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Mental health stigma update: A review of consequences

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Abstract: *Mental illness remains a pervasive social issue that affects the well-being of millions of individuals globally. Despite the overall prevalence of mental illness, increasing numbers of individuals needing mental health treatment do not receive it. Mental Health Stigma (MHS) has been proposed as a significant barrier to seeking/obtaining mental health treatment. Mounting evidence suggests that MHS is experienced in virtually all life domains and that it may significantly influence multiple health outcomes, including treatment seeking behavior. The current review paper uniquely contributes to the literature on MHS in at least four ways. First, this paper provides a recent overview of the prevalence and social costs of mental illness in society. Second, this paper presents a current literature review of MHS and helps to elucidate the impact of MHS on a range of individual outcomes, including psychological and physical health. Third, this paper specifically reviews existing literature on understanding the relationship between MHS and treatment seeking behavior. This is the first known review paper to focus specifically on the MHS–treatment seeking relationship. Finally, the paper presents implications for future research on MHS and treatment seeking which may lead to the development of theory-based interventions to address MHS in clinical practice.*

Keywords: stigma, mental health, health, mental health stigma, stigma consequences, stigma modeling

The prevalence and consequences of mental illness

Mental illness prevalence rates are based on classifications by the Diagnostic and Statistical Manual 5th edition (American Psychiatric Association, 2013) or the World Health Organization's (WHO) International Classification of Diseases (World Health Organization, 1992). In terms of severity, among US respondents with a 12-month disorder, Kessler and colleagues classified 22% as serious, 37% as moderate and 40% as mild (Kessler, Chiu, Demler, & Walters, 2005) and estimated the most prevalent lifetime individual disorders were major depression (16.6%), alcohol abuse (13.2%), specific phobia (12.5%) and social phobia (12.1%). Anxiety disorders were the most prevalent group of disorders (28.8%), followed by disruptive behavior disorders (24.8%), mood disorders (20.8%) and substance use disorders (14.6%) (Kessler et al., 2005). Overall lifetime prevalence of any mental illness was 46.6% suggesting nearly half of American adults are likely to experience a mental disorder during their lifetime.

Equally significant are the financial costs associated with mental illness which are estimated to range from 57.5 to 300 billion dollars annually (Insel, 2011; Reeves et al., 2011). Researchers have noted challenges in estimating cost both because mental illnesses are often chronic and there are commonly indirect costs associated with mental illness (Insel, 2011; Wolf, 2007). Smith and Smith (2010) estimated individual families with children having a mental illness lose approximately $300,000 of their lifetime income. Given the chronicity of several mental illnesses, the impact of mental illness on lost income alone is staggering. The WHO reports individuals with serious mental illness earn approximately one third less per year than median earnings for non-mentally ill individuals (Levinson et al., 2010). Similarly, Kessler et al. (2008) found that serious mental illness was associated with a loss of $192 billion dollars in personal earnings. Those with serious mental illness were not only less likely to work than those without illness were but also earned less if they did work.

In addition to significant economic burdens, individuals with mental illness often experience disproportionately higher mortality rates than those with without mental illness (Parks, Svendsen, Singer, & Foti, 2006). For example, people suffering from schizophrenia and other debilitating mental illness die, on average, 25 years sooner than non-mentally ill individuals. Co-morbid disorders also are significantly higher among the mentally ill

with three out of five individuals dying from co-occurring, chronic illnesses including asthma, diabetes, cancer, and heart disease (Parks et al., 2006). These conditions are exacerbated by diminished access to treatment whether due to structural or attitudinal barriers to healthcare.

Despite the significant impact of mental illness at the individual and societal levels, researchers have increasingly documented trends in which individuals with mental illness either delay seeking mental health treatment or go untreated altogether (Kessler et al., 2001; Wang et al., 2006). Because of these trends, individual severity of mental illness may increase along with the myriad costs associated with these illnesses. Therefore, it is imperative that mental health researchers seek to identify pathways and ameliorate barriers to adequate mental health treatment. Early and consistent access to mental health treatment is the most effective antidote to curbing negative mental health trends. While numerous barriers to mental health treatment exist, mental health stigma (MHS) remains a particularly salient factor influencing mental health treatment.

There were three goals of this review paper. First, this paper reviewed literature on MHS to elucidate the impact that MHS may have on basic needs such as employment, housing, and relationships as well as on important psychological and physical health outcomes among people suffering with mental illness. Second, this paper examined the existing literature on MHS and treatment seeking and hypothesized as to the nature of the relationship between MHS and treatment seeking. Finally, this review discussed implications for future research on MHS and treatment seeking and provides a potential theoretical model for future empirical testing.

Methods

In order to perform this narrative review, we conducted a search using the Thoreau database, a search engine examining multiple (EBSCO and ProQuest) databases. In an effort to provide a more current review, we chose empirical research dated from 2000 to 2014. Keywords included: 'mental,' 'physical,' 'health,' 'mental health,' 'physical health,' 'correlates,' 'sequelae,' 'stigma,' 'consequences,' and 'MHS.' We considered any articles addressing either/both mental health and physical health along with MHS. We also considered articles from any geographic location and did not limit the search to research conducted within the United States.

Literature review

Obtaining mental health treatment

There remain multiple potential barriers to seeking treatment for mental illness and access to mental health treatment has not kept pace with the increasing mental disorder incidence. Rosenberg (2010) noted that while demand for mental health and substance abuse treatment has grown approximately 20% within the past year, states continue to cut funding for mental health treatment. Treatment access is limited further by uneven distribution of mental health providers within the United States whom are concentrated in the highly populated, affluent, and urban areas. Therefore, those living in lower income and/or rural areas are less likely to find appropriate treatment (Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003). Ethnic minorities display lower rates of treatment seeking compared to European Americans (Buser, 2009). Language barriers, insufficient mental health professionals of color, and prior experience of racism are factors related to the disparity in treatment seeking for ethnic minorities (Snowden & Yamada, 2005). Mojtabai et al. (2011) found with the US general population, that the significance of mental health treatment barriers depended upon the severity of the illness and the kind of barrier. Structural barriers (e.g., finances, transportation, availability, etc.) and attitudinal barriers influenced those with severe mental illness while attitudinal barriers alone were more likely to influence those with less severe mental illness. These findings suggest that there may be barriers unique to accessing mental health treatment. One potent factor gaining research attention as a barrier to mental health treatment is the prevalence of MHS.

Mental health stigma

Social stigma can be viewed as the discrediting or 'blemishing' of one's behavior, identity or

status (Goffman, 1963). Conceptually distinct, stereotypes are the negative expectations about an identity that ultimately contribute to one's stigmatized status. In other words, stereotypes represent the expectations society holds about a particular stigmatized status (e.g., the mentally ill are dangerous) and these stereotypes contribute to an individual's stigmatized status (i.e., mental illness). For the purpose of the current review, we purport that stigmatization of the mentally ill is perpetuated and reinforced by prejudicial attitudes and/or a multitude of acts of discrimination in all life domains. MHS is a form of social stigma aimed at individuals having a mental illness. Generally speaking, MHS can be construed as a social cognitive process in which the public perceives certain cues as to an individual's mental health status which in turn activate stereotypes of the group in question and may lead to prejudice and discrimination (Corrigan, 2004; Corrigan & Kleinlein, 2005; Goffman, 1963; Pescosolido, Olafsdottir, Martin, & Long, 2008).

The pervasive impact of MHS

Mental health stigma in particular is an attitudinal barrier that has been demonstrated to influence basic human needs, including: Self-perception, employment and housing, interpersonal relationships, and physical and mental health, including mental health treatment seeking. We view these variables as 'basic needs' consistent with Maslow's (1943) hierarchy of needs. MHS influences an individual's ability to meet these basic needs, which in turn affect the individual's ability and/or desire to seek mental health treatment. Though we do not claim a specific ordering to these needs, emerging research indicates that MHS may significantly affect each of these variables. It is possible that MHS also affects these needs through its influence on self-perception; that is, self-perception may act as a mediator in the MHS-mental health treatment seeking relationship. Alternately, it may be that stigmatized individuals experiencing challenges with employment and housing, interpersonal relationships, physical and mental health feel increased stigma with each experienced challenge, similar to the occurrence of multiple stigmas (Logie, James, Tharao, & Loutfy, 2013). In turn, this could decrease an individual's ability and/or willingness to seek treatment. What follows is a review of potential factors proposed to be integral to understanding the relationship between MHS and treatment seeking behavior.

Self-esteem & self-efficacy

Several studies have documented the decrease in both self-esteem and self-efficacy, commonly associated with MHS (Fung, Tsang, Corrigan, Lam, & Cheung, 2007; Hayward, Wong, Bright, & Lam, 2002; Kleim et al., 2008; Link & Phelan, 2001; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Watson, Corrigan, Larson, & Sells, 2007; Wright, Gronfein, & Owens, 2000). For example, Fung and colleagues studied the relationship between mental illness stigma, self-esteem, and self-efficacy in participants diagnosed primarily with schizophrenia or affective disorders. Their findings concur with earlier research such that increased stigma was found to contribute to decreased self-esteem and lower self-efficacy (Fung et al., 2007). Recent work suggests that the impact of MHS on self-esteem/self-efficacy can be remediated (Ilic et al., 2012; Sorsdahl, Kakuma, Wilson, & Stein, 2012), as has been also demonstrated in other health areas (e.g., HIV, eating disorders, renal disease treatment; Berger, Ferrans, & Lashley, 2001; Jansen, Rijken, Heijmans, & Boeschoten, 2010; Mond, Hay, Rodgers, & Owen, 2008). Taken as a whole, this literature indicates that an individual's self-perception may act to mediate between MHS and one's willingness or ability to seek/maintain mental health treatment.

Employment & housing

Employment needs may go largely unmet for individuals with MHS in turn causing increased psychological, emotional, and financial harm. Caltaux (2003) noted that internalized stigma could interfere with productive job related behaviors such as searching for employment and/or the ability to perform and function within the workplace. Numerous studies have indicated that individuals having a mental illness are significantly more likely to be unemployed than those without a mental illness (Adewuya, Owoeye,

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Erinfolami, & Ola, 2011; Corrigan, Tsang, Shi, Lam, & Larson, 2010; Ngui, Khasakhala, Ndetei, & Roberts, 2010; Seeman, 2009; Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009). Individuals having a mental illness were also more likely to be underemployed than those without a mental illness (Cook, 2006). Thornicroft et al. (2009) found in a sample of individuals having severe mental illness that 29% reported discrimination both while attempting to obtain or maintain employment. Dunn, Wewiorski, and Rogers (2008) reported that 48–73% of those having mental illness are employed compared to 76–87% of those not having a mental illness. This study like many others, however, focused solely on those having severe mental illness. Working individuals having a mental illness may experience increased workplace discrimination or pressure due to their health status (Corrigan, 2004; Corrigan et al., 2003; Gray, Robinson, Seddon, & Roberts, 2010; Lyons, Hopley, & Horrocks, 2009; Peterson, Pere, Sheehan, & Surgenor, 2006). The impact of MHS on employment could in turn negatively affect self-perception resulting in decreased likelihood of seeking treatment. Additionally, a practical consideration is that lack of employment or underemployment often affects individuals' insurance status and/or ability to afford adequate treatment. Consistent with this, Roeloffs et al. (2003) utilized a clinical sample and found that different kinds of MHS related differentially to health outcomes. Depressed individuals reporting greater *friend stigma* also reported greater unmet mental health treatment needs and those reporting greater *health insurance stigma* reported more medical visits.

Researchers have also documented the challenges individuals having a mental illness may experience securing housing and/or maintaining adequate housing, often for financial reasons (Corrigan & Kleinlein, 2005; Forchuk, Nelson, & Hall, 2006). Researchers have found that individuals with mental illness report numerous incidents of discrimination when looking for housing (Corrigan et al., 2003; Peterson et al., 2006). For example, Corrigan et al. (2003) found that as many as 32.2% of mentally ill participants in a multistate study on consumer services experienced housing-related discrimination due to their psychiatric disability. Studies examining both individuals with mental illness and as well as their caregivers have indicated that individuals with mental illness desire to live on their own and want to have safe housing with adequate support but are often not able to meet these goals (Browne & Hemsley, 2010; Browne, Hemsley, & St. John, 2008; Forchuk et al., 2006). Given these findings, it is possible that fear surrounding diagnosis and the reality of experiencing MHS once diagnosed, may actually contribute to mentally ill individuals delaying or avoiding seeking diagnosis and treatment for their condition.

Interpersonal relationships

Researchers have overwhelmingly demonstrated that MHS adversely affects close interpersonal relationships with family and/or friends (Boyd, Katz, Link, & Phelan, 2010; Gray et al., 2010; Roeloffs et al., 2003; Wong et al., 2009). Perlick et al. (2001) specifically examined the impact of perceived stigma on social functioning among individuals having bipolar or schizoaffective disorders and found that higher perceived stigma predicted impaired social functioning in the form of greater social avoidance, at 7-month follow-up even with baseline social adjustment and symptoms controlled. The negative impact of stigma on interpersonal relationships can also extend to those who provide services to individuals having mental illness. Several researchers have shown that mental health practitioners (Covarrubias & Han, 2011; Flanagan, Miller, & Davidson, 2009) and case managers (Kondrat & Early, 2010) stigmatized individuals with mental illness. For example, Covarrubias and Han (2011) found that MSW students who maintained negative stereotypes toward those having a mental illness were more likely to desire social distance from those having a mental illness. Nurses, nursing students, medical doctors, and medical and pharmacy students have also been shown to endorse stigmatizing attitudes/beliefs (Gouthro, 2009; Nguyen, Chen, & O'Reilly, 2012; Ross & Goldner, 2009; Serafini et al., 2011; Wallace, 2012). Serafini et al. (2011) for example, found higher rates of MHS among medical doctors and students than among

patients or nurses. While the evidence has shown that not *all* health practitioners stigmatize, the extent to which such stigmatizing attitudes occur and influence the practitioner–patient relationship may have adverse consequences for patients engaging with the healthcare system.

Lundberg, Hansson, Wentz, and Bjorkman (2008) examined the experiences of individuals with a mental illness and found that stigmatizing experiences in the form of discrimination and rejection related to quality of life and separately, that quality of life related to one's social network. These findings underscore the importance of social relationships that not only define the experience of stigma but also directly affect the quality of life for stigmatized individuals. On one hand, mentally ill individuals need social support from peers/loved ones to confront their mental health issues; however, MHS may erode this critical support. On the other hand, individuals may be aware and/or fearful of MHS and its existence among health care providers and thus delay or avoid seeking treatment altogether.

Physical health

Numerous researchers have documented the relationship between stigma, including MHS, and physical health. Perceived stereotypes and condition specific stigmas have been found to correlate with health behaviors including obesity stigma relative to eating behavior (Puhl, Moss-Racusin, & Schwartz, 2007; Seacat, Dougal, & Roy, 2014) and perceptions of back pain stigma influence treatment seeking (Slade, Molloy, & Keating, 2009). Similarly, sexually transmitted disease stigma influences sexual health care behavior (Rusch et al., 2007) and sexual risk taking (Hamilton & Mahalik, 2009) while MHS can impact HIV risk behavior (Collins et al., 2008). MHS has also been related to perceptions of physical health (Bahm & Forchuk, 2008) and to self-reported physical condition (Bahm & Forchuk, 2008; Quinn & Chaudoir, 2009). Smith, Damschroder, Kim, and Ubel (2012) studied willingness to pay for mental versus physical health treatment and found that participants were willing to pay 40% less for a mental versus a physical illness despite perceived equal burden of these conditions. It may be therefore, that to the extent physical health or physical symptoms are correlated with MHS, that it is more preferable for individuals with MHS to receive treatment for their physical conditions rather than psychological ones.

Mental health symptoms, treatment adherence & coping

Mental health stigma has also been associated with increased mental health symptoms, decreased treatment compliance and reduced coping efforts (Bahm & Forchuk, 2008; Hayward et al., 2002; Pyne et al., 2004; Quinn & Chaudoir, 2009; Roeloffs et al., 2003; Stevens, McNichol, & Magalhaes, 2009; Verhaeghe, Bracke, & Christiaens, 2010). For example, Kleim et al. (2008) found among individuals diagnosed with schizophrenia perceived stigma predicted poorer coping. Vauth, Kleim, Wirtz, and Corrigan (2007) found that use of negative coping (withdrawal and secrecy) in individuals having schizophrenia was associated with both increased stigma anxiety and decreased personal empowerment and self-efficacy. It may be that decreased coping in turn, predicts less treatment adherence. Consistent with this, Broadbent, Kydd, Sanders, and Vanderpyl (2008) found negative attitudes about mental illness were associated with unmet mental illness needs and decreased medication compliance. Fung and colleagues found that for individuals with severe mental illness, stigma led to poorer treatment adherence (Fung et al., 2007). This literature indicates that MHS can adversely influence subsequent mental health, through its impact on symptomatology and treatment as well as its impact on the individual's ability to cope.

The MHS–treatment seeking relationship

The evidence of MHS' direct impact on treatment seeking has been mixed. Many researchers have found support for a direct relationship between MHS and treatment seeking. For example, Barney, Griffiths, Jorm, and Christensen (2006) found greater perceived stigma to be related treatment seeking behavior among a community sample of adults. Other researchers found evidence that MHS impacts treatment attitudes

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negatively (Barney et al., 2006; Bathje & Pryor, 2011; Brown et al., 2010; Cheng, Kwan, & Sevig, 2013; Conner et al., 2010; Hackler, Vogel, & Wade, 2010; Mojtabai, 2010; Nadeem, Lange, & Miranda, 2009). Bathje and Pryor (2011) for example found that MHS was associated with both attitudes and intention toward mental health treatment seeking. Having greater sympathy (a measured subscale of MHS) for someone getting help for depression was associated with more positive attitudes toward seeking help for self; greater attributions about controllability of mental health (a measured subscale of MHS) were associated with less positive attitudes about seeking help for self. Attitudes toward seeking help fully mediated the relationship between self-stigma and intensions to seek mental health counseling when needed for self. Cheng et al. (2013) found that perceived MHS from others affected stigma for seeking treatment across racial and ethnic groups.

Conversely, some researchers have found no significant relationship between MHS and treatment related attitudes or behaviors (Golberstein, Eisenberg, & Gollust, 2008; Komiti, Judd, & Jackson, 2006). In addition, Golberstein et al. (2008) found that stigma related to perceived *need* for mental health treatment, with greater perceived treatment need associated with increased stigma perception. Komiti et al. (2006) did not find MHS related to treatment, though attitudes toward seeking help were related to actual treatment. These findings were inconsistent with study hypotheses and potentially reflect the use of a rural sample. Roeloffs et al. (2003) found that MHS related to age, ethnicity, gender, and physical health status but did not relate to treatment.

What is increasingly apparent is that the MHS–treatment relationship is nuanced and that there may be certain patterns of mediation and moderation, which when clarified, may more accurately identify how stigma influences treatment. Roeloffs et al. (2003) did not find a direct relationship between stigma and treatment though did find that depressed participants who felt stigma negatively influenced their social support also reported greater unmet treatment needs. Vogel, Heimerdinger-Edwards, Hammer, and Hubbard (2011) found support for a mediational model but one in which self-stigma mediates between perceptions of masculinity in males and treatment seeking behavior. While this finding supports a *direct* stigma–treatment seeking relationship, the authors note that the main contribution of their work was to highlight the need for more complex help-seeking models that include populations that are more diverse. Conner, Koeske, and Brown (2009) found that internalized stigma and not public stigma mediated between race/ethnicity and attitudes toward mental health treatment. Similarly, Brown et al. (2010) specifically found that internalized/self-stigma mediated between public/perceived stigma and attitudes toward treatment. This effect, however, was further moderated by race as African American participants reported that internalized MHS *directly* influenced mental health treatment.

With regard to the importance of race, Menke and Flynn (2009) found that African Americans reported greater stigma than their White counterparts did while White participants used treatment more than did African American participants. This research also found that the severity of illness mediated the MHS–treatment relationship. The authors suggested that stigma and mental health beliefs might be uniquely important for those with less severe forms of mental illness, a conclusion that has received very little attention in the literature. Golberstein et al. (2008) reported high levels of MHS particularly for males, Asian/Pacific Islanders, students with low SES, and those with current mental health problems. Mojtabai et al. (2011) found that both perceptions of the need for treatment and attitudes toward mental health treatment were stronger predictors of initiating and maintaining treatment than were structural barriers such as finances, treatment availability, convenience and transportation. Similar to Menke and Flynn, these researchers note the importance of illness severity when examining and attempting to explain the stigma–treatment relationship. They found that barriers to treatment depend on illness severity, with individuals having severe mental illness being influenced more by structural barriers and attitudes toward

treatment while those with mild and moderate mental illness were more likely affected by perceptions of the need for mental health treatment. Cheng et al. (2013) also found that the stigma–treatment seeking relationship was influenced by illness severity, with individuals experiencing greater psychological distress in turn, experiencing greater public stigma and then in turn, greater stigma for mental health treatment.

Summary

The above research suggests that greater sophistication is needed when looking to examining MHS and its consequences. It is important to note that in all of the aforementioned studies, social and/or personal MHS was consistently reported. This was true even when MHS was not found to directly influence treatment variables. That MHS appears universal in prevalence is an important consideration not only with regard to future research but also for application and remediation. Second, while MHS appears to be *directly* related to a number of variables including age, ethnicity, race, illness severity and treatment related variables, researchers have also found support for an *indirect* or mediated relationship between perception of stigma and these outcomes. Research on the MHS–treatment relationship to date has been largely atheoretical and there is a significant need for providing a more holistic model of MHS as it pertains to important outcomes such as mental health treatment.

General discussion

As was previously stated, the overarching goal of this study was to examine key physical and psychological consequences of MHS in order to better understand MHS as a barrier to mental health treatment. One limitation of the current study is that it was a narrative literature review. Therefore, not every study on MHS during the dates of this review was necessarily included. The many studies from our literature review documenting the relationships between MHS and self-perception, employment and housing, interpersonal relationships, physical and mental health and mental health treatment seeking collectively indicate that MHS is part of a complex network of relationships. When these relationships are considered comprehensively and in conjunction with empirically validated theoretical models, the impact of MHS on treatment seeking may become more predictable. Given that approximately one in two adults will experience a mental illness in their lifetime, the need for mental health treatment is apparent. While many barriers may prevent individuals from seeking mental health treatment, research indicates that MHS is both common and has wide-ranging mental and physical health implications for the individual experiencing it. This latter possibility is important, particularly given both the high rate of comorbidity between psychological and physical health conditions (Bahm & Forchuk, 2008; Cook, 2011; Currid, Turner, Bellefontaine, & Spada, 2012; Quinn & Chaudoir, 2009) and the ballooning costs of psychological and physical healthcare (Deloitte Touche Tohmatsu Limited, 2014; Industry Report Healthcare: United States of America, 2013; Insel, 2011; Reeves et al., 2011). Further, an increasing number of primary care physicians report treating patients for mental health concerns in additional to physical health (Currid et al., 2012). If MHS contributes to physical health, it will be important to understand how and when this occurs.

While evidence supports that MHS affects treatment seeking, this literature is relatively new and social scientists do not fully understand the explicit paths by which this occurs, particularly as it influences different social groups. For example, considerable research documents the impact of MHS on individuals having severe mental illness while we know less about how individuals with mild-moderate mental illness experience MHS. The idea that MHS could be experienced differently depending upon the social group in which it is measured is supported by social identity research. Specifically, research on social identity indicates that how we choose to identify ourselves through social categories (e.g., by health condition, gender, race/ethnicity) affects both individual and societal expectations for members of that group (Deaux, 1984; Deaux & Major, 1987; Major, 2012). Our social identities are integral to our overall functioning. These identities are believed to be both active and malleable and affect

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how we think, feel, and behave (Ashmore, Deaux, & McLaughlin-Volpe, 2004; Deaux, 1993; Deaux & Major, 1987; Major, 2012). However, the functional centrality of social identity suggests that individuals with a stigmatized identity might experience negative consequences because of that identity. In addition, individuals having multiple stigmatized identities may have unique challenges to treatment seeking (Kidd, Veltman, Gately, Chan, & Cohen, 2011). If an individual has an already stigmatized identity (e.g., such as a racial/ethnic identity, or social class) they may be less willing or even capable to acknowledge the additionally stigmatizing identity of mental illness. This then could influence the individual's willingness to seek treatment. Research on social identity therefore supports MHS as a potential catalyst in human functioning. The current review provides insights into potential factors that may play a role in a more comprehensive model explaining the role MHS plays in treatment seeking behavior. It is our hope that this paper will contribute to an empirically verifiable model to predict MHS outcomes.

Future directions of MHS & treatment seeking

First, as Figure 1 demonstrates, MHS is increasingly understood to correlate with multiple aspects of an individual's life and therefore should be considered holistically or as potentially influencing a range of human experiences. In this light, it is important to acknowledge that comparatively few studies examine individuals having less severe forms of mental illness and that relatively little is known about MHS as it impacts more general populations including but not limited to younger individuals and children and individuals of varying ethnicities. While studies suggest that MHS may be even stronger in some ethnicities compared to others, few studies have examined this specifically or the relationship between cultural attitudes toward mental illness and its impact on treatment seeking in ethnic minority populations (Snowden & Yamada, 2005). As Ngui et al. (2010, p. 235) speculate, the burden mental health disorders will have globally is expected to increase by 2020 and common mental disorders (e.g., depression, anxiety and substance abuse disorders) will 'disable more people than complications arising from AIDS, heart disease, traffic accidents and wars combined.' More research therefore needs to be conducted with the various subgroups both within the general population and within the population of those having a mental illness.

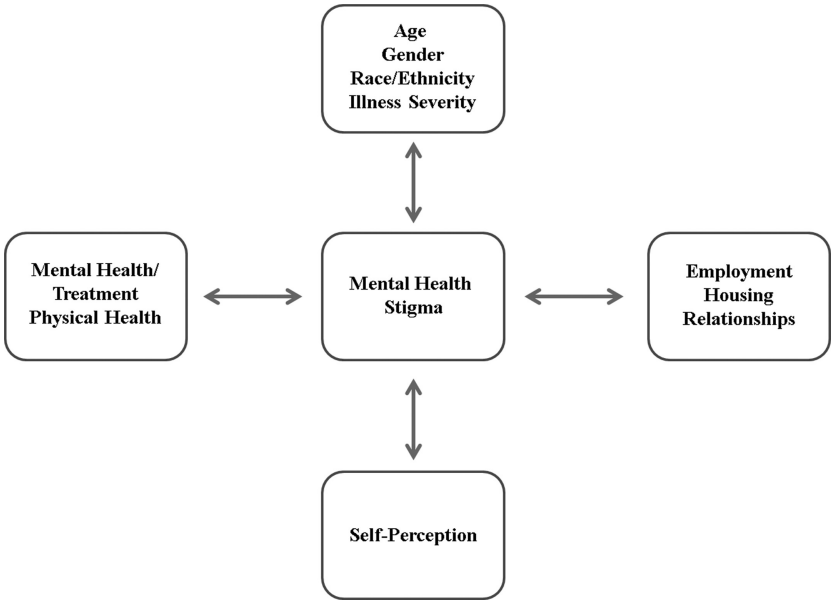

Figure 1: The pervasive influence of Mental Health Stigma can be seen to influence and potentially be influenced by multiple aspects of an individual's life

Second, there are differences in the measurement of treatment seeking with some work assessing treatment attitudes versus treatment behavior. In addition, certain populations may define *treatment* differently

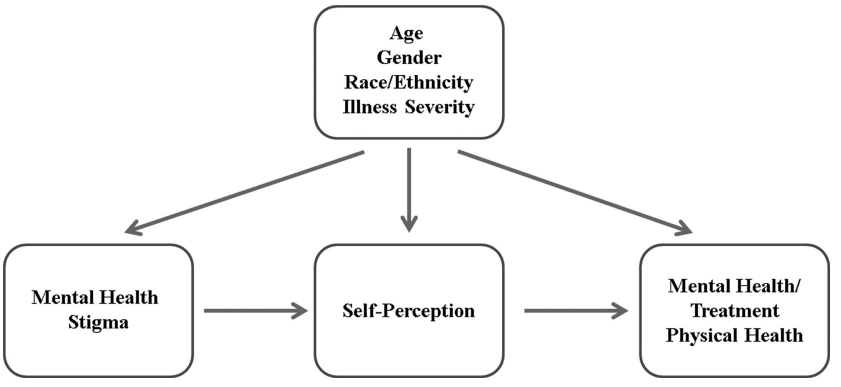

Figure 2: While demographic factors such as age, race/ethnicity, gender, and illness severity relate to mental health stigma, these variables may moderate any relationship between stigma and outcomes such as mental health treatment and health. In turn, variables internal to the individual such as self-perception may act as mediators in the stigma-mental health treatment/health outcomes relationships

and favor social support for example, over formal treatment. This distinction is not well realized in the literature and it not only needs to be conceptualized further but the efficacy of less formal treatments must be assessed. It is therefore important that research on MHS seek to unify conceptualizations of all terminology for greater efficacy and accuracy in disseminating information.

Lastly, while evidence supports that MHS does affect treatment seeking behavior, we do not yet understand the comprehensive pathway through which this relationship occurs. The current review is an initial step in developing a viable theoretical model, but future researchers will need to empirically test and validate possible interrelationships between these factors Research since the 1960's suggests that certain variables may intervene between MHS and its impact on treatment, including variables both internal and external to the individual as have been discussed here (Goffman, 1963). Continued research is needed on these variables as potential mediators and moderators in the MHS–treatment seeking relationship so that a more complete and causal model can be derived to denote the MHS/MHS–treatment seeking relationships as depicted in Figure 2. For example, given the support for mediational models to date, it may be that because of the direct negative consequences of public MHS (e.g., impacts on employment, housing, interpersonal relationships) stigma adversely affects self-perception, which in turn influences treatment and health variables; self-perception in this case acting as mediator between MHS and treatment/health variables. As others have indicated, public stigma may lead to self-stigma (Corrigan, 2004; Corrigan, Watson, & Barr, 2006). The relationship between MHS and outcomes such as health and treatment seeking, in turn, may be contingent upon or moderated by a number of variables known to influence stigma, such as age, gender, ethnicity, race, and/or illness severity.

It is our perspective that MHS has a pervasive impact on both an individual's social, psychological and physical functioning and therefore represents a sizeable barrier to the health and productivity of our society. Unfortunately, a significant percentage of individuals delay treatment or do not seek treatment at all. Though mental illness will never be eliminated, much of the burden could be ameliorated if the effects of MHS are minimized. The possibility of early and consistent treatment for mental health conditions has favorable consequences for individuals, family members, researchers, clinicians, and policymakers alike.

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