experiencing self-stigma have been able to achieve significant reductions in perceived alienation, stereotype endorsement, and total scores of

stigmatized attitudes, while experiencing an increased capacity for stigma resistance, or the ability to remain unaffected by stigmatized attitudes.

For the most part, self-stigma confrontation and reduction is an endeavor best handled by the afflicted individual, as well as by mental healthcare professionals with therapeutic training and relevant psychological knowledge. My sense is that the counter-intuitive nature of this process, as well its connection to one's conceptions of identity, self-esteem, and personal capability and self-worth mean that misguided or ineffective attempts at reducing self-stigma may in fact do more harm than good. However, positive social contact, display of non-stigmatized attitudes, and the active confrontation of social stigma can all work to reduce the process of self-stigmatization in others. Much like the overarching process of social stigma, self-stigma is not going to be completely resolved any time soon. However, this does not mean that it is not worth the effort, as refusing to address the problem will inevitably make it worse. Ultimately, slow and incomplete progress is progress nonetheless, as every bit of improvement contributes to the paramount goal of mental health stigma elimination.

Conclusion

Mental health stigma is a complex process, involving labeling, stereotyping, prejudice, and discrimination directed towards those with mental illness, or those who associate with mental health consumers. While stigmatization can occur on an individual level, it is ultimately a societal mechanism that transcends any one individual. It occurs across many different contexts and populations, presenting itself in many ways depending upon a host of sociocultural, developmental, and evolutionary factors. Like any process driven by societal pressures and historical precedent, stigma of mental illness is deeply entrenched within the collective

psychology of nearly all cultures and civilizations. Processes such as this can seem nigh impossible to overcome, as there are so many factors working to maintain and perpetuate the process of mental health stigma that it seems as if it will never go away. After centuries of documented stigmatization towards those with mental illness, it can be quite discouraging to confront mental health stigma as an individual. However, it is this discouragement that individuals must force themselves to overcome, as relegating oneself and others to a place of helplessness is the only way to *truly* ensure that nothing changes.

Ultimately, there are multiple of methodologies through which people with and without political power can work to address the stigma of mental illness and reduce its prevalence throughout society. From educational and therapeutic techniques to methods of verbal persuasion and attitude reformation, it is possible for even the most disenfranchised individuals to make an impact. Will the impact of a single individual be so large that society overturns its mistaken conception of mental illness and mental healthcare, prompting a new age of stigma free interactions? I doubt it. However, there is no doubt that individuals can have a real impact on the process of mental health stigma, even if that impact is localized to a single town, or even a single other person. Yet, even the smallest possible impact on the reduction of mental health stigma is an impact nonetheless. Furthermore, when seemingly insignificant reductions in global mental health stigma are combined, the aggregate reduction in societal attitudes may in fact be quite large. Additionally, given the cascading nature of societal forces and personal interactions, there is ultimately no way of predicting how important one's own efforts may be in fostering reductions in mental health stigma, increasing the quality of life for those who experience stigmatization, and possibly even providing life-saving hope for someone who may see themselves, the world, and the future as terminally hopeless.

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