



Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review

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ABSTRACT

The current literature on the problem of mental illness stigma in the United States must be expanded to better account for the role of culture. This article examines the relationship between mental illness stigma and culture for Americans of American Indian, Asian, African, Latino, Middle Eastern, and European descent. In this review, culture refers to the shared beliefs, values, and norms of a given racial or ethnic group. The reviewed literature indicates that there are differences in stigma among the various cultural groups; however, explanations as to why these differences exist are scant. Qualitative and quantitative studies indicate that cultural values are important with regard to stigma, particularly for Asian Americans and African Americans. Less is known about the interaction between cultural values and mental illness stigma for other cultural groups. Continued research in the area requires better organization and more exploration of the role of cultural history and values as they relate to mental illness stigma. To that end, a detailed, systematic approach to future research in the area is proposed.

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Mental illness stigma, the devaluing, disgracing, and disfavoring by the general public of individuals with mental illnesses, is “the most formidable obstacle to future progress in the arena of mental illness and health,” according to the Surgeon General’s report on mental health (Hinshaw, 2007; U.S. Department of Health & Human Services, 1999). Much of that report, in addition to over forty years of research, was dedicated to identifying the mechanisms and effects of mental illness stigma. Mental illness stigma is of dire concern because of its many detrimental effects on stigmatized individuals. The social impact of stigma has been well documented (e.g., Corrigan, 2004; DHHS, 1999; Martin, Pescosolido, & Tuch, 2000; Wahl, 1999). The majority of Americans are unwilling to have people with a mental illness marry into their family (68%), work closely with them (58%), or spend an evening socializing with them (56%; Martin et al., 2000). Also, individuals with mental illnesses often encounter fewer opportunities and reduced access to resources because of discriminatory practices by employers who tend to avoid giving jobs to them and proprietors who are less inclined to rent housing to them, thus depriving those with mental illnesses of the chance to fully participate in society in ways that others can (Corrigan, 2004; DHHS, 1999; Wahl, 1999).

Perhaps most troubling is that the mental health of those with mental illnesses is further negatively impacted by stigma. They may internalize society’s stigmatizing notions, diminishing their sense of worth and self-esteem (Corrigan, 2004). In a longitudinal study by Link and colleagues, participants, all of whom had been previously diagnosed with a mental illness, were asked questions about their self-esteem, their perception that others would devalue or discriminate against someone who has a mental illness, and the extent to which they withdraw socially to avoid rejection due to stigma (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). Participants completed follow-up measures at six and 24 months. Results indicated that when baseline self-esteem and demographic variables were controlled, those who perceived the most devaluation–discrimination (90th percentile on the measure) were almost nine times as likely to have low self-esteem than those in the tenth percentile at the follow up time points. Similarly, those in the 90th percentile on the stigma-withdrawal measure were seven times as likely to have low self-esteem as compared to those in the tenth percentile. Stigma has also been associated with lower self-esteem among those with mental illnesses, and those who disclosed their mental illness to a greater degree had more substantial negative effects on their self-esteem (Bos, Kanner, Muris, Janssen, & Mayer, 2009). By compounding mental health problems, self-stigma may serve as a barrier to recovery from mental illness (Link et al., 2001; Shah & Beinecke, 2009).

Stigma may also be an impediment to recovery from mental illness by serving as a barrier to seeking help for mental health problems (Corrigan, 2004). Qualitative studies by Mishra, Lucksted, Gioia, Barnett, and Baquet (2009) and Alvidrez, Snowden, and Kaiser (2008) indicate that stigma is a major barrier to obtaining information about mental health problems to aid in recognizing the existence of mental health problems. Alvidrez et al. (2008) found that 32% of study participants recognized that they had mental health problems, but because of stigma, they initially failed to recognize the need to seek help. Cooper, Corrigan, and Watson (2003) found that people were less likely to consider

seeking mental health services if they viewed those with mental illnesses as personally responsible for their disorders, reacted to them with anger, and did not feel pity or a desire to help them. Therefore, when determining a help source, these participants’ stigma may influence them to consider other health services or informal sources of help rather than mental health services for their own problems. Ayalon and Alvidrez (2007) and Alvidrez et al. (2008) found that perceived stigma was a commonly endorsed barrier to actually using mental health services. In fact, 62% of participants in one study stated that they or someone they knew was reluctant to actually seek professional help despite knowing that they needed it (Alvidrez et al., 2008). Stigma continues to have an impact on people with mental illnesses, even after help is initially received. Studies have indicated that particularly among older clients, greater perceived stigma predicted antidepressant medication noncompliance (Sirey et al., 2001) and premature treatment discontinuation (Sirey et al., 2001).

1. Considering culture

Culture, which materializes as a result of human–environment interaction (Triandis, 2007), refers to the shared attributes, belief systems, and value orientations that a group of people have in common and that influence their customs, norms, practices, social institutions, psychological processes, and organizations (APA, 2003; DHHS, 2001; Fiske, Kitayama, Markus, & Nisbett, 1998). In this article, culture primarily refers to the shared beliefs, values, and norms of a given racial or ethnic group. Culture is used instead of ethnicity or race to emphasize our focus on values and the examination of those values based on a person’s more immediate (within the past 500 years) ancestral heritage. Although all people of the same race or ethnicity may not identify the same primary culture (e.g., one may identify more with religious, gender, or sexuality cultural ties than ethnicity cultural ties; DHHS, 2001), for many people, the cultural commonalities related to ethnic background are deeply entrenched. Some people may not even realize the link between their cultural values and their ethnic background, but lack of insight does not diminish the importance of this link. We acknowledge the heterogeneity that exists within cultural delineations; however, in the absence of the ability to study each person individually, the focus of this article is on the cultural similarities that exist within groups.

Most stigma research is predicated on the assumption that stigma operates in the same way for everyone. However, the notion that mental illness stigma varies across cultures is not a new one. Rao, Feinglass, and Corrigan (2007) reasoned that, “diagnoses of mental illness are given based on deviations from sociocultural, or behavioral, norms. Therefore, mental illness is a concept deeply tied to culture, and accordingly, mental illness stigma is likely to vary across cultures” (p. 1020). By lumping everyone together, we miss important ways that groups may differ in the stigmatizing attitudes they hold.

Those studies that have examined stigma cross-culturally have indicated that there are cultural differences associated with racial and ethnic group membership in stigmatizing attitudes toward mental illness (e.g., Anglin, Link, & Phelan, 2006; Cooper-Patrick et al., 1997; Rao et al., 2007; Whaley, 1997). Further, stigma may contribute to racial and ethnic disparities in mental health service use (DHHS,

2001). However, the differences in stigmatizing attitudes and utilization of services are most likely not due to a person's belonging to a certain racial or ethnic group. Ethnicity is a demographic indicator that is typically not the proximal cause of differences (Sue, 1999), but rather it is a proxy for unmeasured cultural and contextual factors that are the proximal causes of group differences (APA, 2003).

We contend that understanding stigma's crucial relationship with mental illness would be greatly expanded by using a cultural anthropology approach. Such an approach would provide descriptions of the value, norm, social, political, and economic contexts in which clients or research participants, and mental health professionals or researchers operate (Price, Shea, Murray, & Hilditch, 1995; Van Dongen, 2000). Cultural anthropologists emphasize the importance of researchers' examination of disorders and other psychological constructs as "part of a culturally specific system of beliefs and practices" (Price et al., 1995, p. 10). Therefore, the purpose of this review is to use a cultural anthropology approach to examine the relationship between culture and mental illness stigma. First, we define stigma, based on historical and current conceptualizations. We also discuss the factors that are believed to make individuals susceptible to stigma, the types of mental illness stigma, and several theories regarding how mental illness stigma operates. Next, we provide historical, sociological and anthropological background for the way mental illness stigma is manifested in different cultures by first examining the literature on cross-cultural patterns in mental illness stigma and then making connections between mental illness stigma and the cultural values and attitudes toward mental illness for people of American Indian, Asian, African, Latino, Middle Eastern, and European descent. Throughout this section, we speculate as to why and how mental illness stigma may be expressed differently for members of different cultural groups. Finally, based on the review of extant literature, we discuss a proposed systematic approach to future research on mental illness stigma and culture. Our aim is to provide helpful directives for future research investigating culture's role in the conceptualization of stigma in terms of tailoring stigma measures and anti-stigma campaigns toward certain groups and their particular stigma beliefs.

2. Stigma

The word stigma is derived from a Greek term that refers to marks or signs that were cut or burned into people's bodies to indicate that there was something immoral, unusual, or bad about them and they should be avoided (Goffman, 1963). Thus, stigma is an attribute that discredits an individual, makes the person different from others, and essentially reduces the person's status from a "whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 3). Pescosolido, Martin, Lang, and Olafsdottir (2008) defined stigma as "a mark separating individuals from one another based on a socially conferred judgment that some persons or groups are tainted and 'less than'" (p. 431). Stigma has also been thought of as an attribute that associates a person with unfavorable stereotypes (Jones et al., 1984) and subsequent discrimination (Link & Phelan, 1999), and as a combination of labeling, stereotyping, separation, status loss, and discrimination (Link & Phelan, 2001). Perhaps the most thorough definition describes stigma as a pervasive and global "devaluation of certain individuals on the basis of some characteristic they possess, related to membership in a group that is disfavored, devalued, or disgraced by the general society" (Hinshaw, 2007, p. 23). Applied specifically to mental illness, stigma then refers to the social judgment, degradation, or devaluation of individuals because they have mental illness symptoms or have been labeled as having a mental illness.

3. Stigma susceptibility

Several dimensions have been identified as contributing to an individual's susceptibility to stigmatization. Jones et al. (1984)

conceptualized six dimensions to describe characteristics or conditions prone to stigmatization: concealability, course, disruptiveness, peril, aesthetics, and origin. Although they did not apply their dimensions to mental illness stigma, others have. Concealability refers to how easily detectable the characteristic or condition is. With regard to mental illness, any display of symptoms can activate stigma. People with less severe disorders that are perceived to be able to be concealed but are not may be subject to just as much as or even more stigmatization than those displaying symptoms that cannot be concealed (Hinshaw, 2007). Course is how stable across time a condition is. Those with mental illnesses that are chronic are at greater risk of being stigmatized (Hinshaw, 2007). Although social functioning varies among those with mental illnesses, the perception that mental disorders are damaging to interpersonal interactions (disruptiveness) and the negative expectations that many have about their encounters with those who have mental illnesses may also contribute to stigma (Hinshaw, 2007). Peril refers to how threatening the condition is. A pervasive view is that those with mental illnesses are dangerous, and feeling threatened by those with mental illnesses can lead to stigmatization because people are more willing to discriminate when they relate mental illness to aggressive behavior (Feldman & Crandall, 2007). The aesthetics dimension pertains to how visually disconcerting the condition is. Aesthetics can be associated with mental illness stigma because at times, people with certain mental disorders may have tics, impaired motor ability, appear disheveled or wear very eccentric clothing, and some medications have side effects causing noticeable involuntary movements, all of which may lead to social rejection (Hinshaw, 2007). Origin refers to what caused the condition. Although there is some research suggesting that the belief that mental illnesses have genetic or biological causes is associated with greater stigma, the predominant view is that mental illness stigma is less likely when people perceive the illness as outside of the affected person's control (Feldman & Crandall, 2007; Hinshaw, 2006). Although these six dimensions seem plausible, only one study has investigated their relationship to mental illness stigma.

Feldman and Crandall (2007) examined the six dimensions proposed by Jones et al. (1984) in addition to other dimensions in relation to mental illness stigma (operationalized as social distance). Results of their study indicated that people generally desire more social distance from those with mental illnesses when the disorder is perceived to be the individual's own fault (origin), when the mental illness is perceived to cause the individual to be dangerous to others (peril), and when the mental illness is perceived as uncommon or rare. These three predictors accounted for about 60% of the variance in stigma.

4. Types of stigma

There are two types of mental illness stigma: public stigma and self-stigma (Corrigan & Kleinlein, 2005; Corrigan & Wassell, 2008). Each type impacts the stigmatized person differently, but they likely interact to exacerbate the occurrence and negative effects of stigma.

4.1. Public stigma

Public stigma refers to the general public's discriminatory response to people with mental illnesses (Corrigan & Kleinlein, 2005). When considering stigma, this is typically the type of stigma that is discussed. Public stigma affects the person with a mental illness and the person's friends, family members, and mental health professionals (Corrigan & Kleinlein, 2005). Public stigma can cause individuals with mental illnesses to lose or be unable to obtain gainful employment and adequate housing (Corrigan, 2004; DHHS, 1999; Wahl, 1999) and increase their interactions with the criminal justice system (Corrigan & Kleinlein, 2005).

Also impacted by public stigma are family members of those with mental illnesses. Families may experience reduced social status in their communities (Gary, 2005). Parents of people with mental illnesses are often blamed for causing their children's illnesses, and the general public blames siblings and spouses for not ensuring that people with mental illnesses adhere to prescribed treatment (Corrigan & Miller, 2004; Larson & Corrigan, 2008). There is also evidence that children of people with mental illnesses are viewed as having less worth because of a parent's mental illness (Corrigan & Miller, 2004; Larson & Corrigan, 2008).

4.2. Self-stigma

Self-stigma is the internalization of public stigma regarding mental illness (Corrigan, 2004; Corrigan, 2007; Corrigan & Wassell, 2008). According to Corrigan (2007), self-stigma "leads to automatic thoughts and negative emotional reactions; prominent among these are shame, low self-esteem, and diminished self-efficacy" (p. 32). In other words, people with mental illnesses may believe that they are less appreciated and respected because of their disorder, and this may lead to demoralization and diminished self-worth and self-efficacy (Corrigan, 2004). These emotional reactions may exacerbate mental health problems. Also, self-stigma may result in a person having negative expectations about his or her interactions with others, leading the self-stigmatizer to act self-protectively and with less self-assurance (Link & Phelan, 2001), reactions that may make social interactions difficult. Individuals with mental illnesses may also attempt to avoid diagnostic labels by not seeking treatment despite knowing something is wrong in an effort to feel less like part of the stigmatized group (Corrigan, 2004; Corrigan & Wassell, 2008).

5. How stigma operates

Researchers have proposed several theories regarding how mental illness operates on a social level. Early competing theories were labeling theory (Scheff, 1984) and the "psychiatric perspective" (Gove, 1982). Labeling theory proposed that public stigma is associated with labeling because of the "heavy weight of moral condemnation" (Scheff, 1984, p. 30) that labels such as "mentally ill" carry. Labeling leads to the arousal in the general public of negative emotions such as anger and fear that are stronger than necessary and lead to stigmatizing responses. Being labeled can cause a person to begin to act in accordance with the label, exacerbating or perpetuating the person's mental illness (Corrigan & Kleinlein, 2005). Proponents of the psychiatric perspective, on the other hand, supported the strictly biological view that public stigma was transient and occurred solely because of the public's reactions to the abnormal, socially undesirable behavior displayed by people with mental illnesses, and any continued or subsequent mental illness was a result of the nature or recurrence of their disorders rather than the lingering effects of public stigma (Corrigan & Kleinlein, 2005; Gove, 1982).

Link, Cullen, Struening, Shrout, and Dohrenwend (1989) proposed a modified labeling theory, which although not specified by them as doing so, explains self-stigma as opposed to public stigma. Their approach proposed that once labeled by a mental health or medical professional as having a mental illness, society's views on what it means for a person to have a mental illness become salient and are internalized. People with a mental illness may respond by keeping the label a secret, withdrawing from others and associating only with those who are accepting, or attempting to educate others about their illness. Negative consequences result from being labeled and from the person's response to the label, and these consequences leave a person susceptible to further mental health problems (Link et al., 1989).

Most recently, a social-cognitive approach has been applied to mental illness stigma. This approach conceptualizes mental illness stigma as a process that begins with cues or indicators that a person

may have a mental illness (Corrigan, 2004). Psychiatric symptoms, lack of social skills, unusual physical appearance, and labels are the four major cues the public uses as an indication of mental illness (Corrigan, 2004). These cues elicit stereotypes, which are ways of cognitively categorizing people and creating expectations about them based on notions learned from the general public. Stereotypes, or stigmatizing beliefs, about individuals with mental illnesses are generally negative beliefs, and they can, if endorsed, lead to prejudice. Prejudice is an often negative, evaluative, stigmatizing attitude towards persons with mental illnesses that is at times coupled with an emotional reaction (Corrigan, 2007). Prejudice can bring about discrimination, which is the behavioral manifestation of prejudice. Discrimination may include negative actions that are harmful in some way towards individuals with mental illnesses or it may be displayed in the form of explicit favoritism towards all those who do not have mental illnesses and, therefore, are not part of the stigmatized group (Corrigan, 2007).

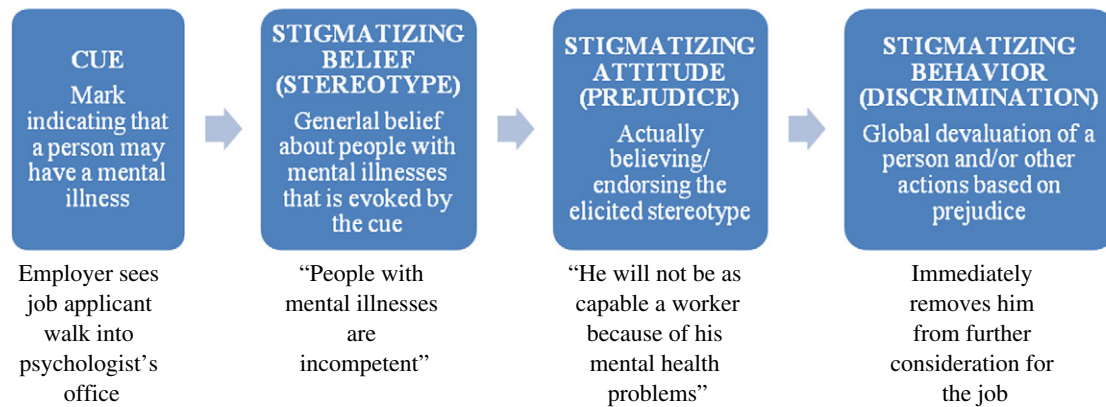
As depicted in Fig. 1, the social-cognitive approach can be applied to both public stigma and self-stigma. For public stigma and self-stigma, the first two parts of the process (cues and stereotypes) are the same because they stem from socialization that occurs with practically all members of the general public. As related to public stigma, prejudice involves a person without a mental illness endorsing a stereotype as it relates to those who do have mental illnesses (e.g., believing that people with mental illnesses are incompetent), while self-stigma involves a person with a mental illness internalizing stereotypes about mental illness and believing those stereotypes as they apply to him/herself (e.g., believing "I am incompetent because I have a mental illness;" Corrigan, 2004). Applied to public stigma, discrimination occurs when a person or system (e.g., the government, criminal justice system, and healthcare system) devalues people with mental illnesses and, because of prejudice toward people with mental illnesses, engages in unfair behaviors that negatively impact them (e.g., an employer believes that people with mental illnesses are incompetent and does not hire an applicant because he or she has a mental illness). Within self-stigma, discrimination or stigmatizing behaviors occur when a person devalues himself or herself because of having a mental illness and engages in detrimental or self-sabotaging behaviors (e.g., not attempting to find employment because of the belief that my mental illness means I am incompetent).

Unfortunately, none of the research on stigma susceptibility or types of stigma considers the role of culture. Yet, stigma is inextricably bound to culture because the behaviors and beliefs we value and the standards we favor are based on norms that are influenced by culture. That is, our beliefs about what it means to be mentally healthy versus mentally ill are culturally informed, as are our stigmatizing beliefs about those with mental illness. Thus, in the next section, we review the limited research on culture and stigma and, based on that review, we speculate about the interplay between culture and stigma for people of American Indian, Asian, African, Latino, Middle Eastern, and European descent in the US.

6. Stigma and culture

Studies conducted in other countries have investigated cross-national differences in mental illness stigma (e.g., Angermeyer, Buyantugs, Kenzine, & Matschinger, 2004; Littlewood, Jadhav, & Ryder, 2007; Weiss, Jadhav, Raguram, Vounatsou, & Littlewood, 2001) and found that culture is of critical importance in the variation in stigma experience. While these studies examined stigma using groups in different countries, few studies in North America or Western Europe, which have countries and cities with some of the most racially diverse populations, have examined differences in mental illness stigma across different racial or ethnic groups within a given country or city. The few studies that have done so have, for the most part,

Public Stigma



Self-Stigma

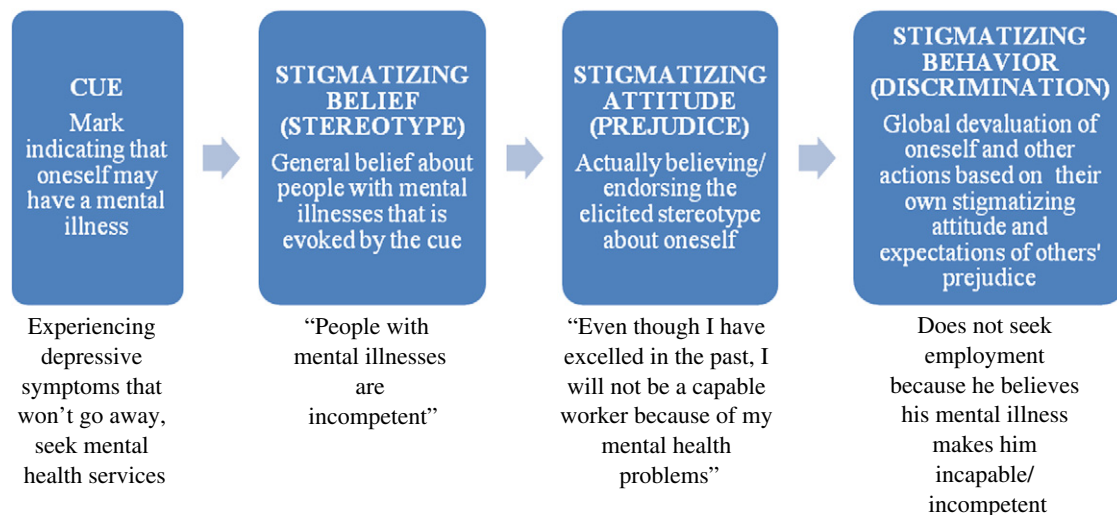


Fig. 1. Operation of the stigma process for public stigma and self-stigma. These models were influenced by the work of Corrigan (2004, 2007), Corrigan and Kleinlein (2005), and Watson and Corrigan (2005).

yielded comparable results. Primarily, they have indicated that ethnic minorities express more stigmatizing attitudes than European Americans. For example, Cooper-Patrick et al. (1997) conducted separate focus groups with African American patients with depression, Caucasian patients with depression, and health care professionals. The researchers asked participants about their experiences with depression, help-seeking behaviors, and treatment preferences, and found that the African American focus group made significantly more comments expressing concerns about stigma than the Caucasian focus group. However, a major limitation of this study was that the researchers asked the focus group with African American patients to discuss why African Americans utilize mental health services much less than Caucasians with similar problems, but did not ask a parallel question of the other two groups. Therefore, it is unclear if African Americans made more statements about stigma because it is a greater concern for them or because they were asked a question that elicited comments about stigma or made stigma more salient.

Whaley (1997) used a nationally-collected sample of 1468 American Indian, Asian American/Pacific Islander, African American, Latino, and Caucasian participants to determine ethnic/racial differences in perceptions of dangerousness of those with mental illness, a proxy for public stigma. Contact with those with a mental illness was also examined as a moderator of ethnic/racial differences in perceptions of dangerousness. Results indicated that Asian Americans/Pacific Islanders,

African Americans, and Latinos perceived those with mental illness as significantly more dangerous than did Caucasians. Asian Americans/Pacific Islanders and Latinos perceived those with mental illnesses to be more dangerous than Caucasians did regardless of level of contact with people with mental illnesses. For Caucasians, more contact was associated with less dangerous perceptions, but for African Americans, more contact was associated with more dangerous perceptions. This study was limited in that the questions asked were related specifically to *homeless* people with mental illnesses. Also, Whaley (1997) used Caucasians as the reference group, comparing each of the other racial/ethnic groups to Caucasians as opposed to comparing across all groups. And, despite the large sample size, 82% of the sample was Caucasian, and there were likely not enough American Indian participants to detect effects, as they accounted for just 1% of the sample. Still, Whaley's (1997) study supports the importance of examining cross-cultural differences and suggests that although Caucasians may benefit from more contact with people with mental illnesses to reduce stigmatizing attitudes, other types of stigma reduction interventions should be explored for African Americans.

A more recent study by Anglin et al. (2006) supports some of Whaley's (1997) findings. Anglin et al. (2006) used a nationally representative sample of 81 African Americans and 590 Caucasians to examine racial differences in the public's stigmatizing attitudes toward people with schizophrenia and depression. Even when

controlling for age, income, education, political views and religion, the researchers found that African Americans were more likely than Caucasians to hold the stigmatizing belief that those with mental illnesses were dangerous. Despite their beliefs, African Americans were less likely to blame individuals with mental illnesses for violent acts and less likely to believe that those with mental illnesses should be punished for violent acts (Anglin et al., 2006). These findings support the notion that cultural variation exists not only in stigmatizing attitudes, but also in the behaviors related to stigmatizing attitudes.

At baseline for their anti-stigma intervention study, Rao, Feinglass, and Corrigan (2007) also found results supporting Anglin et al. (2006) and Whaley (1997). Prior to the intervention, African Americans perceived people with mental illness as more dangerous than Caucasians did, Latinos perceived them as less dangerous than Caucasians did, and there was no difference between Asian Americans and Caucasians. African Americans and Asian Americans expressed wanting more segregation from those with mental illnesses than Caucasians did, but Latinos were not different from Caucasians on desire for segregation (Rao, Feinglass, and Corrigan (2007)). The intervention involved participants either having in-vivo contact with a person with mental illness by listening to him speak in person about his life experiences, or having videotaped contact with the same person by watching a video of him speaking about his life experiences. Post-intervention, there was no difference between African Americans and Caucasians on perceived dangerousness, but Latinos and Asian Americans perceived people with mental illness as less dangerous than Caucasians. Asian Americans were lower than Caucasians on desire for segregation, and the only group that differed from Caucasians on that measure after the intervention. Asian Americans seemed to benefit most from the intervention (Rao et al., 2007). Like Whaley's (1997) study, the Rao et al. (2007) study is limited in that they used Caucasians as a reference group as opposed to comparing all of the groups to each other. Further, they did not examine within-group pre- and post-intervention differences in perceived dangerousness and desire for segregation. Yet, these results illustrate the complexity of the interactions among race/ethnicity, stigmatizing attitudes, stigmatizing behaviors, and potential interventions.

Collectively, the results of the preceding studies suggest that there are racial/ethnic differences in stigmatizing attitudes toward mental illness. However, it is unlikely that these differences are actually due to the demographic constructs of race or ethnicity (Sue, 1999). A more plausible explanation is that differences in cultural values, socialization, and/or cultural conceptualizations of mental illness influence stigma (Rao, Feinglass, and Corrigan (2007)).

7. Cultural norms, values, and socialization impacting stigma

Fig. 2 depicts our new conceptualization of how public and self-stigma operate based on the idea that cultural influences, rather than race and ethnicity, influence people's stigmatizing beliefs, attitudes and actions. There may be several features of cultural influences that impact public and self-mental illness stigma, including culture-specific beliefs regarding the etiology of mental illness, culture-specific stigmatizing beliefs about mental illness, historical injustices and mistreatment by the health care system and government, and cultural norms, values and socialization. We propose that the way in which culture impacts public stigma is analogous to the way in which culture impacts self-stigma.

As depicted in Fig. 2, cultural norms are likely influential at the first step of the stigma process. Cultural norms help us determine what behaviors to consider normal, which to consider odd, and which may denote mental illness. For example, it may be accepted and seen as normal or even ideal in certain Middle Eastern cultures to have visions and hear imaginary voices, while in most Western cultures, such occurrences would be categorized as hallucinations indicative of

significant mental illness (Al-Issa, 1995). Cultural history and values, which vary both across and within groups, help us to determine a group's predominant beliefs regarding people with mental illnesses. For example, it is not surprising that American Indians vary in their beliefs about mental illness; their history is one in which, prior to contact with Europeans, there was no concept of mental illness (Grandbois, 2005). It is understandable, given attempts at assimilation, that some American Indian tribes would have views of mental illness that are similar to Caucasians' views, while others maintained views similar to those they held prior to contact with Europeans.

Whether or not a stereotype is actually endorsed is likely influenced by cultural history, socialization, and culturally-informed attitudes regarding mental illnesses. When growing up, a person may be socialized to believe that people with mental illnesses are dangerous because of being constantly inundated through media outlets with depictions of people with mental illnesses as dangerous. Since this is consistent with the stereotype, it is easy to accept the stereotype when given evidence supporting it. For people with mental illness, the same process is at play with self-stigma, and they likely more readily internalize stereotypes about themselves that are consistent with what they were socialized to believe about people with mental illnesses. Agreeing with the stereotype does not, in all cases, lead to discrimination. Whether or not a person engages in stigmatization of individuals with mental illnesses probably depends on their cultural values in combination with the person's views on the acceptability of discriminating against those with mental illness. For example, a person of African descent who values spiritualism might believe that those with mental illnesses are cursed and discriminate against individuals with mental illnesses because of that belief. Alternatively, the person could believe that people with mental illnesses are cursed, but not devalue or discriminate because of the view that doing so is inappropriate.

In the rest of this section, we discuss some of the cultural influences that might be relevant for understanding public and self mental illness stigma among those in the US of American Indian, Asian, African, Latino, Middle Eastern, and European descent. We acknowledge that the composition of each of these cultural groups is extremely diverse, making the task of identifying cultural influences that apply to *all* individuals within any group impossible. In the absence of the ability to study each person individually, we must group people together and use samples in an effort to better understand individuals. Please keep in mind that all possible cultural influences could not be discussed and those that are discussed are broad generalizations that certainly do not apply to each person in that cultural group, but do represent a summary of the norms, attitudes, socialization, values, etc. of the group as a whole. Despite the inevitable generalizations, based on the racial and ethnic differences that have been reported, this examination for each cultural group of the salient cultural values is critical for a more comprehensive understanding of the relationship between culture and mental illness stigma. Further, a review of extant research on mental illness stigma among Americans of American Indian, Asian, African, Latino, Middle Eastern, and European descent, taking into consideration important cultural influences, will contribute immensely to our understanding of past research and provide a foundation for research of the future.

7.1. American Indians

The term "American Indian" refers to the indigenous people of North America. There are 564 federally recognized American Indian tribes in the United States (U.S. Department of the Interior Bureau of Indian Affairs, 2010), which is indicative of the diversity that exists among American Indians. Some members of different tribes speak different languages, and tribes have varying traditions and customs (BIA, 2010; Grandbois, 2005).

Despite being the original inhabitants of the land, the US government forced American Indians to relocate to areas less desired

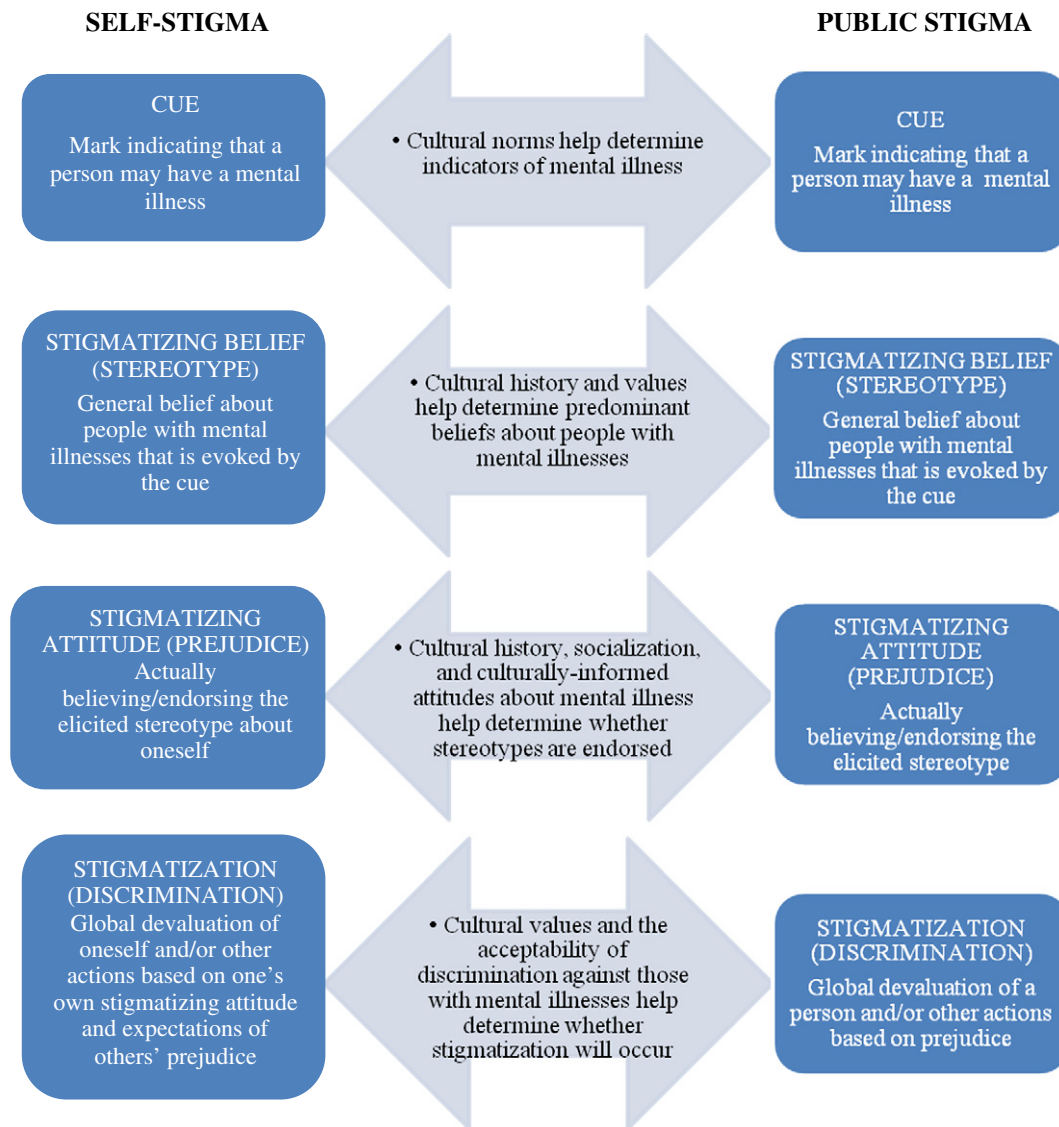


Fig. 2. Hypothesized influence of cultural factors on the operation of the stigma process for public stigma and self-stigma.

by settlers (Thompson, Walker, & Silk-Walker, 1993). Further, in the late 1880s, the government established the Hiawatha Asylum for Insane Indians specifically for American Indians because of the belief that they had “unique mental afflictions” (Grandbois, 2005, p. 1006). American Indians’ painful history, which includes policies with intended outcomes of annihilation or assimilation that were implemented and enforced by the U.S. government, has led to mistrust of the government, its policies, and related institutions and systems. This mistrust contributes to American Indians’ stigmatization of mental illness treatment by mental health professionals (Thompson et al., 1993).

7.1.1. Cultural values’ influence on stigma

Despite major social, political, linguistic and even cultural differences among American Indians, many have in common certain cultural values. These common values are being, noninterference, harmony with nature, spirituality, sharing and cooperation, and family (Garrett & Garrett, 1994; Tyler et al., 2008). American Indian cultures tend to value being over doing, and living in the present over focusing on the future (Garrett & Garrett, 1994). “Being” means that existing and developing one’s inner self are enough; there is less worth in “doing” things to gain wealth, education, status, or power

(Garrett & Garrett, 1994). Since there is less value in things like wealth, education, status, and power that, in many cases, may be more difficult to attain for someone with a mental illness, it seems logical that a person with a mental illness would not be stigmatized because of his or her inability to be productive in those ways. Rather, a person with a mental illness may be valued if the time spent in treatment is seen as a form of introspection and way of developing the person’s inner self.

Noninterference is the concept that everything was created and occurs to satisfy a particular purpose, and hindering the satisfaction of that purpose is viewed disapprovingly (Tyler et al., 2008). Harmony with nature and spirituality are related to the concept of noninterference because they all emphasize allowing situations to occur in order to fulfill their natural, intended purpose (Garrett & Garrett, 1994; Tyler et al., 2008). It would make sense that valuing noninterference would protect against mental illness stigma, particularly since individuals struggling with psychological or emotional problems are allowed to withdraw and be left alone during their struggle, and are subsequently “welcomed back into the larger group without any explanation needed” once the problems are resolved (Tyler et al., 2008, p. 288). However, if noninterference, harmony with nature, and spirituality are analogous to nonintervention, then those

who seek mental health services may be stigmatized by the public or may self-stigmatize because they are not adhering to those values.

Sharing and cooperation, as well as the intrinsic worth of the family are also emphasized in American Indian cultures. These values are indicative of an orientation that stresses the importance of the group (e.g., family, tribe, etc.), as opposed to the individual (Tyler et al., 2008). The family includes much more than immediate, blood relatives. It includes distant relatives, the tribe, and community members as well (Garrett & Garrett, 1994). Anything belonging to an individual belongs to the group, and an individual's survival and the group's survival are one and the same (Tyler et al., 2008). This may mean that any ailment, including mental illness, that an individual has is seen as an ailment of the group. This could lead to stigmatization because the group may discriminate against the person or distance themselves so as not to be associated with the person's ailment. Sharing and cooperation could also motivate the group to encourage a person struggling with a mental illness to withdraw from the group to engage in spiritual exploration and problem resolution, consistent with the noninterference value.

7.1.2. Research

Thompson et al. (1993) indicate that mental illness stigma differs among American Indians. Some tribes do not stigmatize mental illness at all, while others stigmatize some mental illnesses but not others, and other tribes stigmatize all mental illnesses. There are no published empirical studies examining mental illness stigma among American Indians. Whaley (1997) included American Indians in his sample, but there were not enough American Indian participants to formulate any meaningful conclusions about them. Clearly, little empirical evidence exists regarding the prevalence and patterns of mental illness stigma among American Indians, and research in this area is greatly needed.

7.2. People of Asian descent

Asia is the most populated continent in the world. Thus, it is not surprising that people of Asian descent come from a wide variety of cultural backgrounds. Most research referring to people of Asian descent typically includes Pacific Islanders (e.g., indigenous people of Hawai'i, Tahiti, Samoa, etc.) and those from eastern (e.g., China, Japan, Korea, etc.), southern (e.g., India, Pakistan, Nepal, etc.) and south-eastern (e.g., Vietnam, Thailand, Philippines, etc.) Asia. There is generally little research including people from Central Asia (e.g., Kazakhstan, Tajikistan, Kyrgyzstan, etc.), and despite the fact that Middle Eastern countries such as Iraq, Saudi Arabia and Jordan are technically part of Asia, members of these groups are typically (and reasonably) excluded from research on people of Asian descent. The term "Asian descent" is used here to describe people of Pacific Island and East, South, South East and Central Asian heritage. People of Middle Eastern descent are not included here and have a separate section below. Although Russia is one of the largest countries in Asia, Russians are not included here because most Russians are of European descent and live in European Russia. In discussing Asian culture, many sources used the term "Asian" generally, but where specific distinctions have been made regarding the values held by those of different nationalities or from different regions of Asia, that distinction will be indicated.

7.2.1. Cultural values' influence on stigma

In many Asian cultures, the distinction between mind and body that has historically been prevalent in Western cultures does not exist (Wheeler, 1998). In Asian cultures, the mind and body are seen as inseparable; there is no differentiation between bodily distress and mental or emotional distress (DHHS, 2001). For this reason, people of Asian descent may express psychological symptoms somatically. They also may be more likely to seek help for any physical or emotional problem from a traditional healer as opposed to

a physician or psychologist (DHHS, 2001; Sanchez & Gaw, 2007; Wheeler, 1998). Researchers have suggested that people of Asian descent generally believe mental illness is a punishment from God (Fogel & Ford, 2005), caused by supernatural influence (Lauber & Rössler, 2007), the result of bad deeds in a previous life (Raguram, Raghu, Vounatsou, & Weiss, 2004), or indicative of "bad genes" (Chen, 2005). The beliefs that mental health problems are a result of weak character, having evil spirits, or punishment for not respecting ancestors are prevalent in China (Lam, Tsang, Chan, & Corrigan, 2006). These beliefs about the causes of mental illness likely contribute to the stigma attached to it in Asian cultures.

Despite the heterogeneity of Asian cultures, according to Kim, Atkinson, and Yang (1999), most Asian cultures have in common the values of conformity to norms, emotional self-control, collectivism, family recognition through achievement, and filial piety. If Asian cultures typically value conformity to norms, it is not surprising that anything viewed as outside of the norm, including mental illnesses, would be devalued and thus subject to stigmatization. Many people of Asian descent view people with mental illnesses as dangerous and aggressive (Lauber & Rössler, 2007), and unpredictable (Sanchez & Gaw, 2007). Moreover, in cultures where emotional self-control is valued and the norm, any display of emotions, especially an expression of dangerousness or aggression, might be indicative of a mental illness and/or a personal weakness, leading to stigmatization (DHHS, 2001). Also, going to therapy or counseling typically involves a great deal of emotional expression, which may increase the likelihood persons with mental illnesses would be stigmatized if they have sought treatment.

Given the collectivist nature of many Asian cultures, having a mental illness is a reflection on the person's family and can bring the family shame (DHHS, 2001; Lauber & Rössler, 2007). In Filipino culture, a person's mental illness is seen as the family's mental illness (Sanchez & Gaw, 2007), and in many Asian cultures, if a member of a person's family or the person himself/herself has a mental illness, marrying may be difficult (DHHS, 2001; Weiss et al., 2001). Further, a person who has a mental illness may have difficulty accomplishing those achievements that are worthy of recognition in Asian cultures such as academic and occupational success. An inability to bring recognition to the family for achievements may also lead to stigmatization. Similarly, filial piety, the value of respecting and taking care of one's parents and conducting oneself in a way that reflects positively on one's parents, can also be a factor in the stigmatization of mental illnesses. Individuals with mental illnesses may be stigmatized because they may reflect negatively on their parents, and may be incapable of taking care of their parents when they become old or sick.

7.2.2. Research

Fogel and Ford (2005) examined self-stigma among Asian Americans with depression. To measure stigma, the researchers asked participants to indicate their agreement with statements regarding feeling embarrassed if their friends knew they were receiving professional mental health care, not wanting their employers to know that they were receiving professional mental health care, and if their families would be disappointed in them if they had depression. Results indicated that Asian American participants over the age of 16 endorsed greater stigma than their Caucasian counterparts. Among the Asian American participants, males endorsed greater stigma and older participants (ages 46–60) endorsed less stigma.

Miville and Constantine (2007) examined perceptions of public stigma as a mediator of the relationship between adherence to Asian cultural values and intent to seek counseling among 201 Asian American college women. Results indicated that Asian cultural values and stigma were positively correlated, meaning more Asian cultural values were associated with greater counseling stigma. Also, Asian cultural values and stigma were negatively correlated with intent to seek counseling. The results supported stigma as a weak, partial mediator, indicating that

greater endorsement of Asian cultural values was associated with increased stigma, which in turn negatively influenced intent to seek counseling. [Shea and Yeh \(2008\)](#) explored the impact of Asian cultural values, public stigma, and attitudes toward seeking professional psychological help in Asian American college students. Like [Miville and Constantine \(2007\)](#), they found that Asian cultural values were positively correlated with stigma; however, Shea and Yeh's results indicated that stigma did not mediate the relationship between Asian cultural values and help seeking attitudes. While the results of these two studies support the notion that cultural values impact mental illness stigma, the relationship of cultural values, stigma, and psychological help seeking remains unclear.

As previously mentioned, [Whaley \(1997\)](#) found that Asian Americans were higher than Caucasians in perceiving individuals with mental illnesses to be dangerous, regardless of the amount of contact they have had with them. However, Asian Americans accounted for just 1.5% of the study's sample, making it difficult to be confident in the study's findings. [Rao, Feinglass, and Corrigan \(2007\)](#) found that Asian Americans were significantly higher than Caucasians on the desire for segregation from those with mental illnesses at baseline, but they were no different from Caucasians in their perception of people with mental illnesses as dangerous. However, following an intervention involving in vivo or video contact with a person who has a mental illness, Asian Americans' perception of them as dangerous dropped significantly. For Asian Americans, research indicates that public and self-stigma exist and are influenced by cultural values but more research is needed, especially research delineating Asian American subgroups, to meaningfully inform the development of programs aimed at combating mental illness stigma among Asian Americans.

7.3. People of African descent

The term "African descent" is used here to more broadly include people of non-Hispanic, sub-Saharan African ancestry, including those whose recent ancestry is tied to Africa, South America (e.g., Brazil, Guyana, Suriname, etc.), and the Caribbean (e.g., Jamaica, Haiti, Bahamas, etc.), as well as those of distant African ancestry in Europe and the United States. When specifically referring to people of African descent in the United States, the term "African American" will be used. There is considerable heterogeneity among people of African descent. Even among Africans, there is not just one "African culture." Africa has 54 countries with varying colonial histories and with people from a variety of tribes who speak different languages and have different customs. African Americans are also a diverse group. African Americans may be of recent African, South American or Caribbean immigrant ancestry, or the descendents of African slaves brought to the United States centuries ago. Given those historical differences, as well as differences in degree of identification with their African heritage, SES, and level of education, it is apparent that African Americans are not a monolithic group. Still, there are some cultural values that many people of African descent share given their common African ancestry, regardless of how distant that ancestry is.

7.3.1. Cultural values' influence on stigma

Although people of African descent are diverse in a multitude of ways, some general cultural values many people of African descent have in common are collectivism or communalism, kinship-like bonds, role flexibility, and spiritualism ([Hill, 2003](#)). Similar to Asian cultures, African cultures value collectivism, attaching importance to group identity and the basic interdependence of people ([Hill, 2003](#); [Tyler et al., 2008](#)). A value related to collectivism is kinship-like bonds, which refers to having family-like relationships with those who are not actually part of one's family ([Hill, 2003](#)). This is exemplified by the use of the words "brother" and "sister" as terms of endearment to address others within the cultural group whom they may not even know. Because of these cultural values, the way that one person acts

may be seen as affecting the whole group. This view can affect stigmatization because others may distance themselves from, exclude, or in other ways discriminate against a person with a mental illness to avoid being associated with the person. Alternatively, people of African descent may react to a person of African descent who has a mental illness with sympathy and support in an effort to strengthen the group as a whole. Research examining the relationship between collectivism and mental illness stigma among people of African descent is needed to determine which explanation is more accurate.

Role flexibility refers to the ability to change roles within a family such as grandparents taking on roles traditionally held by parents who work a lot or a mother taking over the role of an absent father. A person suffering from a mental illness may not be able to "step up" when needed to take over a different role, and may feel inadequate or self-stigmatize in some other way. Additionally, other people of African descent may stigmatize the person for not being able to change roles because of a mental illness. The person may be viewed as irresponsible or unreliable, particularly if he or she is seen as at fault for having a mental illness or blamed for not being able to control it.

Spiritualism refers to the recognition that there is a Higher Power who plays a significant role in a person's life ([Hill, 2003](#)). This value could be protective against mental illness stigma if the illness is seen as something for which the affected individual is not responsible ([Griffith & Baker, 1993](#)). For example, if mental illness is viewed by others as a lesson from God about patience or a test of faith, people may be less prone to stigmatizing a person with mental illness because they may view the mental illness as an opportunity for spiritual growth. Alternatively, mental illness may be stigmatized more if it is seen as a curse or punishment from God because of the affected person's sins or moral or spiritual weakness ([Mishra et al., 2009](#)). In such cases, those with mental illnesses would be blamed or viewed as culpable for their disorders, which provides for less sympathetic, more condemning reactions towards them. Further research is needed to determine the nature of the relationship between spiritualism and mental illness stigma for people of African descent and whether causal attributions moderate that relationship.

7.3.2. Research

There is far more research on African Americans' attitudes toward therapy and mental health help seeking than on stigma, but the few studies that have examined stigma specifically among African Americans indicate that African Americans stigmatize those with mental illnesses more than Caucasians ([Anglin et al., 2006](#); [Rao et al., 2007](#); [Whaley, 1997](#)). Many researchers speculate that their negative attitudes toward mental health services are due to stigma. However, because stigma is just one of many possible factors that may contribute to negative attitudes, our review only includes studies that specifically measured stigma.

[Conner, Koeske, and Brown \(2009\)](#) examined the effects of public and self-stigma on racial differences in attitudes toward mental health treatment. Their community-based sample consisted of 48 African American and 51 Caucasian adults age 55 or older. Participants completed questionnaires regarding public stigma, beliefs about how they would feel if they were diagnosed with a mental illness (a measure of self-stigma), and attitudes about professional mental health treatment. Results indicated that African Americans had higher public stigma, higher self-stigma, and more negative attitudes toward mental health treatment, and the relationship between race and attitudes toward mental health treatment was partially mediated by self-stigma. This indicates that greater internalization of stigma may lead to the development of more negative attitudes toward mental health treatment.

[Cruz, Pincus, Harman, Reynolds, and Post \(2008\)](#) examined barriers to seeking mental health care among 43 African American participants in therapy for depression by asking them why they thought African Americans with psychological problems use mental health services at

half the rate of Caucasians with similar problems. Stigma was the most frequent response given. This study suggests that even African Americans who are in therapy see stigma as a problem; however, an analysis of why the participants are engaged in therapy despite stigma would have made for a stronger study. Of the 34 African Americans in therapy [Alvidrez et al. \(2008\)](#) interviewed, most reported stigma prevented them from seeking mental health treatment sooner, it hindered their recognizing or admitting they had a mental health problem, they feared being socially rejected, judged, ridiculed, or the subject of gossip, and they had experienced stigmatization as a result of receiving treatment.

[Mishra et al. \(2009\)](#) conducted focus groups with 42 African American adults who were not receiving mental health services. The focus groups began with a discussion of what mental health is, and included views on specific mental illnesses, mental health professionals and services, and other beliefs about mental health care. Results indicated that fear of stigma and racism were the primary barriers to seeking mental health services or information about mental illnesses or available services. Participants pointed to several underlying factors that contribute to stigma, including the stereotype that mental illness is contagious and chronic; that those with mental illnesses are dangerous, unpredictable and hopeless; that a mental illness is a personal weakness, curse or sin; and that seeking professional mental health care will result in labeling and forced treatment. Participants also mentioned that historical and current racism were factors contributing to stigma.

7.4. Latinos

The term “Latino(a)” is used here to describe people with origins in Mexico, Central America (e.g., Nicaragua, Guatemala, etc.), South America (e.g., Venezuela, Chile, etc.), and the Caribbean (e.g., Cuba, Dominican Republic, etc.). Despite sharing the same language and many of the same cultural values, Latinos are heterogeneous, particularly in generational status, level of acculturation, SES, nationality, race, and reasons for immigration ([DHHS, 2001](#)).

7.4.1. Cultural values' influence on stigma

Despite their heterogeneity, Latinos, like people of Asian and African descent, have in common several cultural values: collectivism, interdependence, and cooperation ([Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006](#)). These values in particular are contradictory to mainstream US values such as individualism and autonomy promoted through the mental health care system. For example, individual therapy, with emphasis on the individual and medications, is typically indicated for depressive disorders. Inherent in this practice is a disregard for the integration of family and community in treating Asian Americans, African Americans, and Latinos in the US with collectivist, interdependent, cooperative traditions. Such an indifference towards cultural traditions likely contributes to stigmatization of mental health services.

More specific Latino values include marianismo, machismo, personalismo, familismo, simpatía, and dignidad y respeto ([Andrés-Hyman et al., 2006](#); [Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002](#)). Marianismo means that women should endure suffering with dignity, and be moral, nurturing and self-sacrificing, while machismo means that men should be strong and provide for, protect and defend their families ([Andrés-Hyman et al., 2006](#); [Santiago-Rivera et al., 2002](#)). Because mental illness is associated with weakness and uselessness in Latino culture ([Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007](#)), a Latino with a mental illness may be stigmatized if admitting to or showing any signs of mental illness is seen as contradictory to marianismo and machismo. Personalismo refers to valuing and building interpersonal relationships ([Santiago-Rivera et al., 2002](#)) and preferring personal, reciprocal relationships rather than formal relationships ([Andrés-Hyman et al., 2006](#)). Those with mental illnesses may isolate themselves

from others or act in ways that damage their interpersonal relationships. This discord between the interpersonal characteristics of some mental illnesses and personalismo may contribute to stigmatization.

Familismo refers to valuing the family, maintaining close connections to the family, and being loyal to nuclear and extended family members ([Andrés-Hyman et al., 2006](#)). Simpatía, translated as kindness, stresses politeness and congeniality ([Santiago-Rivera et al., 2002](#)). Dignidad y respeto (dignity and respect) is a value emphasizing the intrinsic worth of all individuals and promotes equality, empathy, and connection in one's relationships ([Andrés-Hyman et al., 2006](#)). A person's feeling that he or she is not worthy of dignidad y respeto due to a mental illness could be a manifestation of self-stigma. However, emphasizing familismo, dignidad y respeto, and simpatía in attitudes toward and interactions with individuals with mental illnesses may be a way to work within the Latino cultural context to decrease public stigma.

7.4.2. Research

[Interian et al. \(2007\)](#) conducted a study on medication adherence among 30 Latinos in the US and reported that, although no questions were asked about stigma, the topic was raised by 73% of participants who indicated they experienced stigma or were concerned about experiencing stigma in the future, and that stigma was a common reason for not taking their medications as prescribed. Admitting they have depression and taking antidepressants were described by many participants as contrary to cultural expectations that they should be resilient and able to cope with problems without any professional help ([Interian et al., 2007](#)). As mentioned previously, [Whaley \(1997\)](#) found that Latinos in the US perceived those with mental illnesses to be more dangerous, whereas [Rao et al. \(2007\)](#) found that they perceived those with mental illnesses to be less dangerous and had less desire for social distance from them. It is possible that during the ten years between the two studies, perceptions regarding those with mental illness changed. [Rao et al. \(2007\)](#) used only community college students in their study, a presumably narrower and younger sample than the participants in [Whaley's \(1997\)](#) study. Thus, another potential reason for the conflicting results could be that the younger participants in [Rao et al.'s](#) study were more acculturated and less tied to the Latino cultural values that may be associated with more stigmatizing views of those with mental illnesses.

7.5. People of Middle Eastern descent

“Middle Eastern descent” is used here to refer to the people of western Asia (e.g., Saudi Arabia, Iran, Jordan, etc.) and northern Africa (e.g., Morocco, Egypt, Libya, etc.), including those of Arab, Persian, Turkish, and Berber descent. In the United States, those of Middle Eastern descent have typically been categorized as Caucasian. For example, the 2010 United States Census reads, “Mark the ‘White’ box if this person has origins in any of the original peoples of Europe, the Middle East, or North Africa” ([U.S. Department of Commerce Bureau of the Census, 2010](#)). This is a miscategorization (given the distinct histories and cultures included) and likely produces misleading research results by glossing over the immense variation. Recognizing the diversity that exists even among those considered to be of Middle Eastern descent, an attempt is made here to acknowledge the historical and cultural differences existing between those of European descent and those of Middle Eastern descent by categorizing them separately.

7.5.1. Cultural values' influence on stigma

People of Middle Eastern descent generally value concealing emotions, family honor, patriarchy, respect for authority, and hospitality. Those who seek mental health services are typically encouraged to discuss feelings and emotions. For Middle Eastern cultures in which concealing emotions is valued, this may contribute to stigma towards

mental health services and those who seek them. People of Middle Eastern descent also value family honor; it is important to them to behave in ways that reflect well on others at all times (Erickson & Al-Timimi, 2001). Because they also believe people with mental illnesses are dangerous, have poor hygiene, and are immature and pessimistic (Hamdan-Mansour & Wardam, 2009), admitting one has a mental illness or seeking services could bring shame upon the family and lead to stigmatization. Further, the self-disclosure required in therapy may not only violate the value of concealing emotions but may also violate the family honor value if such disclosures are seen as a betrayal of one's family.

Patriarchy refers to the expectation that men are to be dominant and hold more social power (Haboush, 2007). Because people of Middle Eastern descent believe mental illness is due to possession by evil spirits, sorcery, evil eye, or weakness in faith (Al-Adawi et al., 2002; Al-Darmaki & Sayed, 2009; Cinarbas, Owen, & Ciftci, 2009), men with mental illnesses may be stigmatized because they are not able to fulfill their social role or carry out their responsibilities, as being possessed by evil spirits, being weak in faith, etc. are not indicators of social power or dominance. Respect for authority means one is deferent to those in positions of power over him or her and does not act in ways to subvert or overthrow the authority structure. Those with mental illnesses whose symptoms cause them to act in disrespectful ways (e.g., a person with vocal tics or psychotic symptoms) may be stigmatized. Moreover, given Middle Eastern beliefs that those with mental illnesses are dangerous and immature, it may be assumed that anyone with a mental illness has the potential to be disrespectful and out of control, an assumption that would stigmatize everyone with a mental illness even if they do not behave in ways that disrespect authority or dishonor their families. Conversely, respect for authority could be used in developing anti-stigma interventions to help people appreciate that those with mental illnesses can be more respectful with the aid of a mental health professional. Hospitality, or welcoming and generous behavior, is important among people of Middle Eastern descent because it is viewed as an indication of a person's honor and reputation (Haboush, 2007). It is difficult to see how valuing hospitality could produce stigma but it is easy to imagine how it could be used to decrease stigma if hospitality can be extended to include welcoming and generous behavior towards those with mental illnesses.

7.5.2. Research

Soheilian and Inman's (2009) statement that mental illness stigma among Middle Eastern Americans has yet to be researched is supported by our exhaustive search in the literature for studies on the topic, a search that yielded only Soheilian and Inman's study. Since people of Middle Eastern descent are often miscategorized as Caucasian, it is impossible to know if they have been included in studies on mental illness stigma, and, if so, it is equally impossible to know whether the results for Middle Eastern Americans were the same as for Caucasians since they were not studied separately. Soheilian and Inman (2009) examined self-stigma, public stigma, and attitudes toward seeking counseling among 102 Middle Eastern American college students. They examined self-stigma as a mediator of the relationship between attitudes toward mental health counseling and public stigma. Results did not support mediation but there was a significant relationship between self-stigma and attitude towards counseling; more self-stigma was associated with more negative counseling attitudes. They suggest that self-stigma may result in negative attitudes toward counseling because of the importance of maintaining the family image.

7.6. Caucasians

The term "Caucasian" is used here to describe people of European, non-Hispanic ancestry. Caucasians are not a homogenous group; like other groups, they are diverse in SES, country of ancestry, religious beliefs, and level of cultural awareness. Caucasians are not typically

included in discussions of culture. This could be due to the fact that the focus of most research is solely on Caucasians, so researchers examining cultural factors do not find it necessary to include them. Or, it could be because many Caucasians are not aware of or do not identify with their European heritage (Mizelle, 2009). The inclusion of Caucasians here acknowledges that, like other racial/ethnic groups, despite their heterogeneity, there are important cultural values common among Caucasians.

7.6.1. Cultural values' influence on stigma

Values generally attributed to those of European cultural backgrounds are individualism, materialism, competition, and future time orientation (Halbert et al., 2007; Mizelle, 2009; Tyler et al., 2008). Valuing individualism means viewing independence, autonomy, and individual recognition as important, and holding the expectation of individual, independent success (Mizelle, 2009; Tyler et al., 2008). The expectations that people be successful on their own could result in the stigmatization of individuals who require assistance from others in order to be successful, including persons who have mental illnesses (Mizelle, 2009). Materialism is a value in which status and identity hinge on material possessions (Halbert et al., 2007; Tyler et al., 2008). To the extent that those with mental illnesses are unable to accumulate material possessions, they may be stigmatized and relegated to lower statuses in European cultures. Caucasians also generally value competition, a desire to do better than others often involving intense rivalry (Tyler et al., 2008). Competition may be associated with self-stigma and public stigma towards individuals with mental illnesses because competition involves constant evaluative comparison to others. When a judgment of oneself or others involves a mental illness, the evaluation could potentially lead to the endorsement of stigmatizing beliefs regarding those with mental illnesses. Future time orientation is a focus on what is yet to come as opposed to the here and now (Tyler et al., 2008). It is possible that this value can be used as the basis of anti-stigma interventions to emphasize the concept that a person can recover from a mental illness and there is hope for individuals with mental illnesses to have an improved future.

7.6.2. Research

Most research on mental illness stigma in the US has been conducted using Caucasians. An examination of this research has been interspersed throughout earlier sections of this review and presented elsewhere (e.g., Corrigan, 2004; Hayward & Bright, 1997). Overall, this research has indicated that mental illness stigma is prevalent among Caucasians, although at lower rates than for other racial/ethnic groups (Rao et al., 2007; Whaley, 1997). Studies have also indicated that stigma is a reason some Caucasians do not seek needed mental health services (Corrigan, 2004). However, no studies have examined the potential role of cultural values in Caucasians' stigmatizing attitudes and behaviors toward those with mental illnesses.

7.7. Limitations

Some of the studies involving mental illness stigma and culture have methodological problems. Most studies in which cross-group comparisons were conducted used Caucasians as the reference group. There were no direct comparisons among the other ethnic groups, making it difficult to assess those differences. Also, few studies considered within-group comparisons. Such comparisons would emphasize the heterogeneous nature of cultural groups and provide a more complete picture with regard to the different ways members of a given cultural group perceive and experience stigma. In addition, stigma was measured differently in many of the studies. Most studies measured just one stigmatizing belief, usually perceived dangerousness. Those that measured multiple stigmatizing beliefs grouped them together as a total stigma score for analyses. Such an analysis of stigma not only makes it impossible to draw distinctions between different types of stigma (i.e.,

public versus self), but it also may not be culturally valid because dangerousness may not be the stigmatizing attitude that is prevalent for each cultural group and because the primary or most debilitating beliefs about those with mental illnesses may be different for different cultural groups. For example, among Latinos, the primary belief about those with mental illnesses may be that they are weak, a belief that may contribute to stigmatization just as much as the belief among Caucasians that those with mental illnesses are dangerous. Another limitation is that self-stigma was rarely included as a variable of interest in research with different cultural groups in the US. Although the literature on Asian Americans and mental illness stigma is more developed than that of other cultural groups, the general literature in this area is disorganized, does not seem to follow any logical flow, and neglects many important questions.

8. Systematic approach to future research

To address the gaps, disorganization, and limitations of extant research on stigma, we propose a six-step systematic approach to future research in the area (see Fig. 3). This approach assumes that cultural factors are important in the study of mental illness stigma and specifies the research that is needed to develop anti-stigma interventions targeting specific cultural groups. Keep in mind that, although our approach involves steps, the research process is an iterative one, meaning results from one step may necessitate a return to a previous step.

The first step is to determine the cultural values that are salient for each group. In this review, we pulled from anthropological, sociological, and psychological literatures to propose several cultural values often

used in research on people of American Indian, Asian, African, Latino, Middle Eastern, and European descent, and we speculated about how these values may be important in mental illness stigma. Qualitative and quantitative research is needed to validate that the values we identified are most salient for each group, uncover other values that may have been overlooked in the extant literature, and investigate the veracity of our speculations. This can be best accomplished by involving those who would be the target of interventions (e.g., Latinos, American Indians, etc.) at each stage of the research so that all the domains of the constructs of interest can be identified (Vogt, King, & King, 2004). Structured, open ended interviews of target population members can increase construct validity by allowing target population members the opportunity to suggest any refinements to construct conceptualizations (Haynes, Richard, & Kubany, 1995). Collaboration with cultural anthropologists may also be helpful.

The second step would be to determine what the stigmatizing beliefs about mental illness are for each group. This review has included the stigmatizing beliefs about mental illness that scholars suggest may be common for each cultural group, but there is a lack of evidence supporting the suggestions. The manifestations of stigma vary across cultures (Weiss, 2001), making it imperative that we determine what the different manifestations of mental illness stigma are. This is a necessary step prior to intervention because being aware of how stigma is manifested in a particular culture will inform what stigmatizing beliefs and behaviors need to be targeted for anti-stigma interventions for that cultural group. Focus groups and other qualitative research methods can be used to better understand the beliefs and behaviors associated with mental illness stigma for each cultural group, decrease

Step	Action
1	<i>Determine the cultural values that are salient for each cultural group</i> <ul style="list-style-type: none"> • Validate values, use focus groups • Collaborate with cultural anthropologists
2	<i>Determine the stigmatizing beliefs about mental illness for each cultural group</i> <ul style="list-style-type: none"> • Use focus groups • Employ qualitative research methods
3	<i>Create and validate measures for mental illness stigma and cultural values</i> <ul style="list-style-type: none"> • Have a clear understanding of the construct that is being measured at the outset • Measures should be able to be generalized to multiple cultures, so include stigmatizing beliefs as determined in Step 2
4	<i>Determine whether any cultural values actually are related to stigma</i> <ul style="list-style-type: none"> • Examine public stigma and self-stigma • Conduct studies in which members of a given cultural group are asked about adherence to cultural values, as well as attitudes and behaviors towards individuals with mental illnesses • Cultural values for which greater endorsement is associated with lower stigma can likely be emphasized in anti-stigma interventions
5	<i>Examine moderators and related outcomes (assuming that the results of Step 4 indicate a relationship between cultural values and mental illness stigma)</i> <ul style="list-style-type: none"> • Potential moderators: having a mental illness or being close to someone who does, beliefs about the origin of mental illness, etc. • Related outcomes: mental health service-seeking, etc.
6	<i>Develop group-appropriate, targeted anti-stigma interventions</i> <ul style="list-style-type: none"> • Community leaders and advocates should be included in intervention planning • Interventions should emphasize cultural values that are associated with less stigma or change the <i>expression</i> of values that are associated with greater stigma

Fig. 3. Systematic approach to future mental illness stigma research.

bias by allowing researchers to learn about the meaning of mental illness stigma from the perspective of the target population, and help researchers become aware of the language used by the cultural group in reference to mental illness stigma, which can be useful when phrasing items for measures (Vogt et al., 2004). Within each cultural group, separate focus groups should be conducted with those who have mental health problems and those who do not, so that self-stigma and public stigma can be isolated.

The third step in this research approach would be to create and validate measures for mental illness stigma and cultural values. Mental illness stigma measures do not necessarily have to be different for each cultural group, but the stigmatizing beliefs of all cultural groups should be included when developing measures intended for broad use. Regardless of the approach taken, stigma measures should have independently functioning subscales for public and self-stigma so that their additive and multiplicative relationships can be identified. Valid measures of cultural values are needed not only for stigma research; indeed, there are other research areas that could benefit from understanding interactions between cultural values and other variables of interest. It would be desirable for the measure for a given group's cultural values to have independently-functioning subscales for each value. That way, researchers will be able to determine which values are associated with stigma and which values may be able to be used to combat it. Clark and Watson (1995), Kim et al. (1999), and Knight, Tein, Prost, and Gonzales (2002) provide thorough discussions of ways to develop effective measures, development of cultural values measures, and the steps involved to ensure the cross-ethnic equivalence of measures, respectively.

Once stigma and cultural values measures have been separately developed, they should be used to determine whether any cultural values actually are related to stigma (step four). This is necessary to empirically support the claim that cultural values have an effect on public and self-mental illness stigma for a given culture. If scales are developed in such a way that there are subscales associated with each value as opposed to an overall cultural values score, researchers should hypothesize about how the subscales will relate to public and self-stigma before conducting a study. Assuming a solid study design and replicated results, cultural values shown to be positively associated with stigma would increase understanding and conceptualization of mental illness stigma for each group, cultural values shown to be negatively associated with stigma could be emphasized in anti-stigma interventions, and cultural values shown to be unrelated to mental illness stigma should be noted as well.

Assuming that results indicate a relationship exists between cultural values and mental illness stigma for a particular cultural group, step five involves examining various moderators of the relationship. This will help us understand how and under what circumstances certain cultural values are associated with certain types of stigma. Some potential moderators to focus on might include having a mental illness, degree of familiarity with mental illness (e.g., being close to someone with a mental illness versus having had no experiences), level of education, and beliefs about the origin of mental illness. Related outcomes such as mental health service-seeking should also be studied to determine their relationship with stigma and cultural values.

The last step involves developing group-appropriate, targeted anti-stigma interventions, and is predicated on a comprehensive development of the five prior steps. Community leaders and advocates for individuals with mental illnesses should be included in the planning of interventions, as they may have valuable input regarding what methods can be used and how the interventions can be implemented. When developing interventions, it would be inappropriate to attempt to change anyone's cultural values. Rather, the goal of any interventions should be to emphasize or promote those values a group already has that are associated with less stigma or to change the expression of values that are associated with greater stigma. Instead of intervening in the actual value system of the cultural group, interventions should be aimed

at reframing the view of mental illness or mental health services to better fit with the already established values. As indicated in Fig. 2, cultural norms and values likely influence stigma at each step in the stigma process for self-stigma and public stigma. This means that there is potential for intervention at each level of the stigma process. Interventions can be evaluated using the same cultural values and mental illness stigma measures given to participants prior to intervention at certain follow-up intervals. A successful intervention would be indicated if cultural values remained unchanged, but mental illness stigma decreased.

9. Summary and conclusion

Raguram et al. (2004) statement that stigma "is not just a feature of a particular disease or disability but is inevitably situated in a web of social interactions that reflect the influence of cultural meanings" (p. 736) perhaps best describes the findings of this review. There is no overwhelming consensus as to which cultural groups stigmatize mental illness more or less than others; however, we argue that such a comparative evaluation is minimally relevant if at all. Since mental illness stigma is a problem for *all* cultural groups (DHHS, 2001; Yang et al., 2007), a more important question is what are the manifestations, nature, practices, and outcomes associated with mental illness stigma for each cultural group, a question that requires more research than has been conducted to date. In this review, we have speculated about ways in which cultural values may be related to mental illness stigma and proposed a model (Fig. 2) depicting the ways in which culturally-related factors might impact each part of the stigma process for public stigma and self-stigma.

Surprisingly few studies have considered the impact of culture on stigma, which is baffling given the immense cultural diversity of the US and the consensus based on international cross-cultural studies that stigma is invariably influenced by culture. Researchers may be disinclined to study culture because it is difficult to measure and they may be concerned about the over-generalizations involved when discussing culture; however, when culture is ignored, even more gross over-generalizations occur. Psychologists have an ethical obligation to examine the role of culture in their conceptualizations, assessments, research, and practice. Principle E of the APA Ethics Code mandates that psychologists be aware of, respect, and take into consideration cultural differences, and Standard 2.01(b) instructs psychologists to ensure that they have an understanding of the influence culture and other related factors may have on the implementation of services and effective execution of research (APA, 2002). With regard to mental illness stigma, this means considering how culture influences clients' experiences of stigma, research participants' evaluation of stigma, and the public's expression of stigma.

Given the dearth of research involving the interaction between mental illness stigma and culture among Americans and psychologists' ethical obligation to consider culture in their research, there is a significant need for a deeper, more nuanced understanding of the cultural factors that are salient with regard to stigma and the ways stigma shapes attitudes toward mental illness in order to develop ways to change those attitudes. This research can inform interventions targeted at reframing the views of mental illness for specific cultural groups. We proposed a research agenda (Fig. 3) with this goal in mind, but we recognize that it will take time for the agenda to be adopted and seen through. In the meantime, researchers and intervention developers should continue with their research, but take specific measures to include enough members of different ethnic groups in their samples to provide for meaningful comparisons and the investigation of within-group variation. To investigate within-group variation, cultural variables should be used such as acculturation, the degree to which an individual identifies with the values and norms associated with his or her own culture and the values and norms associated with the predominant culture of their area (Lee,

1997). Examining within-group differences in this way will provide valuable information for planning interventions. Also, intervention outcome data should be analyzed in a way that allows us to better understand what interventions are effective for whom. Researchers and intervention developers should also recognize the complexity of stigma and attempt to find other ways to measure it instead of relying solely on perceived dangerousness and social distance scales. For example, it is important to examine the effects and develop appropriate interventions for self-stigma as well as public stigma for members of various cultural groups. Many great writers on the topic of mental illness stigma have been sociologists, psychiatrists, and anthropologists, as well as social and clinical psychologists. Researchers should include professionals from each of these disciplines to provide for a more comprehensive analysis of the role of culture in mental illness stigma. This collaboration, in combination with a systematic research plan focusing on the influence of culture, can advance efforts to tackle the formidable obstacle of mental illness stigma in the US.

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