Stigma involves the deep discrediting of an individual as a function of his or her membership in a devalued group with low social power (Goffman, 1963; Link & Phelan, 2001). Tragically, mental illness has been identified as one of the most stigmatized attributes a person can have in modern society. In fact, stigmatization has been shown to add considerably to the burden incurred by mental illness per se, in terms of predicting decreased life opportunities and enhanced impairment (for a review, see Hinshaw, 2007). For a number of reasons, it is also a key barrier to mental health services access and utilization (e.g., Corrigan, 2005; Thornicroft, 2006).

First, stigmatization may lead to a lack of recognition that problematic behavioral patterns signify mental disturbance. Such problems may instead be attributed instead to weak personal will or moral flaw, meaning that psychological services are not even considered. Second, stigmatization often produces a strong sense of shame and/or personal failure, so that an individual or family may not seek assessment or treatment even if they recognize that mental disturbance is present. Third, at an economic level, stigma has traditionally led to low rates of reimbursement for mental health services, so that even if treatment is sought, it may not be funded or covered (Hinshaw, 2007). At a wider societal level, stigmatization has undoubtedly led to lower prioritization of mental health research and services than for conditions believed to be “physical” in nature. Indeed, Sartorius (1998) has claimed—with substantial justification—that stigma is the core issue faced by the entire mental health field, as it underlies the low stature of the mental health professions, the marginal priority given to mental health research, the poor access to treatment that exists, and the difficulties in attaining ultimate life goals experienced by far too many persons with mental disorders.

Across the past several decades, the general literature on stigma has become large and multifaceted, spanning such topics as the evolutionary psychology of the stigmatization of outgroup members (Kurzban & Leary, 2001), social psychological forces driving prejudice and stigma (Fiske, 1998), the extremely high rates of stigma propagated against individuals with mental illness (Hinshaw, 2007; Thornicroft, 2006), the key role of internalized stigma (often termed self-stigma) in diminishing life opportunities (Major & O’Brien, 2005; Watson & Corrigan, 2005), and the effects of programs designed to counter stigmatization (see, for example, Sartorius & Schulze, 2005).

The focus of the present manuscript is the interface between stigma and the huge issues of mental health service underutilization among children and adolescents in need of care. Although often assumed to be a significant factor in child mental health services research, the role of stigma is under-conceptualized and under-researched in this domain. One of our chief contentions is that the field lacks conceptual frameworks regarding help-seeking that could adequately account for the role of stigma as a barrier to receiving care. Indeed, our overarching...
Professional and Institutional Stigma

premise is that just such conceptual frameworks and methodological guidance are needed to examine stigma and its relationship to help-seeking and service use for children and adolescents—and that a prime population of relevance involves parents/caregivers of youth with emotional and behavioral problems, given that youth themselves rarely self-refer for assessment or treatment.

Most of the literature on the stigmatization of mental illness focuses on the general population as a source of stigma—and on the consequences of such stigma for individuals and families who deal with mental disorder. Yet it may well be the case that those entrusted with the responsibility to treat people with mental disorders, as well as the very service structures created by the field, are also contributors to stigmatizing attitudes and practices (e.g., Sadow & Ryder, 2008; Wahl, 1999). A key objective for this paper is to explore this contention and to provide a conceptual model that may prove heuristic in understanding professional and institutional stigmatization. Our main focus is on child and adolescent mental health in this regard, even though the issues related to professional and institutional stigma exist across the age span (Hinshaw, 2007; Servais & Saunders, 2007).

Why is child and adolescent mental health so important with regard to research, services, and stigma? Although the developmental psychopathology of child and adolescent mental disturbance cannot be quickly summarized (see Beauchaine & Hinshaw, 2008), it is first clear that the majority of mental disorders of adulthood have their origins in childhood or adolescence. In other words, mental disorders rarely begin in the adult years de novo; developmental precursors are highly likely to be evident in childhood. Thus, early detection, assessment, and intervention are of paramount importance; and if stigmatization precludes such evaluation and treatment, the consequences may be felt for decades to come. Second, the mental illnesses that begin in childhood and adolescence—such as autism, attention-deficit/hyperactivity disorder, learning disorders, child-onset conduct disturbance, and child depression—are extremely likely to persist beyond the child or adolescent years. That is, early-onset conditions have a high likelihood of continuation. Thus, any factors that can help to initiate accurate detection and evidence-based service utilization during childhood or adolescence are at a premium. If stigmatization operates from the earliest years of life, then developmental models of stigma and stigma reduction are essential in order to prevent many years of suffering and impairment.

In this manuscript, we first document the existence of professional and institutional stigma (especially in relation to child and adolescent mental disorders) and review the current research on what is known about this phenomenon. Next, we highlight the importance of several key constructs needed to understand the significance of professional and institutional stigma and its consequences for children with mental health problems and their families. We then present a conceptual model for examining those who stigmatize, with a focus on the causes of professional and institutional stigma, linking it to broader conceptual frameworks on service utilization and stigmatization. We conclude with implications for research and intervention, including the need to overcome resistance to the model we present. The reader will note that work in this area is quite preliminary; our manuscript is primarily an attempt to generate research and action in this important domain.

Professional and Institutional Stigma

A small but growing literature documents that those who serve in the health and mental health professions, including medical doctors, psychologists, nurses, and trainees/students in
these fields, hold many of the same stigmatizing attitudes toward mental illness (at least as evidenced in adults) as the general public. Space does not allow a systematic review of all investigations in this area, but we note that such findings are not new. Indeed, nearly half a century ago, Nunnally’s (1961) groundbreaking research included a survey of a large number of general medical practitioners. Although these professionals had good knowledge of mental disorder, their attitudes were as negative toward mental illness as were those of the general public. On semantic differential measures, for example, the medical professionals described the term “psychotic” as ineffective, twisted, dangerous, and dirty. Because a large percentage of professional contacts for those with mental disorder emanate from general practitioners rather than specialists (e.g., psychologists or psychiatrists), such stigmatization may be felt widely.

During the 1960s, research focused on staff who worked in the still-prevalent domain of large public mental hospitals. Core findings were that employees in lower status positions (e.g., psychiatric aides or technicians) showed the most authoritarian and pessimistic attitudes, which may have reflected their lower socioeconomic status in general, whereas professional-level staff were generally more optimistic and humanitarian (see Rabkin, 1974). Some staff members held attitudes considered “benevolent,” yet these perspectives were actually associated with poor outcomes in patients. In other words, not only were authoritarian, harsh attitudes among staff linked (understandably enough) with negative outcomes, but attitudes of benevolence—which may actually betray a kind of superiority, to the effect that those with mental illnesses are not fully responsible—were also counterproductive (e.g., Cohen & Struening, 1962).

Across the ensuing decades, mental health care shifted from institutions to communities, but stereotypic beliefs and stigmatizing attitudes continued to be documented among professionals and trainees in both Western and non-Western venues (e.g., Aydin, Yigit, Inandi, & Kırpınar, 2003; Keane, 1990; Mirabi et al., 1985). For instance, psychiatric patients have been branded by professionals as more immature, selfish, and aloof than general medical patients (see review in Hinshaw, 2007). Half of the medical students and physicians surveyed in London held beliefs in the dangerousness and unpredictability of individuals with schizophrenia and drug/alcohol problems (Mukherjee et al., 2002). In Switzerland, psychiatrists were just as likely as the general population to desire social distance toward persons with schizophrenia (Lauber et al., 2004). Negative attitudes continue to be documented in recent investigations (e.g., Servais & Saunders, 2007).

A landmark investigation in the U.S. by Wahl (1999) revealed that, among a large sample of adults with serious mental disorders, hurtful, demeaning attitudes from mental health professionals—and, in particular, low expectations for change—were viewed as a primary source of the stigmatization that these adults had received in their entire lives. This is a devastating finding, and the vignettes and anecdotes recounted by Wahl should give pause to anyone who believes that mental health professionals are uniformly helpful and professional in their communication of respect and hope for those entrusted in their care.

It is not only the people who are professionals in the mental health realm but also institutional policies and practices that are stigmatizing. Institutional stigma is demonstrated as discrimination when policies reduce patient choice, whether intentional or not (Yang et al., 2007). During the days of massive state institutions, for example, much of the mental health enterprise was based on stripping so-called mental patients of fundamental rights and individuality as they entered “total institutions” (e.g., Goffman, 1961). Yet, as is now well known, a major shift occurred during the latter half of the 20th century, when public mental hospitals were closed down in record numbers (note that over 550,000 U.S. citizens were in public facilities in the
1950s, compared to under 45,000 today). Yet the community alternatives in states such as California and New York were often just as dehumanizing as the large state facilities they were designed to replace (see Barron, 2009). With respect to child and adolescent mental health, recent exposes of the harshly abusive practices in special education and juvenile detention facilities are graphic in their portrayal of shocking conditions, in which neglect and even abuse are daily occurrences (see Hinshaw, 2007).

In adult mental health services, coercion continues to exist through commitment to outpatient therapy, often as an alternative to inpatient care or incarceration. Despite some positive effects found of outpatient commitment to treatment (Swartz et al., 1999; Swanson et al., 2000; 2001), the erosion of quality of life for those committed to treatment and increased anticipation of stigma through perception of coercion has been linked to these institutional policies (Link, Castille, & Stuber, 2008; Swanson et al., 2003).

A related issue is that many mental health workers, as well as special education teachers and juvenile detention and residential care staff, are employed in low-status, low-paying positions. Even clinical psychologists and psychiatrists are less valued by their respective psychological and medical communities than specialists in other areas of these respective fields (see review in Hinshaw, 2007). What Goffman (1963) termed “courtesy stigma”—the stigmatization that accrues from being linked or associated with a stigmatized outgroup—has surely existed for a long time in the mental health fields.

Additionally, the health and mental health professions have been extremely slow to accept that mental disorders exist among their own members. Among such professionals receiving any form of mental health treatment, the majority report do not disclose this fact to their peers and many do not even discuss it with their spouses or partners—largely because, when such disclosures were in fact made, ostracism and professional damage to reputation resulted (Goode, 2003; Gottfredson, 2004).

In short, through a combination of low-prestige jobs, stressful work situations, admittedly difficult clientele in many instances, and denial and shame regarding mental disorder within the mental health fields, it is quite conceivable that many mental health staff and professionals would blame or take out frustrations on their own clientele, explicitly or implicitly. Such tendencies have been compounded by prevailing scientific and clinical models, which link mental disorder to both inner weakness and faulty family socialization practices (Hinshaw, 2007). In other words, the very foundations of psychological and psychiatric theory during much of the 20th century were marked by overt blaming of clientele for their own problems, particularly in the domain of child and adolescent psychology and psychiatry (with families explicitly viewed as the causal forces underlying the mental disorders of their offspring). Furthermore, institutional policies and practices have reflected stigmatization from the time of monolithic state facilities to more recent community alternatives that are, in many instances, as woeful as the large hospitals they were meant to replace. Special education and juvenile justice have played major roles in the placement and treatment of youth with mental disorders, and longstanding issues of discrimination, segregation, and even abuse are documented. Even without overt stigmatization, the sheer red-tape and bureaucracy attending to institutions and systems of care doubtless increase alienation and disenfranchisement on the part of many who seek or receive services (see discussion in Hinshaw, 2007).

In addition to the attitudes and actions of professionals and institutions, the very nature of mental health services could well be stigmatizing. That is, the typical model posits that a patient or client has psychological or psychiatric symptoms, in need of treatment by an expert. This
patient or client rather passively receives intervention (in the form of medication or some form of psychological therapy). There is little room, in this view, for a strength-based approach, for one that fosters protective factors, or one that includes an explicit focus on the child/adolescent and family as experts regarding their own situation. The recovery movement in adult mental health is focused on a view that symptoms of mental disorder can indeed be overcome on the basis of a far more co-equal relationship between provider and recipient, one that intentionally builds competencies and strengths rather than focusing on deficits, symptoms, and weaknesses. Stigma is viewed as a major factor preventing such recovery (e.g., Perlick et al., 2001). Some of the most evidence-based intervention strategies in adolescent mental health are based on fostering strengths and employing an ecological model of understanding problem behavior (e.g., Multisystemic Therapy; Henggeler et al., 2009). Whereas in our view the recovery movement has the potential to overlook the fact mental disorders do need symptom-based intervention and that professionals do indeed have relevant expertise, it does recognize that a one-sided, expert vs. ignorant patient perspective may well be inherently stigmatizing.

**Linking Stigma to Service Use (or Lack Thereof)**

*By Children with Mental Health Problems and Their Families*

Because of their nearly exclusive focus on adult mental health conditions, existing stigma frameworks stop short when trying to understand the role of stigma, including institutional stigma, on service use patterns by children with mental health problems and their families. A recent paper (Mukolo, Heflinger, & Wallston, 2009) presented needed expansions to make stigma theory more relevant to children’s experiences and to link stigma directly to service use. In our review, we focus on the concept of stigma by association and the relationship of stigma and service use as we expand their work.

**Stigma by Association**

The phenomenon of stigma by association was introduced by Goffman (1963) as “courtesy stigma,” which connoted that stigma toward a given devalued person typically extends to others who are associated with that person, including family members and professionals. (This term has been challenged by Thornicroft, 2006, and others; we utilize the more contemporary term “stigma by association.”) Stigma among family members was reviewed initially by Lefley (1989). The experiences of family caregivers of individuals with stigmatizing disorders have been documented and explored primarily among those caring for adults with mental illness (e.g., Gonzalez, et al., 2007; Larson & Corrigan, 2008), including parents and adult children as caregivers (Angermeyer, Schulze, & Dietrich, 2003; Perlick, et al., 2007). Direct exploration of stigma by association among families of children with mental health problems is rare (e.g., Gray, 1993; Norvilitis, Scime, & Lee, 2002). More recently, stigma by association has been reported indirectly in the literature on caregiver strain. Brannan and Heflinger (2006) included stigma items in their “family perceptions of barriers” subscale, with greater endorsement of stigma associated with higher reports of caregiver strain among parents of children with serious emotional disorders. Mechanisms underlying the concept of stigma by association among families of children with mental health problems need to be delineated, but the phenomenon is now on the radar screen of those in the field.
The Association of Service Use with Stigma

Again, the focus of most literature examining stigma as a deterrent to service use has been with adults with mental illness (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Thormicroft, 2006). Both avoidance and delay of help-seeking by individuals with mental illness has been documented, along with early termination from treatment (e.g., Sirey et al., 2001; others). The fear of stigma by association in families of adults with mental illness has also been shown to lead to an unwillingness to acknowledge the mental illness and a consequent avoidance of help-seeking (Yang et al., 2007). With children, stigma influences service use via the role of parents in help-seeking (Brannan et al., 2003; Corrigan et al., 2001). Indeed, given that parents or guardians are the primary gatekeepers of service use (i.e., the ones who usually make and keep appointments and must give permission to treat), stigma by association is positioned to play a key role in services access. Among families of children with serious emotional disorders, stigma has been documented as a potential barrier to receiving mental health services because of the influence of stigma on parents (Brannan & Heflinger, 2006; Owens et al., 2002). Stigma issues, including concern that not only would people in their community be likely to find out if a child received professional help but also would blame parents for their children’s problems, were the most often endorsed barrier to services in a study of rural caregivers (McMurry, Heflinger & VanHooser, in review).

Indeed, despite an underdeveloped empirical database, most of us in the field can think of multiple examples of families who have been far too ashamed to seek assessment for their troubled child, to explore obtaining school-based services or accommodations, or to consider family therapy or medication treatment options. In many instances, the problems of the child are considered to be a direct reflection of failures in parenting.

Thus, the overarching relationship between service use and stigma follows the following chain of logic: (1) Not only are children with mental health problems targets of stigma, but so are their family caregivers; and (2) such stigma, and the anticipation thereof, is a powerful deterrent to seeking services, as it egatively influences whether services are used and referrals are followed, and it restricts the types of services sought (increasing delays of receipt of services if they are, in fact, sought). We are now ready to discuss the role of professional and institutional stigma as it affects both avoidance and delay of service use and as it perpetuates the psychological and social consequences of stigmatizing attitudes and behavior.

Modeling Professional and Institutional Stigma

To date, as we have noted throughout this manuscript, reports of stigmatizing practices and attitudes relate primarily to adult consumers; far less appears to be known about such experiences in child and adolescent services. Our objective is to present a theoretical model that incorporates professional and institutional stigma in relation to child and adolescent mental health.

A recently published stigma framework entitled Framework Integrating Normative Influences on Stigma, or FINIS (Pescosolido et al., 2008) takes an interdisciplinary and multi-level perspective on factors that influence stigma and their consequences/responses. Individual/psychological-, social/community-, and societal-level factors are noted as contributing to stigma. However, for understanding the role of institutional stigma and its impact on children with mental health problems and service delivery, the FINIS needs further explication. First, this
framework omits what we believe to be crucial constructs and domains that are necessary to better understand stigma and its consequences for children with mental health disorders and their families. As discussed above, Mukolo, Heftinger, and Wallston (2009) have proposed expanding this framework along the following lines: (a) acknowledging the phenomenon of stigma by association; (b) adding services and service utilization as an essential domain influenced by stigma, particularly in relation to children and their families; and (c) adding the delay or avoidance of help-seeking as a particularly pernicious consequence of stigma. In other words, this extended framework adds a closer look at who is stigmatized and the consequences of stigma for service utilization for children and adolescents.

The FINIS and other theoretical models also fail to explicate the factors that influence the stigmatizer(s). Available stigma theory and research, almost all in the adult area, have acknowledged public and private/personal stigmatizing of persons with mental health problems, but there has been little attention specifically to the professionals who serve those with mental health problems—and the institutions within which they work—as core sources of stigmatization, especially related to child and adolescent mental health. In short, those entrusted with the care of children, adolescents, and their families may actually create barriers to services for the very populations they should be serving and supporting, whether their attitudes and practices are intentional or not. Thus, the factors that influence institutional stigmatizers need attention.

Drawing from what literature that exists on the stigmatizers themselves, factors that have been hypothesized to influence the stigmatizing process/stigmatizer can be described at three levels: individual, social, and societal (see Figure 1). These levels are associated with what Phelan and colleagues (Phelan, Link, & Dividio, 2008) delineate as three functions of stigma and prejudice: a) avoidance of disease (keeping people away), b) enforcement of social norms (keeping people in), and c) exploitation and domination (keeping people down).

At the individual/psychological level are (1) characteristics of the individual being stigmatized (the “target”), and (2) characteristics of the stigmatizer, both individual and social. Target characteristics mentioned in the research literature linked to those who are stigmatized include features of the disease/condition (e.g., concealability, contagion risk, formal diagnosis) and the individual’s behavior (severity, frequency, visibility). Characteristics of the stigmatizer include the following: (a) beliefs, attitudes, and values; (b) personality and emotions; (c) knowledge (about the disease/condition); and (d) anxiety, or the level of threat felt. At the social level are (a) the stigmatizer’s familiarity with the disease/condition (e.g., contact); and (b) community values and norms, including the American focus on individualism (Kleinman & Hall-Clifford, 2009) and professional culture and values (Vawter et al., 2003). The structure and content of professional training and supervision certainly need examination for potential contributions to stigma. The primary factors influencing stigmatizers at the societal level discussed in the literature include personal power associated with wealth, as well as group membership (Phelan, Link, & Dividio, 2008). Still extant literature on such characteristics when the stigmatizer is a professional and the target is a child with mental health problems is almost nonexistent.

Let us speculate on just one aspect of the potential for stigmatization at a professional and institutional level along these lines. Not only are clinical psychology and psychiatry viewed as less prestigious aspects of general psychology and general medicine, respectively, than are other subdisciplines, but those in the field working with children and adolescents—who have less legal power and “social capital” than adults—are even lower on the hierarchy. Given that an
essential component of stigma involves power differentials between those who stigmatize and those who are stigmatized (see Link & Phelan, 2001), those professionals and those institutions dealing with individuals with extremely low power (i.e., individuals with mental disorders, who are also children—and potentially of minority status) are in the territory of doubly and trebly stigmatized groups (see review in Hinshaw, 2007). This low-status/low-power situation is likely to be a breeding ground for blaming and stigmatizing attitudes on the part of professionals, staff workers, and institutional settings themselves.

Overcoming Resistance to the Message

Many in the field continue to believe that scientists, practitioners, and educators in the mental health arena could not possibly contribute to stigma; after all, such individuals have been trained to directly counter prejudice and stigmatization. But without acknowledgment of the strong possibility of professional and institutional stigma—which is highly likely to spread quickly to communities, parents, and youth themselves—it will be extremely difficult, if not impossible, to provide for optimal mental health care for youth in need of services. We acknowledge at the outset that this topic area is controversial and contentious. How could it be the case, many might ask, that the very individuals and professional groups entrusted with the care of children and adolescents with mental disorders would be those who perpetuate stigmatizing attitudes and responses? In building our model, we have had to take a hard look at training models, professional practices, and relationships between consumers and practitioners—and we must ask that readers do the same. What could result is a fresh look at the ways in which all of us conceptualize our roles as scientists, clinicians, and policymakers in the area of child and adolescent mental health.

Implications for Research, Practice, and Intervention

A major research agenda is to document the prevalence and intensity of such professional and institutional stigma among caregivers of youth who receive mental health assessment or intervention—as well as the child and adolescent recipients themselves. We simply don’t know enough at this time about the extent of such practices for this population, although our suspicion is that perceptions of stigma and disenfranchisement are extremely high. Indeed, as just one indicator, mental health service utilization is quite low for children and adolescents in dire need of relevant care. Despite the many structural barriers related to such underutilization, it may well be the case that the low status of child mental health professions and professionals, along with the communication of frustration and low expectations to such consumers as parents, teachers, and youth themselves, are key contributors to the problem.

Next steps to examine and address our concerns regarding professional and institutional stigma toward children with mental health problems and their families include both research and intervention.

Research

(1) Theoretical models and programs of research need to recognize and measure the presence, causes, and consequences of professional and institutional stigma.
(2) Conceptual models and programs of research must be multi-faceted, multi-level (Link & Phelan, 2001), and multi-disciplinary (Kleinman & Hall-Clifford, 2009). We need to integrate organizational and political theory into our current model to better capture factors influencing stigmatizers and maintaining stigmatizing behavior, structure, and policy.

(3) A range of research methods need to be included. Qualitative studies are needed to help build theory and initial measures, and ethnographic methods are particularly suitable for recognizing the multiple perspectives (Yang et al., 2007). As in true mixed-method research (see Weisner, 2005), such qualitative insights can and must be translated into quantitative indicators subject to hypothesis testing.

**Intervention**

(1) Clinicians and administrators need to be sensitized to this phenomenon of stigmatization and pay attention to (and even analyze) the policies and practices in their offices with the collaboration of consumers, in this case parents/family caregivers of children with mental health problems and youth who are willing to participate.

(2) Intervention specifically needs to be aimed at the health services sector – not just the lay public.

(3) Any interventions to address stigma must recognize the role of the professional/institutional stigmatizer and also be multi-faceted, multi-level, and multi-disciplinary.
References


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Figure 1: Modeling the Role of Professional Stigmatizers