the Behavior Therapist

SPECIAL ISSUE

STIGMA
in Mental Health

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Introduction to the Special Issue on Stigma in Mental Health

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OUR FIELD'S AWARENESS of stigma and its consequences has grown considerably in recent years, but our ability to effectively decrease stigma remains limited. One only needs to turn on the news after a tragic mass shooting to hear ubiquitous sentiments that the perpetrators were driven by mental illness, with broad calls to ensure that those with mental illness never have access to a gun. Words like "dangerous," "crazy," and "deranged" begin to be used interchangeably with "mentally ill," feeding the stereotypes and misinformation that research demonstrates have only grown, not decreased, over time (see Parcesepe & Cabassa, 2013, for a review). Certainly, many mass shooters have mental illnesses, but this does not make the converse true. That is, the vast majority of individuals with mental illnesses are not dangerous (Knoll & Annas, 2016). These misperceptions of individuals with mental illness are associated with a host of negative outcomes, including more severe impairment, lower quality of life, and lower rates of treatment seeking (Hinshaw, 2009). As a field, we have long demonstrated a commitment to providing science-based information to counter these and other similarly stigmatizing beliefs and attitudes to the public (e.g., American Psychological Association, 2018), but more can be done both to advocate for individuals with mental disorders and to develop effective interventions to decrease stigma.

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In addition to addressing the general problem of the stigma of having a mental disorder, there are a number of groups that are particularly highly stigmatized. Often, such groups face pronounced barriers to accessing and engaging in treatment. It is promising that our field's understanding of the unique challenges faced by racial and ethnic minorities, sexual and gender minorities, immigrants, individuals with disabilities, and individuals living in poverty continues to expand. However, awareness of the difficulties individuals belonging to these groups face is necessary but not sufficient for addressing them. We must develop interventions that meet the needs of these specific populations and ensure equal access to high-quality, culturally sensitive care.

In this special issue, we present a diverse group of articles, including commentary, reviews, and empirical work, that address stigma in mental health and its treatment, both broadly and among specific highly stigmatized groups. This collection of work includes clinical recommendations, novel paradigms for societal attitude change, and interventions aimed at decreasing stigma. This is a vast problem that cognitive and behavioral clinicians and researchers alike should be paying attention to and seeking to address in their work. We thank the authors for their meaningful contributions and hope the ABCT membership will find this special issue to be informative and thought provoking.

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Stigma, Humanization, and Mental Health: The Next Frontier

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IN THIS BRIEF OVERVIEW for *the Behavior Therapist*, I discuss issues related to the essential topic of the continuing stigmatization of mental illness. Given what seems to be greater openness in society, it might appear that such stigma no longer constitutes a problem, as we near the end of the second decade of the 21st century. Yet key data, along with examination of cultural practices, tell a different story, both in the U.S. and internationally (Pescosolido et al., 2013). Indeed, I contend that the destigmatization—fostered by inclusion and humanization—of individuals and families dealing with mental illness remains one of the final frontiers for human rights (Hinshaw, 2017a).

What are the relevant data? There's no question that the U.S. public knows, at a factual level, far more about mental illness than was the case a generation or two ago. Reasons undoubtedly include the presence of psychology courses in high schools, greater media attention, and a general societal increase in mental health "literacy." Discouragingly, however, public attitudes—in terms of low desired social contact with vs. high social distance from individuals with mental disorders—have essentially remained flat (see review in Hinshaw, 2007). Worse, three times more Americans now believe in the inevitable link between mental disorder and violence than was the case during the middle of the last century, potentially attributable to deinstitutionalization without adequate community-based care—as well as to pervasive media images of deranged-looking, young male school shooters as the unfortunate public face of mental illness.

Even more, despite the growing tendencies for U.S. citizens to endorse neurobiological views of serious mental disorders, such underlying beliefs are almost completely unrelated to stigma-related attitudes (Pescosolido et al., 2010). In fact, contradicting core tenets of attribution theory, through which ascribing undesirable behavior to uncontrollable causes like illness or genetic liability should reduce blame and stigma, meta-analyses reveal that holding such beliefs actually *increases* pessimism and desire for social distance (Kvaale, Haslam, & Gottdiener, 2013). Reducing mental illness to the product of aberrant genes neither tells the whole truth about the multiple, interacting causes for mental-health conditions, nor does it provide a panacea in terms of stigma reduction.

Mental illness stigma is a fascinating, complex, and hugely depressing topic (see Corrigan, Druss, & Perlick, 2014; Hinshaw, 2007; Hinshaw & Stier, 2008; Link & Phelan, 2001). Space allows mention of only a few salient facets of this area of investigation and social action. My hope is that the rapid-fire points and arguments below may inspire those in the mental health fields to become more aware of its pervasiveness, power, and hugely negative impact on our entire enterprise. Despite their generally enlightened perspectives, cognitive-behavioral scientists and practitioners are not immune to stigma.

Basic Definition

Stigma literally signifies a brand or mark, burned into the skin of members of devalued groups, to indicate their low social status and disgrace (Hinshaw, 2007). Most stigma today is inferred from group membership rather than reflecting a literal "brand." Nonetheless, it is still toxic, placing strong limits on human potential for those in the devalued outgroups. Stigma involves social power, as disenfranchised

social groups often have little "capital" to combat their stigmatization. Tellingly, mental disorders have been stigmatized throughout histories and across nearly all cultures studied (Hinshaw, 2007).

Comprising stereotypes, prejudicial attitudes, and discriminatory actions, stigma is a multifaceted construct. Stigma tends to be quite pervasive, in that nearly all aspects of an individual's "being" and value are typically inferred from the devalued group membership he or she embodies. Once believed to be the product of a minority of society (e.g., the subgroup of actual bigots), at least some degree of stigma is currently conceptualized as nearly universal, the product of everyday social cognition that humans apply to members of those outside their in-group. Some pervasive stigmas may even have evolutionary roots, with natural selection having created mental "modules" to protect against potential contagion or exploitation (Kurzban & Leary, 2001). As a result, reducing stigma and enhancing acceptance is no simple matter.

Two key corollaries follow. First, though not inevitable, members of stigmatized groups often internalize the pernicious attitudes of mainstream society. Along with structural barriers (e.g., a lack of parity for mental health care; lack of evidence-based practitioners in many regions), such *self-stigma* related to mental disorder is predictive of reduced help-seeking. Second, Goffman (1963) coined the term *courtesy stigma* to refer to societal tendencies to castigate and stigmatize anyone associated with a member of a stigmatized group. Such a pervasive "shadow" cast by stigma clearly applies, in the case of mental disorder, to family members. Indeed, parenting practices were explicitly blamed as causing autism, schizophrenia, anxiety disorders, and most other forms of mental disorder during much of the 20th century (Hinshaw, 2017b). As well, mental health professionals—scientists, clinicians, trainees, and the like—are also victims of such courtesy stigma. For example, are clinical psychology and psychiatry the most highly valued subfields of psychology and medicine? I sincerely doubt it.

Consequences of stigmatizing actions from mental health scientists and professionals can be dire. The reports of all too many individuals with serious mental disorder about the sources of stigma they encounter typically focus on demeaning practices and low expectations stemming from the very clinicians treating them (see Wahl, 1999). In short, it behooves all who are engaged in the mental health enterprise, including those who practice and investigate CBT, to examine their own attitudes, practices, and expectations. Opening up dialogue with fellow professionals, and soliciting and acting on feedback from research participants and clients, can provide a great start.

Evidence and Impacts

A host of research (reviewed in Hinshaw, 2007) reveals that the general public strongly stigmatizes mental disorders and the people who confront these conditions. Indeed, mental illness, substance use, and homelessness are among the "bottom three" attributes a person can hold, prompting denigration and stigma (Hinshaw & Stier, 2008). Note, as well, that most relevant research on stigma utilizes overt attitude scales, which may well mask the even-higher levels of stigmatization held and conveyed implicitly and less consciously. Much remains to be done to understand the developmental roots of stigmatizing attitudes and practices from childhood through adulthood.

As well, examination of cultural practices reveals that a history of mental illness precludes being a viable marriage partner in many societies and allows nearly unthinkable ridicule in the public press around the world. At the level of state legislation, admitting to mental disorder may well remove the rights of voting, running for public office, serving on a jury, or maintaining custody of one's children (see Hinshaw, 2007). The snake-pit public hospitals prevalent in the U.S. during much of the 19th and 20th centuries may have been closed across much of the U.S. and many parts of the world—but the lack of systematic, programmatic community care in their place is an ongoing tragedy.

With respect to consequences of mental illness stigma, negative impact on help seeking (or staying in treatment) has been documented, as noted above. The ultimate paradox here, of course, is that evidence-based treatment can and does relieve symptoms and impairments. Thus, stigma may become a huge wedge against successful intervention, in a kind of self-fulfilling prophecy that guarantees its own continuation. The consequences of serious forms of mental disorder are bad enough—e.g., greatly reduced life expectancy, diminished income and quality of life, family distress (Hinshaw, 2017b)—yet when stigma is added to the mix, the situation can quickly become nearly intolerable.

What Can Be Done?

As with any social problem, solving the stigma of mental illness cannot occur through any one tactic or strategy alone. Multiple levels of effort will be required (for a U.K. example of multilevel approaches, see Evans-Lacko, Corker, Williams, & Thornicroft, 2014). Starting with "top-down" strategies, we need to ensure parity of mental health coverage—as well as adequate health care overall—to enforce antidiscrimination laws (such as the Americans With Disabilities Act). As highlighted above, we also need to assure far better training in and dissemination of evidence-based clinical care for professionals and paraprofessionals.

Perhaps exemplifying "middle-out" tactics, a far less stereotyped set of media images could go a long way. Indeed, virtual or actual contact is arguably the optimal means of overcoming prejudice and discrimination (Pettigrew & Tropp, 2006), particularly when contact is regular and linked to equal social footing.

In terms of "bottom-up" strategies, people of all stripes should be allowed (even encouraged) to disclose their own, or their families', struggles and triumphs related to mental disorder. At the same time, those in the mental health field must understand that communication with those experiencing mental health problems is a two-way street (rather than a doctor-patient, hierarchical diatribe); that recovery is a distinct possibility even if cures are still not yet in sight; and that questioning the kinds of authoritarian, "us-versus-them" training that may have been part of their training is essential to level the playing field.

In the end, I hold to the belief that the ultimate answer lies in the process of humanization of those with mental disorders, along with their family members and associates. Cancer was rarely, if ever, mentioned in obituaries during the early part of the 20th century. Indeed, it was believed to be a shameful disease brought on by weak personal will. As we all know, fighting cancer is now a major social cause—largely through greater understanding of its origins and via multiple testimonials from all kinds of individuals and families.

My purpose in writing my latest book, *Another Kind of Madness: A Journey Through the Stigma and Hope of Mental Illness* (Hinshaw, 2017a), was expressly to humanize serious mental illness. My warm, philosopher father had lifelong, misdiagnosed bipolar disorder, brutally "treated"

in horrific public mental facilities. Somehow, he overcame his episodes and thrived. When my sister and I were young, he wondered what to tell us of his periodic, lengthy absences. Yet, according to the dictates of his lead psychiatrist, he was expressly forbidden to ever mention the topic. The consequences of this doctor-enforced silence for me and for our whole family comprise the subject matter of the book. In addition, I describe the sense of both mission (to study clinical and developmental psychology and become a clinical psychologist) and terror (believing I'd be next in line for hospitalization) I experienced once Dad finally divulged his past.

Interlaced with commentary on stigma, this trade book aims to dispel myths and convey a deeply human story of shame, redemption, and hope for a more open future. Only as I've become more comfortable, over the years, in opening up our family's story, have I begun to integrate my research, clinical, and human-interest motivations. A growing number of such testimonials give reason, I believe, for optimism regarding the future of mental health research care and research, around the world.

Final Thoughts

Overall, despite huge strides both scientifically and clinically, the mental health crisis remains a dire reality. Prevalence is growing, not shrinking; the majority of relevant individuals and families do not receive treatment (much less optimal, evidence-based care); and economic productivity and personal thriving take a huge hit when mental disorder is part of the picture. Stigma is the underlying issue in this regard, limiting the prioritization of mental health and keeping the entire topic enshrouded in shame and silence to this day.

Young people (e.g., teenagers) may well be the key to turning the corner, the way they've been for reversing attitudes toward gay marriage over the past 20 years in our nation. Much of my stigma-related work encompasses the goal of preventive strategies for all high-school students to open dialogue and unleash their natural empathy, compassion, and social activism, related to acceptance and humanization (see Murman et al., 2014).

I deeply appreciate the editorial team of *the Behavior Therapist* for giving me the opportunity to shed light on what I consider the rate-limiting factor for the entire mental health arena—that is, taking on the final frontier for human rights, in the form of humanizing, destigmatizing, accepting, and treating mental illness—the latter with integrated, biopsychosocial perspectives.

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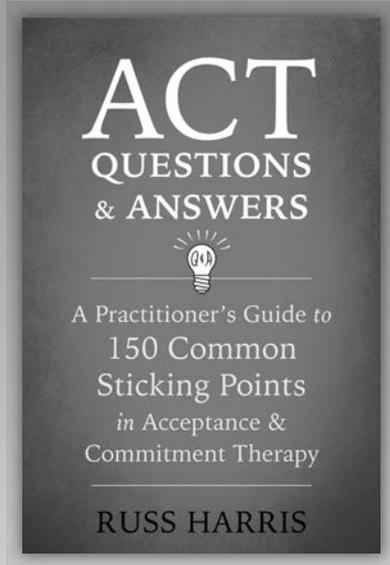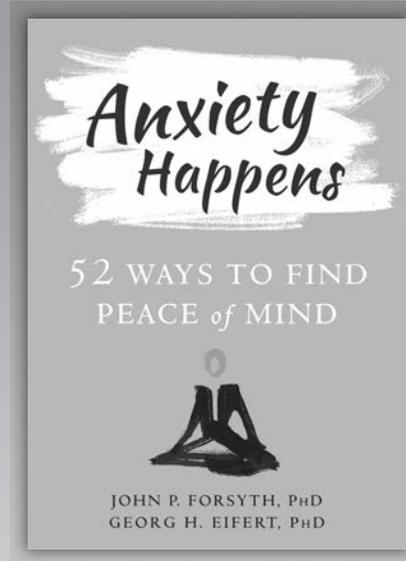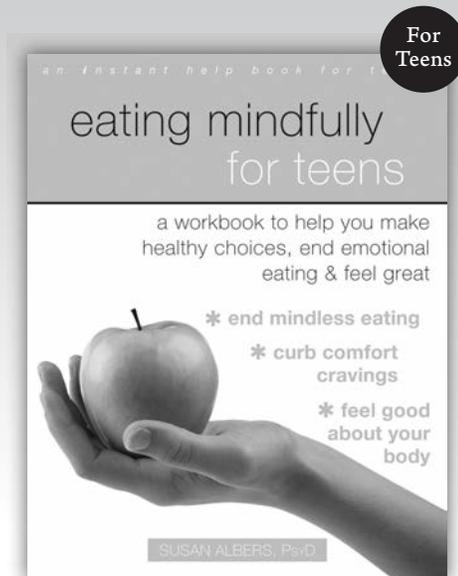
Biogenetic Etiologies of Mental Disorders: Stigma, Mental Health Literacy, and Prognostic Pessimism

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STIGMA ASSOCIATED WITH MENTAL disorders contributes to significant harm. Various attempts to reduce stigma are under way, including emphasizing mental health literacy (MHL). MHL refers to knowledge about mental disorders, including their causes, symptoms, and treatments. While admirable, there are reasons to believe that emphasizing MHL may have unintended, negative consequences. This article provides a brief overview of stigma associated with mental disorders, reviews MHL and some of its central components, summarizes the relationship between biogenetic etiologies of mental disorders and stigma, then reviews the literature exploring the relationship between biogenetic etiologies and prognostic pessimism. The evidence reviewed suggests double-edged effects of biogenetic etiologies of mental disorders that should be considered by MHL programs, mental health professionals, and health policy organizations and advocates.

Stigma

Stigma is a concept used to describe a collection of processes related to social hierarchies, social judgment, discrimination, and shame (Goffman, 1963; Martinez & Hinshaw, 2016). It has been defined as an attribute conveying a socially devalued identity that can be visible or concealed (Crocker, Major, & Steele, 1998). In most instances, stigma attaches to individuals and groups, acting as a marking or branding indicating badness, danger, and otherness. Pescosolido and Martin (2015) argued stigma requires four components: distinguishing differences, negative attributions, separation ("us" and "them"), and discrimination. Distinctions of stigma's manifestation include anticipated stigma, internalized stigma, perceived stigma, endorsed stigma, and treatment stigma (Clement et al., 2016). Stigmatized attributes or characteristics vary within cultures and over time. Being left-handed was stigmatized (McManus, 2004). Yet, stigma associated with being left-handed has dramatically reduced. This shows that attitudinal changes toward stigmatized traits can go through pronounced changes. Such a change is hoped for regarding stigma associated with mental disorders.

Mental disorders are widely stigmatized by both the public (Schomerus et al., 2012) and those experiencing mental disorders (Corrigan, Watson, & Barr, 2006). Stigma contributes to a variety of harmful impacts, including reduced help-seeking behavior (Casados, 2017; Clement et al., 2014; Corrigan, Druss, & Perlick, 2014), increased distress via lower levels of hope, empowerment, self-esteem, and self-efficacy (Livingston & Boyd, 2010), and harming social opportunities via discrimination in employment (Hipes, Lucas, Phelan, & White, 2016), housing (Corrigan, 2004), and criminal justice (Council of State Governments, 2002).

Early research on stigma associated with mental disorders drew upon knowledge from attribution theory. Attribution theory concerns explanations of behavior and how those explanations influence perception (Boysen & Vogel, 2008; Kelley & Michela, 1980). Previous research identified that an important component of attributions associated with stigma are attributions of onset-uncontrollable and onset-controllable (Weiner, 1993; Weiner, Perry, & Magnusson, 1988). Onset-uncontrollable stigmas are associated with conditions believed to be outside the responsibility of the person, such as being diagnosed with Alzheimer's disease or becoming blind, and are associated with pity, liking, and helping behaviors. Conversely, onset-controllable stigmas are associated with conditions believed to be the responsibility of the person, such as being obese or being diagnosed with AIDS, and are associated with lack of pity, decreased liking, anger, and less likelihood to help (Crandall & Moriarty, 1995; Weiner, 1993).

Corrigan (2000) drew upon this research and applied it to mental disorders. Corrigan identified research demonstrating that mental disorders are viewed as more controllable than physical illness. From this perspective, mental disorders can be seen as moral failures or personal weaknesses. Corrigan contrasted this view with a biological model of mental disorders, which is more consistent with the idea that mental disorders are onset-uncontrollable and thus not moral failures or personal weaknesses. Corrigan proposed that this research suggested changing attributional judgments about mental disorders through educational efforts may decrease stigma associated with mental disorders.

Mental Health Literacy and Stigma

Many aspects of MHL appear to have followed Corrigan's (2000) suggestion. Jorm (2012) defined MHL as "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention" which is "linked to the possibility of action to benefit one's own mental health or that of others" (p. 182; see also Jorm et al., 1997). A more recent definition of MHL provided by Kutcher, Wei, and Coniglio (2016)—prominent examples of MHL researchers—stated: "understanding how to obtain and maintain positive mental health; understanding mental disorders and their treatments; decreasing stigma related to mental disorders; and, enhancing help-seeking efficacy" (p. 155). Note the emphasis on reduced stigma in the latter definition: Kutcher et al. emphasized the data identifying stigma's variety of harmful consequences, especially obstructing help-seeking behavior, and, thus, decreasing stigma is a central component of refined understandings of MHL.

Kutcher, Bagnell, and Wei (2015) argued schools are a primary vehicle for increasing MHL, and Kutcher and others developed a school curriculum designed to increase MHL. Research driven by Kutcher and colleagues has identified that their MHL curriculum increased MHL and decreased stigma in both educators and students (Mcluckie, Kutcher, Wei, & Weaver, 2014; Kutcher, Wei, McLuckie, & Bullock, 2013; Kutcher, Wei, & Morgan, 2015; Milin et al., 2016).

However, despite the important positive contributions MHL curriculum appear to have, it is important to note that the MHL curriculum promoted by Kutcher and colleagues may also contribute to unintended negative consequences via inadvertently contributing to increased stigma and increased prognostic pessimism. To see how, it is important to begin by noting that Kutcher and Wei's (2017) MHL curriculum consistently emphasizes biogenetic etiologies of mental disorders. For instance, Kutcher and Wei stated: "A mental illness is a health condi-

tion arising from changes in usual brain functioning" (p. 9), "Mental illnesses have complex causes that include a biological basis and are therefore not that different from other illnesses" (p. 9), mental disorders "Derive from perturbations in the function of various brain circuits" (p. 16), "When the brain is not functioning properly… and the person experiences problems that interfere with their life in a significant way, these circuits are disrupted and the person may develop the signs and symptoms of a mental disorder" (p. 17), "… brain function determines both mental health and mental illness" (p. 67), "Mental illnesses have complex causes including a biological basis and are therefore not that different from other illnesses" (p. 67), and "Mental illnesses are the result of changes that arise in usual brain function as a result of a complex interplay between a person's genes and environment. When a person has a mental disorder, their brain is not working as it should be" (p. 73). Supplementary material to Kutcher and Wei asserted that "Mental illnesses are not caused by a "moral failing" or laziness" (Teenmentalhealth.org, 2017, p. 7), "Mental illness is a brain disorder and not a per-

sonal weakness" (p. 15), mental disorders are caused when "The brain is not functioning as it is supposed to function," and "In a mental disorder, some of the various brain circuits that underlie all brain functions are not working the way they should be. These disturbances in the brain circuits create the signs and symptoms of mental illness" (Teenmentalhealth.org, 2017, p. 13). Kutcher and Wei make it clear they conceptualize mental disorders as brain disorders. By emphasizing that mental disorders are brain disorders, not personal weaknesses or moral failings, Kutcher and Wei seem to adopt an attribution theory approach to reducing stigma.

Biogenetic Etiologies and Stigma

Despite the literature identified above, which suggests that MHL programs can decrease stigma, substantial evidence from both surveys and experimental studies suggests that emphasizing biogenetic etiologies of mental disorders does not decrease stigma and pose the danger of increasing it. Angermeyer, Holzinger, Carta, and Schomerus (2011) conducted a systematic review of representative population studies

measuring beliefs about mental disorders and attitudes toward people experiencing mental disorders. Their review identified 33 studies—from Europe, North America, Asia, South America, Africa, and Australia—including 72,963 respondents. Their review focused on acceptance of people with mental disorders, such as depression, schizophrenia, and alcoholism, measured via desire for social distance, perceived dangerousness, and unpredictability. The authors identified that biogenetic explanations of mental disorder are not significantly associated with either increased or decreased acceptance of people with mental disorder, though there was a desire for increased social distance associated with biogenetic explanations of schizophrenia. The authors also identified that public attitudes about responsibility (e.g., weak character or lack of willpower) are less powerful in relationship with desire for social distance than perceived dangerousness and unpredictability. Further, because the authors point to numerous studies identifying biogenetic explanations increasing stereotypes of dangerousness and unpredictability, they concluded that "promulgating biogenetic causal models of

mental illness cannot be regarded as a rational evidence-based strategy to decrease individual discrimination against people with mental illness, but rather entails a risk of increasing stigma" (p. 370).

Kvaale, Haslam, and Gottdiener (2013) conducted a series of comprehensive meta-analyses investigating the relationship between biogenetic etiologies and stigma that identified 28 eligible experimental studies. Kvaale et al. divided their conceptualization of stigma into four categories, including blame, perceived dangerousness, desire for social distance, and prognostic pessimism, and then conducted a meta-analysis for each of these areas. Their meta-analyses identified that biogenetic explanations of mental disorders tend to decrease blame, have no effect on desire for social distance, increase perceptions of dangerous, and increase prognostic pessimism. The authors concluded that their research suggested mixed-blessings (see also Haslam & Kvaale, 2015) of emphasizing biogenetic etiologies of mental disorders. On one hand, congruent with attribution theory and suggestions found in Corrigan (2000), biogenetic etiologies reliably reduced blame associated with mental disorders. Kvaale et al., argued that since blame can be a problematic and unproductive component of those experiencing mental disorders, reducing it could have significant clinical impact. At the same time, their meta-analyses also identified an increase in perceived dangerousness and prognostic pessimism, which can also affect clinical trajectory and public attitudes. Thus, they argued that it is difficult to draw firm conclusions about the implications of their research over and beyond two important upshots. First, it is unlikely that biogenetic explanations of mental disorders will cure stigma. Second, it is problematic if mental health professionals and educators withhold information surrounding the ways in which biogenetic explanations may contribute to increased perceived dangerousness and increased prognostic pessimism.

When considering Angermeyer et al. (2011) and Kvaale et al. (2013), it is difficult to make sense of the claim from Kutcher, Wei, and Morgan (2015) that MHL curriculum successfully reduces stigma. That is, the claims of Kutcher et al. (2015) seem to contradict the meta-analyses reviewed above. Angermeyer and Schomerus (2017) suggested that a challenge of stigma research is that some instruments used to measure stigma have questionable psychometric properties or vary in the way stigma

is conceptualized. To illustrate this, consider that in Kutcher et al., stigma is measured via eight items, ranked on a 7-point Likert scale ranging from *strongly disagree* to *strongly agree*, which includes statements as varied as "A mentally ill person should not be able to vote in an election" to "Most people who have a mental illness are dangerous and violent" to "Mental illness is usually a consequence of bad parenting or poor family environment." The Cronbach alpha for internal consistency of their sample was 0.652.

Nevertheless, Corrigan (2016)—a leading researcher studying mental health stigma—argued that, taken as a whole, current stigma research suggests that MHL programs which frame mental disorders as brain disorders have unintended consequences. That, is, while consistently reducing blame, emphasizing mental disorders as brain disorders also reliably increases perceived dangerousness and prognostic pessimism. Thus, MHL programs that emphasize biogenetic etiologies are unlikely to be a cure for stigma.

Biogenetic Etiologies and Prognostic Pessimism

While biogenetic etiologies of mental disorders have a varied effect on stigma, research suggests that biogenetic etiologies of mental disorders have a consistent, significant negative impact on prognostic pessimism. That is, individuals who more strongly endorse biogenetic etiologies believe that mental disorders will have more severe symptoms and last longer. Below is a brief review of this literature.

Farina, Fisher, Getter, and Fischer (1978) provided students with one of two booklets. One booklet explained mental disorders as a disease (e.g., biochemically caused) and the other booklet explained mental disorders as caused by social learning deficits. Farina et al. identified that a disease etiology of mental disorders—compared to a social learning etiology—caused increased prognostic pessimism via increased perceptions of helplessness to overcome emotional distress.

Phelan, Cruz-Rojas, and Reiff (2002) conducted a cross-sectional study including 56 individuals. In their study they provided a vignette of an individual experiencing symptoms of schizophrenia and then asked participants etiological questions about these symptoms. They found that participants with stronger genetic beliefs about etiology had decreased levels of blame worthiness and increased levels of

prognostic pessimism toward the individual described in the vignette.

Lam, Salkovskis, and Warwick (2005) administered questionnaires to 110 non-clinical participants. Participants were allocated to one of three questionnaires which described the etiology of psychiatric conditions in either biological/genetic, psychological/environmental, or cause unknown. Lam et al. identified that those in the biological/genetic group had significantly increased prognostic pessimism related to decreased perceptions of curability and increased perceptions of psychiatric conditions as disabling.

Phelan, Yang, and Cruz-Rojas (2006) conducted a survey with 601 respondents. Within the survey, participants were read a vignette describing an individual with symptoms of depression or symptoms of schizophrenia. After being read the vignette, participants were asked, "In your opinion, how likely is it that [the individual described in the vignette] might be caused by a genetic or inherited problem?" (p. 383). The authors found that genetic etiological beliefs led to increased willingness to participate in biomedical treatment (e.g., hospitalization or medication) and increased prognostic pessimism.

Lam and Salkovskis (2007) conducted a study in which 49 anxious and depressed clients were assigned to one of three conditions. In each condition, the client was exposed to a video portraying a client with panic disorder. The conditions varied regarding the explanation of panic disorder. Explanations included biological, psychological, or unclear (control condition) explanations. They found that the biological condition led to increased prognostic pessimism when compared to the psychological condition.

Deacon and Baird (2009) administered one of two possible questionnaires to 90 undergraduate students. The participants were asked to imagine they were feeling depressed and were seeking help. All questionnaires included sections eliciting demographic and mental health history information. All questionnaires also included two explanations of depression, a chemical imbalance explanation and a biopsychosocial explanation. One of the questionnaires listed the chemical imbalance explanation first and the other listed the biopsychosocial explanation first. After each explanation, participants were asked to respond on a Likert scale to questions regarding stigma, prognosis, treatment efficacy. The authors found that the chemical imbalance explanation was associated

with decreased stigma, increased prognostic pessimism, and more positive treatment expectancies of medication.

Lebowitz, Ahn, and Nolen-Hoeksema (2013) conducted three studies. The first two studies included 148 participants who were administered the Beck Depression Inventory-II (BDI-II). Individuals who scored higher than 15 were then provided items regarding 10 causes of their depressive symptoms, ranging from biochemical to genetic to psychological and social. Participants then provided responses regarding expected duration of symptoms. The authors identified that individuals who more strongly attribute depressive symptoms to biochemical and genetic causes had increased prognostic pessimism. The third study was identical to the first two but included individuals with scores 15 or lower on the BDI-II and included a new section in which participants were randomly assigned to one of three conditions: malleable, biological illness, and control.

Participants in the malleable and biological illness conditions watched a 6-minute video. In the malleable condition, the video emphasized epigenetics. In the biological illness condition, the video emphasized that depression runs in families and that the brains of depressed individuals and nondepressed individuals are different. As in the first two studies, the authors found that individuals who more strongly attribute depressive symptoms to biochemical and genetic causes had increased prognostic pessimism. The authors also identified that participants in the malleability condition had decreased prognostic pessimism and increased perceived agency regarding mood.

Read, Cartwright, Gibson, Sheils, and Haslam (2014) administered a questionnaire to 1,829 participants, all of whom had been prescribed an antidepressant medication within 5 years. The questionnaire was designed to gather information about participants' beliefs surrounding the causes of

depression, antidepressant medication, and pharmaceutical companies. The authors identified that biogenetic causal beliefs were associated with greater prognostic pessimism.

Kemp, Lickel, and Deacon (2014) conducted a study with 73 individuals who reported currently or previously experiencing a depressive episode, measured with an online screening tool. The participants were randomized into either the chemical imbalance condition or the control condition. Participants in both conditions were administered the Rapid Depression Test (RDT), a credible assessment tool designed to determine if an individual's depressive episode was caused by a chemical imbalance. The RDT was conducted via a mouth swab administered by a lab-coat-wearing research assistant. After the mouth swab, the research assistant left the room for 10 minutes and returned with a graphic readout depicting either a deficiency of serotonin (the chemical imbalance condition)

or serotonin within normal limits (control condition). The authors identified that between-group comparisons yielded increased prognostic pessimism and decreased mood regulation expectancies within the chemical imbalance condition. Participants in the chemical imbalance condition also rated pharmacotherapy more credible and effective than psychotherapy.

Lebowitz, Pyun, and Ahn (2014) conducted a study with 351 participants designed to explore the relationship between a biological etiology of generalized anxiety disorder and prognostic pessimism. All participants read a paragraph describing the symptoms of generalized anxiety disorder. Participants in the biological condition subsequently read an empirically based biological explanation of generalized anxiety disorder. Participants in the control condition did not read an explanation. Participants in both conditions then were asked to imagine a person with generalized anxiety disorder and respond to questions designed to measure prognosis and responsibility. The authors identified that participants in the biological condition attributed less personal responsibility for symptoms of generalized anxiety disorder and had increased prognostic pessimism for symptoms of generalized anxiety disorder.

Schroder, Dawood, Yalch, Donnellan, and Moser (2015) conducted two studies measuring the relationship between implicit emotion theory and symptoms, emotion regulation, and treatment choice. The authors describe implicit emotion theory as encompassing entity and incremental theory. Entity theory takes abilities and traits to be resistant to change and are often attributed to genetic and/or biological causes. Incremental theory takes abilities and traits to be responsive to learning, thus able to improve and grow with motivation and effort. In these studies, 598 participants completed assessments designed to measure implicit theory of intelligence, emotion, and theories of anxiety. The authors identified that entity theory of anxiety was associated with more anxious symptoms, depression, and maladaptive behavior. Entity theory of emotion was associated with decreased cognitive reappraisal, meaning that individuals who more strongly endorse entity theory are less likely to participate in reframing their emotional experience.

Farrell, Lee, and Deacon (2015) conducted a study in which 216 participants completed a variety of assessments designed to measure eating-disorder-related attitudes and symptoms. Participants were then randomly assigned to one of three conditions: biological illness condition, which emphasized brain chemistry in the etiology of eating disorders; malleable condition, which emphasized brain chemistry but stressed epigenetics; and cognitive-behavioral condition, which emphasized cognitive-behavioral components of eating disorders. The authors identified that the biological illness condition led to increased prognostic pessimism in comparison to the two other conditions.

Lee, Farrell, Mckibbin, and Deacon (2016) conducted a study in which participants who had experienced symptoms of major depressive disorder or social anxiety disorder were randomly assigned to view one of three audiovisual presentations that presented an etiological explanation of major depressive disorder or social anxiety disorder from either a biological, cognitive-behavioral, or combination biological and cognitive-behavioral perspective. After viewing the presentation, participants answered a variety of questions designed to measure etiological beliefs, prognostic pessimism, and self-blame. The data did not yield a statistically significant difference in levels of prognostic pessimism in the three groups.

The studies described above identify that biogenetic etiologies of mental disorders are consistently related to increased prognostic pessimism. This relation has been found in surveys and experimental studies. However, the research in this area is relatively sparse and existing research has at least one significant shortcoming: Although studies consistently find a statistically significant relationship between biogenetic etiologies and prognostic pessimism, the research has not investigated the potential magnitude of clinical impacts associated with this relationship. Future research might address this limitation by conducting studies including individuals participating in treatment for mental disorders and measuring their etiological beliefs, prognostic pessimism, and treatment outcomes.

Discussion

It is challenging to comprehensively integrate the research above into confident clinical implications and/or recommendations. Haslam and Kvaale (2015) rightly pointed out that biogenetic etiologies confer mixed blessings: decreased blame but increased prognostic pessimism. It is possible that decreased blame, especially decreased self-blame of those experiencing mental disorders, may have clinically tangible effects via reduced distress. At the same time, biogenetic etiologies are consistently associated with and cause increased prognostic pessimism. This is important because an individual's expectations for improvement are a significant contributor to their improvement. Individuals who expect to do better, do better (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011; Greenberg, Constantino, & Bruce, 2006; Rutherford, Wager, & Roose, 2010; Wampold & Imel, 2015). Future research would likely benefit those experiencing mental disorders by identifying the clinical magnitude of these effects.

Further complicating this picture is that biogenetic etiologies are strongly associated with preference for pharmacological treatment (Speerforck, Schomerus, Matschinger, & Angermeyer, 2017). This is concerning if, as various lines of evidence have argued, pharmacological treatments for depression and anxiety disorders are not generally superior to alternative treatments (Cuijpers et al., 2013; Khan, Faucett, Lichtenberg, Kirsch, & Brown, 2012; Margraf, & Schneider, 2016; Sugarman, 2016) and have a higher risk of adverse effects (Andrews, Thomson, Amstadter, & Neale, 2012; Hengartner, 2017; Jakobsen et al., 2017; Moncrieff, 2018).

Finally, there are concerns about the way in which the MHL movement and research institutions such as the National Institute of Mental Health hold and promote philosophic assumptions emphasizing biogenetic framing of mental disorders. Biogenetic etiologies of mental disorders are ascendant (Deacon, 2013; Lebowitz, 2014). It is increasingly asserted that mental disorders are best understood as disordered brain circuits and that this understanding will, with the help of research programs like the Research Domain Criteria Project, yield improved diagnostic accuracy and treatment outcomes (Insel, 2014). However, despite large research efforts, there continues to be a lack of clinically actionable biomarkers for mental disorders such as anxiety, depression, and schizophrenia (Insel, 2015; Ross, 2013), and commentators have continued to raise concern surrounding the way these biogenetic assumptions can negatively impact research and practice (Lilienfeld & Treadyway, 2016; Schultz, 2015).

Until future research can make inroads on the various unknowns identified above, there appears to be at least one promising

upshot: emphasizing malleability. As reviewed earlier, Lebowitz et al. (2013) identified that emphasizing malleability of biological factors (i.e., epigenetics) can have beneficial impacts on prognostic pessimism. Subsequent research has supported their original findings (Lebowitz & Ahn, 2015; Lebowitz & Ahn, 2018). Thus, reviewing and communicating information on epigenetics and brain plasticity is likely beneficial for those experiencing mental disorders.

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Three Tweets to the Wind: Providing Context Via Simulated Social Media to Decrease Stigma Toward Problematic Drinking

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PROBLEMATIC DRINKING (PD) is a public health issue that has troubled human societies for generations (Room, Babor, & Rehm, 2005). According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2015), slightly over 50% of Americans (approximately 139.7 million persons in the U.S.) over the age of 12 report being current drinkers of alcohol. Of these people, approximately 17 million meet criteria for an alcohol use disorder (Center for Behavioral Health Statistics and Quality, 2015). Although not all, or even a majority, of alcohol users develop an alcohol use disorder, PD deserves attention as it interferes with functioning in several areas (e.g., social, physical, economic; Bouchery, Harwood, Sacks, Simon, & Brewer, 2011; U.S. Department of Health and Human Services, 2010). For example, PD can lead to aggression and interpersonal difficulties, trouble with authority figures, and legal issues (e.g., driving under the influence; Berkowitz & Perkins, 1986). PD can also worsen over time, especially for individuals under stress without additional coping strategies (Windle & Windle, 2015).

Stigma of PD

PD is associated with several stigmatizing attitudes. In his seminal text introducing stigma within social psychology, Goffman (1963) defines stigma as a way of separating and reducing the individual "from a whole and usual person to a tainted, discounted one." Compared to other mental health disorders, individuals who suffer from alcohol dependence are more likely to be blamed, feared, and socially rejected (Schomerus et al., 2011). Furthermore, individuals at risk for alcohol abuse or treatment are perceived as unstable, incompetent, unpredictable, and personally responsible for their actions (Fortney et al., 2004).

Individuals who are stigmatized experience discrimination in multiple domains of their lives, which can affect psychological well-being, physical health, and social status (Major & O'Brien, 2005). This, in turn, can lead to self-fulfilling prophecies and the maintenance of stigmatizing attitudes (Jussim, 2000). Stigma also serves as a barrier to treatment, including therapy and 12-step meetings. Further, stigma reduces the likelihood of remaining sober and of limiting alcohol use (Corrigan, 2004). Stigma contributes to social and economic disadvantages for individuals in recovery from problematic substance use (see Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008, for review of negative impact of enacted stigma for substance use broadly).

Attribution Error

Individuals who hold stigmatizing beliefs about PD tend to think that problematic drinkers are personally responsible for their problems (e.g., Fortney et al., 2004; Schomerus et al., 2011). The determination that PD and its negative outcomes are caused by the person is labeled a dispositional attribution (Jones & Davis, 1965). Research on the fundamental attribution error (FAE; Ross, Greene, & House, 1977) suggests individuals are prone to overly attribute behavior to dispositional characteristics while ignoring potential external causes of behavior. Although attitudes, and attribution errors, have historically been conceptualized as enduring and universal, it is more likely that these constructs are both context-specific and context-sensitive (Schwarz, 2007). This has implications for interventions that aim to decrease stigma and behaviors like PD. In fact, there is some evidence that simply providing individuals with more contextual information may decrease the likelihood of committing the FAE (e.g., Quattrone, 1982) and the strength of stigmatizing attitudes (e.g., Lebowitz & Ahn, 2012). Further, these context-adding interventions seem more effective at decreasing stigma than protest-oriented stigma reduction methods, especially if the context added creates a positive, personal connection (Couture & Penn, 2006; Link & Cullen, 1986; Luoma et al., 2008).

Attributional complexity. When individuals are asked to quickly analyze a situation with limited information, there is a tendency to attribute behavior to less complex, and often singular, causes (Fletcher et al., 1986). As a result, the information that is most salient and easiest to understand may take precedence over more complex explanations. For example, in a study in which participants were to respond to potential causes for lung cancer in a hypothetical patient, their attitudes were equally stigmatizing in conditions that attributed the cancer to both genetic and smoking factors and smoking alone (Hamann, Howell, & McDonald, 2013). Often, the simplest explanation corresponds to dispositional attributions; and individuals lower in attributional complexity are more likely to commit the FAE (Devine, 1989; Follett & Hess, 2002).

Individuals low in attributional complexity support more punitive consequences (e.g., death penalty), are less supportive of rehabilitation efforts, and endorse more racist attitudes (Tam, Au, & Leung, 2008). In the context of a criminal trial, these individuals are more likely to find a defendant guilty before and after they are presented with evidence, and they are more confident in their decision (Pope & Meyer, 1999). A complex attributional style, in contrast, is related to more open and nuanced attitudes, such as acknowledging the existence of subtle racism (Reid & Foels, 2010). Individuals high in attributional complexity tend to have stronger perspective-taking skills and empathic concern (Joireman, 2004), and are perceived as more open, expressive, and socially skilled (Fast, Reimer, & Funder, 2008). Differences in attributional complexity may therefore impact how sensitive individuals are to increasing contextual information. It was hypothesized that this would be the case in the present study.

Intolerant Beliefs

Depending on a variety of factors, contextual information may be viewed as more or less important by an individual. Further, it was hypothesized that tolerance may play a role in committing the FAE. Some individuals may be more prone to intolerant beliefs across a variety of social domains (Zick et al., 2008). Those with a generally intolerant belief system tend to perceive the world as a dangerous and threatening place. These individuals are more likely to engage in inflexible thinking, to be unwilling to consider other perspectives, and to perceive their in-group as superior to other groups (Aosved, Long, & Voller, 2009; Cohrs, Kampfe-Hargrave, & Riemann,

2012; Sibley & Duckitt, 2008). Additionally, they are more likely to support more severe criminal punishments (Ousey & Unnever, 2012), and to support policies that restrict the rights of sexual (Poteat & Mereish, 2012) and racial (Suthammanont, Peterson, Owens, & Leighley, 2010) minorities.

Present Study

PD is a highly stigmatized behavior, which is often attributed to dispositional factors as opposed to situationally based factors. The importance of understanding situational factors that contribute to an individual's behavior is empirically established. Further, recent clinical research gives us a clear picture of the importance of sensitivity to context in treating complex psychological phenomena (e.g., ACT; Hayes, Stroshal, & Wilson 1999). Given that many individuals are familiar with the interface of the social media platform Twitter, this project attempted to provide contextual information via faux tweets from a fictitious person with PD in an effort to reduce stigmatizing attitudes.

Hypotheses

It was hypothesized that participants' PD-related stigma would decrease after being given contextual information via faux tweets. It was further expected that individuals with higher attributional complexity and lower generalized intolerance would demonstrate greater reductions in PD related stigma than those with simple attributional complexity and higher generalized intolerance.

Methods

Participants

The data for this study came from a larger dataset. Participants were recruited using the online human research participant pool, Sona. This sample consisted of undergraduate students (N = 483) who were at least 18 years of age and fluent in English. No other exclusionary or inclusionary criteria were used for participant recruitment. Students received compensation for this study by receiving extra credit toward a psychology course of their choosing. A majority of the participants were female (74.5%; n = 359) and Caucasian/White (49.3%; n = 238). The sample distribution was approximately even across educational classification. Approximately half of the participants were psychology majors.

Measures

Participants completed measures of stigmatizing attitudes, attributional style, generalized intolerance, and a demographics questionnaire. In the larger study, participants received nine other scenarios similar to the one described in this paper. Additional measures assessing psychological distress and flexibility were also completed.

Stigma Ratings/Attitude Questionnaire. A list of 10 questions assessing stigma attitudes was presented to participants after each faux tweet. The same questions, which were, in part, modeled after the Attributional Questionnaire (Corrigan et al., 2003), were used for all scenarios. The questions were based on several domains of stigmatizing attitudes, including dispositional vs. situational attribution and several tolerance related factors. In addition, questions were written to be sensitive to acute changes over time. Therefore, these questions were intended to address the study hypotheses directly. Three questions from the full 10 were chosen for the present analysis. These were based on their broad applicability in terms of stigma. The three questions were: "I like this person"; "I think the situation is the person in the story's fault"; and "I would avoid this person." Participants rated how strongly they agreed with each statement from 0 (*not very much*) to 5 (*very much*) directly after each additional piece of contextual information was presented via faux tweet.

The Attributional Complexity Scale (ACS; Fletcher et al., 1986). The Attributional Complexity Scale is a 28-item self-report measure assessing the complexity of attribution. Participants rate how strongly they agree with each statement from -3 (*strongly disagree*) to +3 (*strongly agree*). The current study utilized only the complex vs. simple subscale. This subscale asked participants to choose complex or simple explanations for observed behavior. An example item is, "Once I have figured out a single cause for a person's behavior I don't usually go any further." The internal consistency for this subscale in the current sample, measured by Cronbach's alpha = .58. While this alpha is questionable, it is noteworthy that this subscale is only four items and it is not uncommon practice to use the individual subscales of the ACS in research (Fletcher et al., 1986). Higher scores on this measure indicate more complex attributional styles.

The Intolerant Schema Measure (ISM; Aosved et al., 2009). The Intolerant Schema Measure is a 54-item self-report measure, which assesses six areas of intolerance: sexism, racism, sexual prejudice, ageism, classism, and religious intolerance. Participants rate how strongly they agree with each statement from 1 (*strongly disagree*) to 5 (*strongly agree*). Example items include "Poor people are lazy" and "I welcome new friends who are gay," the latter of which is reverse scored. Items on the ISM correlate highly with measures of racism, sexism, ageism, classism, and religious intolerance (Aosved et al., 2009). It is common practice to look at individual subscales depending on the topic of interest, but for the purposes of this study, a total score encompassing all 6 subscales to produce a generally intolerant personal schema score was used. Higher scores represent a more intolerant schema. The internal consistency in the current sample, measured by Cronbach's alpha, was .97.

Demographic questionnaire. The demographic questionnaire assessed participants' identified gender, ethnicity, college major and classification in school, relationship status, income, parental SES, and psychotherapy attendance. Not all of these variables were examined for this study, although they are being examined in the larger study from which this project was derived.

Procedure

After signing up in the Sona system, participants were given access to a secure Qualtrics link through which they answered questionnaires confidentially. If participants did not agree to the informed consent on the first page, they were not able to proceed or to receive extra credit. Participants who consented completed several self-report measures and demographic questions, along with attributional scenarios. The order of questionnaires and scenarios was randomized. The university IRB, which is in compliance with federal guidelines, approved all procedures.

The current study evaluated participants' attitudes toward an individual in a specific scenario, which read, "The student sitting next to you bangs a fist on the desk and groans loudly." After participants read this, they completed a series of stigma ratings and open-ended questions about their attitudes and behavioral intentions toward the person in the scenario. Specifically, there were 10 items presented. After completing the 10 stigma ratings/attitude ques-

tions, participants were presented with the first of four tweets. Next, they completed the same 10 questions and then received the second tweet, resulting in a total of five data points. The tweets were designed to appear in a hierarchical fashion, with the first tweet providing the context of PD, and the last one providing the most expansive contextual information related to the character's situation. The tweets read in order as:

@anonymous: Got a text from lawyer – looks like I go to court for dui on an exam day #judgesetdate

@anonymous: I need a C to keep my financial aid #mustdowellonnexttest

@anonymous: I have been sober for a year #hopeprofunderstands

@anonymous: you think war prepares you for everything, but adjusting to college is tough #notreadyforcivilianlife

It is important to note that the person in the story appears as "@Anonymous", as the name handle would appear on Twitter, and all information related to demographics (e.g., gender, age) was left ambiguous.

Results

A repeated measures ANOVA was used to test the hypothesis that increasing contextual information would result in changes in stigmatizing attitudes. Overall, stigma decreased over time, $F(1, 648) = 294.5$, $p = .000$, partial eta squared = .31. Although both the linear trend and quadratic trend were significant, $p = .000$, the effect size for the quadratic trend (partial eta squared = .39) was larger than the linear trend (partial eta squared = .34). Specifically, participants rated their attitudes toward the student as more negative following information about problematic drinking, and subsequently less negative following each additional piece of information.

A mixed-factor repeated measures ANOVA was used to test the hypothesis that attributional complexity would moderate the effect of increasing contextual information on stigmatizing attitudes. The interaction effect for the linear trend was nonsignificant, $F = 2.60$, $p = .11$. Further, while the quadratic interaction was statistically significant, $F = 22.03$, $p = .000$, partial eta squared = .01, the small effect size indicates little, if any, impact of personal attributional style on the overall effect.

A mixed-factor repeated measures ANOVA was also used to test the hypothesis that intolerance would moderate the effect of increasing contextual information on stigmatizing attitudes. The interaction effects for the linear, $F(1, 648) = 6.30$, $p = .002$, and quadratic, $F = 22.945$, $p = .000$, partial eta squared = .07, trends were significant but very small. Specifically, no difference in stigmatizing attitudes was seen between individuals who self-reported average to low intolerance, while those who self-reported the highest intolerance demonstrated less variability in stigmatizing attitudes. In other words, while most participants demonstrated a quadratic trend in which their attitudes toward the person in the vignette became slightly more negative and then steadily became more positive, participants with high intolerance demonstrated consistent attitudes across conditions.

Discussion

Consistent with previous research, the findings of the current study suggest that when individuals are given more opportunities to connect with another's experience, stigmatizing attitudes tend to decrease (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012; Luoma et al., 2008). In all three analyses, a clear trend of stigma reduction, given more contextual information related to the PD, was seen. Although there was a small effect size for attributional complexity as a grouping variable, the final trend was consistent with our hypothesis of more complex attributional ability being related to lower stigmas when presented with the most contextual information. Given that the internal consistency reliability of the ACS subscale was low in this sample, it is possible that the measure was not psychometrically sound enough to pick up on a bigger, actual effect. At the time the ACS was developed, it was theorized that attributional complexity involved seven distinct factors and that each could be assessed separately; however, it has now been empirically established that the construct is more unitary and that the ACS has a single-factor structure (Kerr & Fletcher, 2012). Future research examining the role of complexity in reducing stigma should utilize the total score of the ACS. It is unclear how findings will be affected, but measurement will be more accurate.

When highly intolerant individuals learned about the fictitious student's PD, this did not substantially increase their reported levels of stigma as it did for the

participants with average and low intolerance levels. Conversely, these individuals with high levels of generalized intolerance had the highest levels of stigma after the final tweet was presented, when others reported the lowest stigmatizing attitudes. Stigma variation differences related to intolerance may have clinical meaning. More specifically, the finding that individuals with higher intolerance levels have less stigma variation than people who are less intolerant may have important treatment implications. This limit in variation might make these individuals less affected by context. This would be critical to keep in mind when utilizing therapy models that emphasize expanding context; however, there are several caveats. First, the effect sizes associated with this interaction were quite small and have not been replicated. Second, it is interesting that these individuals displayed less stigma than other participants when initially presented with substance use related issues. People in this group might also be more stigmatizing towards the item specific content of the intolerance measure (age, sexual orientation, etc.) and not about any specific presenting problem. Future research should explore this possibility.

Limitations

Stronger measurement could have been used in several ways. The stigma measure that we created was a total score of several questions from a larger scale measuring an individual's attributional impression of another person. Three questions were chosen to measure stigma based on clinical judgment and theoretical need to address increased personal contact within increasing context (Couture & Penn, 2006; Luoma et al., 2008). It might, however, be that if we asked more specific questions about substance abuse stigma—for instance, "How likely would you be to have a drink with this person?" or "How would you react if this person asked you for money?"—we would have had different results.

Also, knowing the statistics on problematic substance use and the gender bias (NIDA, 2016), having a considerable amount of women might have also affected the results. The number of psychology major participants may have also biased the results. Fletcher et al. (1986) found that psychology majors were more likely to make complex attributions than natural science majors. Future studies might attempt to gather a more even distribution of gender from a variety of university majors.

Finally, we did not ask questions related to individual familiarity with the Twitter apparatus. It might have been that some participants who were more familiar with the nature of Twitter were more likely to understand the hierarchical nature of the context when the tweets were being presented. Incorporating a practice task or a measure of understanding may have been beneficial.

Clinical Application and Future Directions

We see this study as having several clinically applicable findings. For instance, we found that by increasing contextual information over time, an individual is more likely to have decreasing levels of stigma toward individuals with substance use. This finding is consistent with Luoma et al.'s (2013) finding that by increasing positive contexts where individuals are interacting with those who have problematic substance use is important for stigma reduction.

Also, even though there were differences between categorical grouping variables for tweets over time, the effect sizes were not large. This means that whether or not an individual has higher attributional complexity, given the proper intervention with appropriate contextual analysis, an individual will typically have decreasing stigma-related attitudes towards individuals with PD. Further, our findings suggest that individuals with higher levels of generalized intolerance tend to have less drastic variation in their level of stigma, but their trends were also moving toward less stigma. It may be that individuals who endorse high levels of general intolerance may need to have treatments that target more global stigma reduction than problem-specific contextual interventions, but more research is needed. We want to caution readers about detailed interpretation of the moderating effects given that effect sizes were so small.

Future research and clinical work can examine and influence what creates large changes for individuals who present with higher levels of intolerance. On a large scale, the application of this experimental manipulation is simple. It is further consistent with decades of research on the FAE. If people are provided appropriate contextual information for understanding issues like PD, it takes the problems out of the realm of moral concern and into seeing whole individuals with contextually supported problems such as substance use.

Future directions for this research include the continued use of familiar mediums for people to respond to ever-changing contextual information. Twitter is a platform where people are presented with brief snippets of information, which convey powerful messages to a broad audience. We designed this experimental manipulation to mirror a therapeutic intervention. In treatment, we provide relevant, new ways to view self and others. It is our hope that through the use of a faux platform that carefully mimicked a format with which student participants are familiar, we revealed new ways to see others with wider eyes and more open hearts.

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▶ **Applications are due April 23, 2018**

Addressing Mental Health Stigma Through the Arts: Development of a Stakeholder-Academic Partnered Program

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MENTAL ILLNESSES such as major depression, bipolar disorder, and schizophrenia are leading causes of disability and their symptoms contribute to mortality in several ways, including increased risk for suicide (Friedrich 2017; Kessler, Chiu, Demler, & Walters, 2005). While evidence-based treatments exist, such as medications and behavioral therapies, rates of use and access to such treatments are moderate to low in underresourced communities (Miranda et al., 2013). Contributing factors include lack of knowledge of mental health conditions and treatments as well as stigma, or negative societal and self-directed attitudes about mental illness and seeking help. Consequences of stigma may include less engagement in treatment and worse outcomes for people in need of services (Henderson, Evans-Lacko, & Thornicroft, 2013; Parcesepe & Cabassa, 2013).

Approaches used to address mental health stigma include informational and public communication interventions, direct contact with affected persons and "parasocial" or media-based contacts, and arts-based approaches including arts therapy and arts programs, which may include stakeholder-generated art (Heenan, 2006; Lenette et al., 2016; McLean et al., 2011; Myska, 2014; Warren, 2016). Even when not necessarily intended to address stigma, arts programs have been evaluated for audience effects on knowledge and attitudes about mental illness (Hoffner & Cohen, 2015). Developers of mental health arts initiatives have noted ways that creative and therapeutic processes are both similar and different (Ayers et al., 2003; Margrove, Pope, & Mark, 2013). For instance, while both promote reflection, arts programs may permit more psychological distance.

Research on arts-based programs in mental health utilize quantitative, qualitative, and mixed method methods (Gronholm et al., 2017; Hacking et al., 2006; McLean et al., 2011; Parcesepe & Cabassa, 2013). Systematic reviews suggest that effects of arts events on individuals or groups are usually positive, though of modest size and short duration. Qualitative studies suggest, however, that arts events can have a more enduring impact (Michalak et al., 2014). Depictions of dangerous or suicidal behaviors in persons with mental illness have been shown to increase negative perceptions or behaviors (Ayers et al., 2003; Quinn et al., 2011).

Successful interventions to address mental health stigma, in general, promote accurate knowledge and positive or normalizing contact with affected persons (Gronholm et al. 2017; Hanisch et al. 2016; Parcesepe & Cabassa, 2013; Taghva et al. 2017). Mechanisms underlying effects of art events on stigma may include facilitating expression of emotions such as trauma or grief, regulation of anxiety, development of empathy, promotion of reflection and emotional intelligence, fostering opportunities for debriefing and promotion of hope and capacity to recover (Quinn et al., 2011). According to the social contact hypothesis (Allport 1954), positive contact with persons with mental illnesss can decrease prejudice and encourage individuals to reconceptualize assumptions about group characteristics. One such strategy is a "devised theatrical performance," portraying a "hero's journey" or the story of challenges faced, renewal or resilience, and lessons learned. Witnessing this journey at a safe distance through theater may instill reflection on vulnerabilities and on one's negative responses to mental illness, promoting insight and empathy (Patterson & Sextou, 2017). Psychotherapist/playwright Caplan suggests that issues often dealt with in therapy in a pathological paradigm can be addressed more positively in plays, without requiring audience members to acknowledge that issues portrayed apply to them (Caplan, 2011).

Exposure to stakeholder-generated art may also promote more positive attitudes toward mental illness. One noted example is J. K. Rowling, whose publicly shared story of living with major depression as a single mother prior to writing the world-reknowned Harry Potter series serves as an example to inspire others, combat stigma of mental illness, and encourage creativity (Johnson 2008).

Many arts programs in health utilize participatory methods to engage artists, academics, and various stakeholders such as patients, providers, or family members, to experience or create art on a "level playing field." One such method is "photovoice," which encourages participants to use photography to tell stories from their perspectives, promoting dialogue, knowledge exchange, and potential policy change (Wang, 1999). Artists in participatory projects have noted benefits including development of friendships, self-expression, and creativity (Margrove et al., 2013).

Participatory approaches are also recommended by national scientific and policy groups for addressing health disparities and promoting health equity, as well as for programs and research with vulnerable populations including mental health patients and their social contacts (General, Services et al. 2001; Nelson, Stith, & Smedley, 2002; Smedley & Syme, 2001). Thus, participatory approaches may be particularly appropriate to generate art to address stigma in underresourced or vulnerable
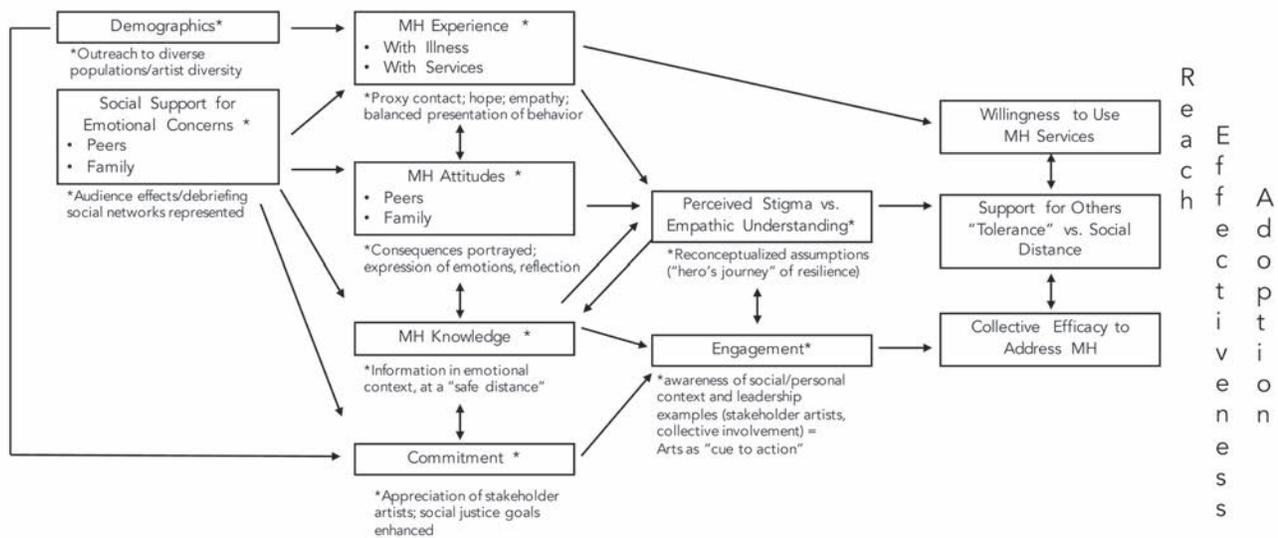
Fig. 1. Framework for arts events affecting stigma and social action.

Note. Table adapted with permission from Chandra, A., & Minkovitz, C.S. (2007). Factors that influence mental health stigma among 8th grade adolescents. *Journal of Youth and Adolescence, 36*(6), 763-774.

groups, including racial and ethnic minorities and persons living with mental illness and family supports.

In this paper, we describe the development of an academic-stakeholder partnered arts program featuring stakeholder-generated arts to address mental health stigma. We describe the participatory approach and conceptual framework, illustrate projects, providing data on impact mainly through social media and audience attendance, and describe next steps for programs to address stigma and promote health equity with more formal evaluation of effectiveness. A unique feature of this program is that it is embedded within a community-academic partnered research program using participatory methods to improve mental health services access, quality, and outcomes, and promote health equity in Los Angeles and nationally, most notably Louisiana (Arevian et al., in press; Springgate et al., 2011; Wells et al., 2013).

Participatory Approach and Conceptual Framework

Participatory Approach

The UCLA Semel Institute's Center for Health Services and Society's (HSS) program on arts to address stigma of mental illness emerged from application of Community-Partnered Participatory Research

(CPPR) to address behavioral health disparities (Chung et al., 2009; Jones & Wells, 2007; Wells et al., 2013). CPPR is a manualized variant of community-based participatory research (CBPR) that promotes equal partnership of academic and community or patient stakeholders, especially underresourced or vulnerable populations, including racial and ethnic minorities and patients with mental illness and their family and community social supports. The key principles of CPPR emphasize development of trust and respect, equal power sharing and authority, and two-way knowledge exchange, within a strength-based framework that celebrates wellness, resiliency, and community assets (Jones & Wells 2007). CPPR initiatives are structured with a partnered leadership council, working groups on key components and larger community conferences for input and feedback. Initiatives proceed in stages, from planning (Vision) to main work (Valley) and products/celebration (Victory). In addition, a major focus of CPPR is on building capacity of communities, participants and all stakeholders who are involved in planning, implementing, and disseminating programs and findings—including academic and community leaders. The approach is manualized (Jones et al., 2009, Autumn) and has been applied to intervention in depression and other phys-

ical and mental health conditions (Kataoka et al., 2011; Lizaola et al., 2011) and disaster preparedness and recovery (Springgate et al., 2009; Springgate et al., 2011; Wells et al., 2013). Stakeholder (community, patient, academic, policymaker) participation in products and dissemination is a common feature, including sharing of stakeholder perspectives (Jones, in press; Mango et al., in press; Meyers et al., 2011).

Conceptual Framework

For a conceptual framework of how stakeholder-generated arts may affect perceived stigma of mental illness and stigma-related outcomes (Caplan, 2011; Patterson & Sextou, 2017), we adapted a model proposed by Chandra and Minkovitz (2007) on predictors of stigma and its impacts on adolescents (Figure 1). From their model, we include demographics and social support for emotional concerns as predictors, mental health experience, attitudes and knowledge as intermediate variables, and as outcomes, perceived stigma, willingness to use services and social distance behaviors. We expanded this model to incorporate stakeholder engagement, commitment and collective efficacy, and expanded perceived stigma to include tolerance as a strength-based value (Brook, 2017). We added implementation outcomes for arts events (reach, effectiveness and adoption of
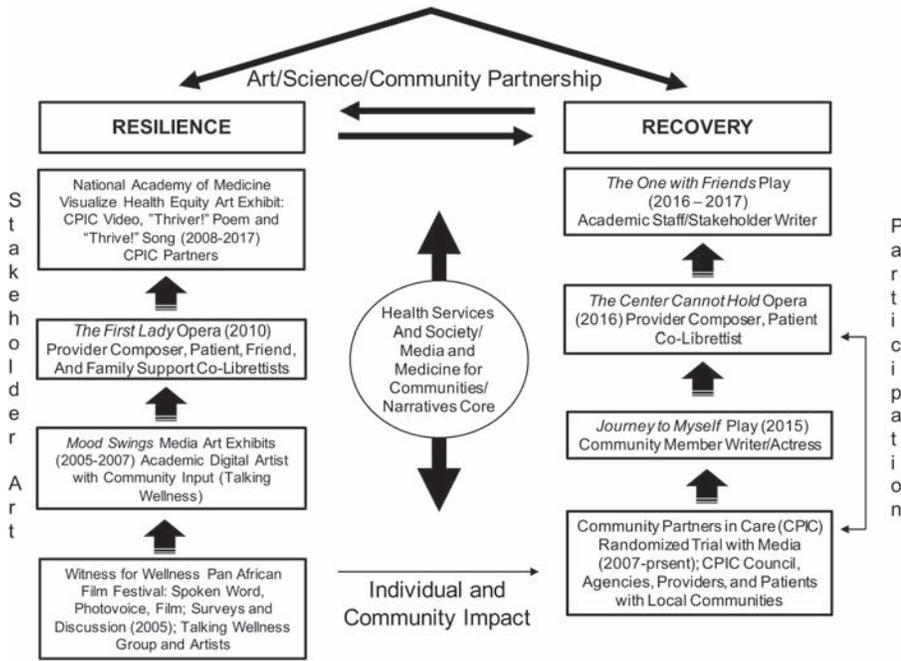
Fig. 2. Stakeholder art to address mental health stigma.

behavior change) from the RE-AIM model (Glasgow et al., 2006), primarily to inform future work. Finally, we used the literature on arts effects on stigma to propose mechanisms by which stakeholder-generated arts, within a participatory approach, may affect stigma-related outcomes. These mechanisms are indicated in Figure 1 by an asterix within each relevant concept with comments below.

Program Structure, Activities, and Impact

Structure

The arts program is supported in UCLA Semel Institute's Center for Health Services and Society (HSS), which sponsors a range of community-partnered reaerch projects in mental health. HSS launched the Media and Medicine for Communities program to increase public understanding and engagement in addressing health and mental health through media and arts, and to support community, patient, and academic partner development in stakeholder-generated arts to address mental health stigma. In 2015, this program received funding for The Narratives Project through the California Center of Excellence for Behavioral Health, supported by the

Mental Health Services Act (MHSA). The Narratives Project explores patient narratives to stimulate reflection and compassion for persons living with mental illness (Mango et al., in press).

Activities

Figure 2 provides a visual overview of the activities supported by the HSS structure, showing for each activity dates and stakeholder roles for works representing either recovery from mental illness or resilience or "thriving" in the context of stress or symptoms. The projects are supported by an arts/science/stakeholder partnership with stakeholder leadership in generating art and and a participatory approach (CPPR) as key features. Table 1 provides detail on each activity, including goals, arts components, stakeholder roles, whether evaluation was present and data sources, and findings (if available) on "reach," or audience attendance, viewings on social media or having reviews. Below we provide a narrative on the evolution and features of the program.

Stakeholder Capacity Building

In addition to the arts activities in Figure 2 and Table 1, the Media and Medicine for Communities program sponsored

activities to develop leadership in community, patient, and academic stakeholders. This included mentoring for postdoctoral fellows by academic, community, and artist leaders with guest lectures by contributors to arts and health (i.e., TV producers Neal Baer and Ben Nemtin, sculptor Deborah Butterfield and McArthur Fellows Drs. Elyn Saks and Gretchen Berland) and partnering with artists to provide community input to stimulate new art works.

Specific Projects

The first major program activity was Witness for Wellness (W4W) to address depression in South Los Angeles (Bluthenthal et al., 2006). Following the CPPR model, W4W had a community-academic Council that supported three working groups (Talking Wellness on addressing stigma [Chung et al., 2006]; Building Wellness on services quality; and Supporting Wellness on policy to promote wellness [Jones et al., 2006; Patel et al., 2006]). W4W had a focus both on developing programs in each area and conducting research evaluation. Talking Wellness (Chung et al., 2009; Jones et al., 2009) had approximately 64 community members and 10 academic partners who worked together monthly, with broader community input in conferences, to develop arts events within the 2005 Pan African Film Festival in South Los Angeles. After piloting a spoken word poetry event, the Talking Wellness group hosted several arts events in the 2-week festival: spoken word (poetry) and sketch comedy; a photovoice exhibit in which members of the community took pictures of areas in their neighborhood that raised or lowered their mood and presented photos in the mall near the festival; and a dialogue with the audience after viewing a film on the "middle passage," documenting the history of slaves brought by boat from Africa to the United States. At each event, audience members were asked to complete a survey on responses to the event and notes were taken for the film discussion. The research evaluation (Chung et al., 2009) suggested that these events increased participants' perceived collective efficacy to address depression as a community.

As shown in Figure 2, W4W was a signature event that influenced several directions in arts and research and (not shown) disasater relief efforts. Specifically, as this approach was developed, the community engagement approach to depression developed in W4W was applied in real time to

mental health recovery in New Orleans post-Katrina (Springgate, Allen, et al. 2009). Other outgrowths from W4W included providing community stakeholder input for a unique exhibit, "Mood Swings" by UCLA Design and Media Arts Professor Victoria Vesna. Dr. Vesna's project created an interactive interface between virtual and real worlds and engaged the viewer by inciting responses to audio and visual transmutations (Vesna, 2005). The exhibit was informed by community members' impressions from discussion groups of how the environment influenced their mood (similar to the Talking Wellness photovoice event). Vesna used images, audio of statements structured from the Indian Chakra perspective, to interact with individual audience stakeholders' physical presence in the exhibit, to stimulate emotional responses. While this was an individual artist's exhibit, the Talking Wellness group had the opportunity to use community insight to shape the artist's vision.

W4W also directly led to the idea and design for Community Partners in Care (CPIC), a group-randomized trial of the effects of multisector (i.e., health and community-based agencies) coalition approach versus technical assistance to individual programs for implementing evidence-based depression care across underresourced communities, primarily African American and Latino communities in Los Angeles (Wells et al., 2013). To engage stakeholders, CPIC used skits at conferences and creative project logos. One comic book in English and Spanish illustrated how an individual with depression may receive help for depression using networks available in the community, including churches, social services and clinics. CPIC evaluation findings supported the benefits of the coalition approach versus the individual program technical assistance approach for improving health, social and utilization outcomes (Chung et al., 2009; Ong et al., 2017; Wells et al., 2013). Creative materials used in CPIC and developed through the communication/dissemination committee were often suggested by community stakeholders, drafted by academic or community partners, revised with community input and products presented for feedback at community events.

The focus on partnership in arts to address mental health stigma was followed by a period of creation of new arts works by stakeholders. Kay Benjamin, an African American community member, actress, and participant in the partnered projects, developed a one-woman show, *Journey to Myself*, illustrating her experiences and personal growth in addressing multiple personality disorder (referred to in the DSM as dissociative identity disorder) performed in Los Angeles with scenes shared in CPIC community feedback conferences. Community stakeholders suggested that CPIC findings be shared in a film featuring CPIC community and academic leaders and collaborated with professional producer/writers to develop a film on 6-month outcomes from CPIC. CPIC lead community partner Loretta Jones (co-author) developed a poem, "I am a Thriver!", for friends that was read at CPIC community meetings and subsequently at national meetings when CPIC findings were presented. The poem was set to music as a choral song, "Thrive!", by academic partner Wells (co-author) and performed and videotaped at a CPIC community feedback conference, as well as postdisaster recovery trainings in Baton Rouge (Keegan, 2017). Co-authors Mango, Wells, Jones collaborated in submitting a video combining the CPIC story of outcomes, "Thriver!" poem, and "Thrive!" song for a National Academy of Medicine competition, Visualize Health Equity, and was selected for permanent online exhibition. This arts award complements team science awards won by over 120 CPIC community and academic partners (i.e., 2014 Association of Clinical and Translational Science Team Science Award, 2015 Campus Community Partnerships for Health Annual Award).

Co-author Wells, psychiatrist and researcher, inspired by the community's response to the arts, completed as co-librettist and composer, two operas: *The First Lady*, on resilience in grief, and *The Center Cannot Hold Part I: The Illness*, on recovery from schizophrenia. *The First Lady* portrays Eleanor Roosevelt's resilience in the weeks following President Roosevelt's death—a time of personal and political challenges at the close of World War II. The premiere was accompanied by a symposium on uses of science and arts to promote resiliency featuring speakers on health care reform, mental health and the arts, with a racially diverse cast and production team and prompted an online series on provider as composer (Rockwell, 2013).

The production was a partnership of HSS with local theater group Needtheater (artistic director Matthew Wells, co-author). Co-librettist Richard Roudebush's courage in facing and surviving cancer and friendships with composer Wells and co-librettist Gayle Patterson inspired the opera's resilience theme, which was featured in the *Los Angeles Times* (Groves, 2010).

One of the preperformance speakers for *The First Lady* was Elyn Saks (co-author), USC law professor and MacArthur Winner, who has a history of schizophrenia. Wells proposed collaborating on an opera based on her memoir (Saks, 2008), leading to *The Center Cannot Hold Part I: The Illness*, produced at UCLA in 2016. The opera focuses on 1 year (1982) when Saks, a first-year law student, was hospitalized for a psychotic break (Act I) but returned to school, developed a lasting friendship, helped others and graduated (Act II). The opera illustrates the trauma of being involuntarily held in restraints and the importance of a patient-centered care. Wells used his own background to illustrate experiences of providers facing limits of treatment knowledge. The video of the workshop performance, a co-production with Pacific Opera Project, was streamed by Mental Health America beginning in October 2016 for National Recovery Month and Global Mental Health Awareness Week (mentalhealthamerica.net/opera), accompanied by online resources on schizophrenia and treatments. The opera used the structure of a "heroine's journey," from Saks' experiences of severe mental illness and extensive time in restraints to finding an approach to treatment and coping (medication and psychotherapy, productivity in work and friendship support) that worked for her, yielding new meaning in life and a path to recovery. In addition, the opera is designed to reflect a balance of more challenging aspects of illness, such as a perceived threat of dangerousness, to reflection on resilience. Created by a psychiatrist and a patient and following the program's conceptual model (Figure 1), the opera is designed to increase knowledge of illness and treatment and share patient and provider experience emotionally but at a "safe distance" to stimulate reflection, empathy, and challenge existing negative beliefs about "inevitable" trajectories in schizophrenia, as well as to humanize the experience of patients, providers, and family members. Building on the CPPR approach, the production featured coaching of the cast by patients and providers, including schizophrenia expert Dr. Stephen Marder. Wells, Saks, and Marder commented directly on themes from the opera in pre- and postperformance talks and subsequent Facebook events. The pro-

Table 1. Characteristics of Arts Events to Address Stigma

Event	Project/Goals	Stigma/Arts Events	Stakeholder Role	Audience	Evaluation/Impact	Media Reach (Through 2017)
Witness for Wellness (W4W), Pan African Film Festival Exhibit 2005 (Chung et al., 2008)	Community engagement to address stigma for depression help seeking	Spoken Word, Sketch Comedy, Photovoice, film presentation and discussion	74 Talking Wellness members (10 academic, 64 community) plan, implement, evaluate	South LA; Largely African American but also ethnic and geographic diversity	748 surveys collected; Participating in arts events associated with increased collective efficacy to address depression	9,054 community viewers of events Joint publications, videos and photos of events used in community and academic conferences, seminars and courses
Community Partners in Care (CPIC) group-level randomized trial, media resources 2007 – Present (Wells et al., 2013; Chung et al., 2015; Ong et al., 2017)	Research study on value of community coalitions over program technical assistance for depression	Skits, comic books, brochures, videos for engagement and education; dissemination of findings; video on 6-month findings with community leaders	Community-academic partnered Council, Working Groups and Community Forums >100 stakeholder leaders; with dissemination committee	Under-resourced communities (South LA; Hollywood-Metro LA); 95 programs; LA and national policymakers, scientific groups	Patients surveys at baseline, 6, 12 and 36 month follow-up; coalitions versus program technical assistance improved health, social and utilization outcomes for depressed clients	95 agencies serving 30,624 patients; 1,250 participants (>90% response rate); 292 providers enrolled with 500+ in agencies; attendees at report-back conferences; national presentations, dissemination projects with Louisiana, New York City; Multiple team science awards (national and international)
The First Lady Opera (Wells KB, Roudebush, Patterson, Wells MB) 2010	Share a "heroine's journey" of grief, betrayal, forgiveness and resilience	Opera with guest speaker, resilience conference; video of workshop; UCLA and Needtheater; screening of video	Provider composer, cancer patient with friend, family as co-lyricists; diverse performers	General audience; vans facilitate attendance by South LA partners; film screening at UCLA	No formal evaluation; LA Times feature article Groves, 2010); health care Vlogs online (5 episodes)	6 performances: over 1,000 attendees Vlogs online views: 953
National Academy of Medicine Visualize Health Equity Art Exhibit (2017): CPIC community video (2014) with "Thriver!" poem (2008), "Thrive!" choral song (2016)	Share community story of building health equity for depression and personal and community resilience	On-line posting of film on 6-month CPIC findings, poem (Jones, 2008) and choral song (Wells and Jones, 2016) on video from CPIC conference	Community-academic partnership in film; Community partner poet and academic provider/composer; racial/ethnic diversity in performers	National audience; South Los Angeles; shared in Louisiana partnerships; multiple partnerships; Facebook live events	No formal evaluation of arts component alone; see CPIC above for scientific findings	YouTube views: 81 CPIC and Louisiana conference attendees: >200 National Academy of Sciences Visualize Health Equity art exhibit winner (posted November 2017)
The Center Cannot Hold Part 1: The Illness (Wells and Saks, 2016) and video streaming by Mental Health America (MHA) (2016-present)	De-stigmatize schizophrenia, show dangers of overuse of restraints, challenges for patients, family and providers; provide online resources	Opera with pre and post events; national streaming with Facebook events; linkage of streaming to resources about schizophrenia and treatments	Provider composer, Patient co-librettist based on memoir; provider/patient coaches for cast; pre-show talks, national streaming with creators, cast and clinical community disparities experts	General audience; providers and consumers following national recovery week	No formal evaluation; Free streaming on Mental Health America's website; *Washington Post* article; *JAMA* article; personal impact stories; social media comments	3 performances: about 420 attendees HSS Opera Website: 1,522 visits MHA Streaming: 1,074 views Facebook Live Videos: 926 views *JAMA* article: 5,549 views UCLA Press Releases: 655 social media likes/share *Huffington Post*: 130 social media likes/shares

[Table 1, continued]

Event	Project/Goals	Stigma/Arts Events	Stakeholder Role	Audience	Evaluation/Impact	Media Reach (Through 2017)
The One With Friends Oct. 2016-Jan. 2017	De-stigmatize anxiety and depression; build awareness of importance of social and parasocial support	Stage play on personal relationships and interactions with TV show "Friends" and narrator interaction with audience	Staff stakeholder writer, diverse cast/production team; provider evaluator	General audience; arts students; mental health consumer and provider communities	Formal evaluation; 298 surveys; *JAMA* article; *Huffington Post* article; KPCC Radio segment; social media comments	5 Performances: about 320 attendees HSS Play Website: 2,264 views *JAMA* article: 3,247 views *Huffington Post*: 320 social media likes/shares Facebook promotional videos: 1,542 views

duction had an ethnically diverse cast and Facebook Live event before the national streaming with opera creators and CEO of Healthy African American Families II (co-author Jones) to increase outreach to diverse populations.

Some clinicians in attendance commented on being touched by portrayal of clinicians' doubts over treatment decisions. Consumer advocates present commented on the realistic portrayal of terror in restraints and impact of psychotic symptoms such as delusions. Many of these themes were echoed in preperformance talks and a postperformance talk-back after the last (third) performance. Co-creators Wells and Saks received numerous follow-up emails, including, as an example of impact, a request from an arts student with a history of mental illness, to perform an aria in a recital, inspired by the streaming event. The opera and the streaming event were reviewed in the *Washington Post* and *JAMA* (Nutt, 2016; Willich, 2017).

Co-author Mango, a playwright and academic staff or co-producer for many of these events, generated two projects within the program. One was a commentary for publication in an academic journal of a synthesis of personal narratives of patient, provider, and community stakeholders involved in CPPR-based projects in mental health in Los Angeles and New Orleans (Mango et al., in press). The second was revising and producing his play about living with depression, *The One With Friends*. The goal was to provide a more "normalized" view of major depression and anxiety to counter the often negative portrayals in media and to clarify the importance of social support and connection in coping with symptoms of mental illness, in order to motivate others to seek and provide social support (Bastién, 2017; Walter, 2004). The play takes place in Los Angeles and follows two young adults living with depression/anxiety, one (Lucy) after the sudden death of her mother, and the other (Callum) with a history of suicide ideation and self-injurious behavior and formally diagnosed with major depressive disorder/anxiety. The characters form a bond over the popular NBC TV show *Friends* and become supportive friends for each other in the process. While Callum realizes he will live with depression for the rest of life, he works to manage it better with therapy, medication, self-care, and support—leaving the audience with hope. The play is based on Mango's and his friends' experiences with stress and using *Friends* and other television shows and films for coping, along with medication and therapy. The play emphasizes the importance of empathy, reflection, and positive social contact and the role of media in the healing process and the power of kindness in countering stigma and enhancing well-being.

Building on the program's partnered stakeholder approach, Mango and director Ashley Griggs sought actors who were understanding of those living with major depression. For example, one actress noted that she had people close to her living with depression and anxiety and that every actor wants to be a part of a production that is going to have social impact. An important goal of *The One with Friends* as presented in Los Angeles (2016—initially at the Ronald Reagan UCLA Medical Center's auditorium) and New York City (2017—New York University) was systematic evaluation of audience impact, building on the prior research emphasis in W4W/Talking Wellness (Chung et al., 2009). The evaluation, co-led by a child psychiatrist (Dr. Bonnie Zima) developing and evaluating media interventions, resulted in collection of about 300 pre-post surveys about mental health stigma and the arts as a means of healing, as well as scribe notes of discussions. The play attracted a diverse audience with ethnic minorities (African American, Asian, Hispanic, Native American) representing more than half the audience at the Los Angeles performances and about 43% at the NYC performances. Findings from the formal evaluation will be presented in a subsequent article. The play was reviewed in *JAMA*.

Reach in Populations

In addition to anecdotal narratives of impact given above for some program activities, Table 1 provides metrics of reach or exposure of populations from data available from social media or collected at events. Most events had at least several hundred viewers. Many of these events are available online or with reviews online, have had several thousand "visitors," giving some notice of the project; and for others data are pending. Quantitative measures of effectiveness consist primarily of published findings from W4W/Talking Wellness (Chung, Corbett et al. 2006) and for the comparison of the CPIC interventions as a whole (Chung et al., 2015; Ong et al., 2017; Wells et al., 2013).

Evaluations of effectiveness of arts components, specifically, is a future goal.

Discussion and Future Directions

We described the development of an academic and community-partnered program of stakeholder-generated art to address mental health stigma, produce creative arts events, and provide public information on mental disorders as well as promote resilience. Common factors across activities in the program were to promote reflection, social connection, and support, instilling hope or a sense of identity, and promote emotional release and empathy to reconsider widely held views of persons living with mental illness. This program was strongly shaped by the application of a participatory model of research developed for interventions with underresourced communities. This model resulted in a focus on stakeholder-generated arts, including academic providers and staff, patient stakeholders and community members, in collaboration with local production companies and venues, and, in some cases, national streaming and exposure through social media. Another consistent focus was engagement of ethnically diverse populations through featuring diverse casts and/or through outreach events. Beginning in a participatory research tradition and applying concepts from the literature on arts and stigma, the program included visual, spoken, dramatic, and musical arts with excerpts shared in community conferences and artistic, academic, and policy events.

All projects sought to achieve a "balance" of positive outcomes and known challenges faced by people living with mental illnesses, often within the context of limitations of treatment approaches of the time. Projects sought to instill empathy and understanding of illness and persons living with them, the importance of patient-centered care and access to treatment, but especially of supportive, understanding relationships as well as conflicts sometimes encountered when seeking treatment or given limitations of treatments or actual changes over time in views of appropriate treatment (e.g., use of restraint initially a common primary treatment but now potentially a sign of treatment failure). For example, the process of development emphasized equity by supporting creative works by patients and community members as well as providers and academics, all collaborating as artists and/or evaluators.

The use of participatory principles also facilitated collaborations with production partners and performers. The approach of stakeholder inclusion, such as coaching by patients or involvement of knowledgeable stakeholders (i.e., actual protagonists portrayed), was noted by production teams and cast members as inspiring. Another common goal was to give a "human face"—through stories—to the complex personal, family, social network, health care, and community context for mental illness or other psychological stresses like coping with grief. Sometimes this was accomplished through fictional characters, even if based on authors' personal experience, as well as portrayal of public figures and a widely read memoir (*The Center Cannot Hold*). While the intent was to broadly affect public perception, formal evaluation was inconsistent, a limitation to date.

In terms of future directions, the Narrative Project, with community partner Healthy African American Families II and affiliated scholar Dr. Kia Skrine Jeffers (co-author), received funding from the California Arts Council to produce a participatory play using narrative data collected from the CPIC project on coping with depression and social issues among racial/ethnic minorities. Dr. Skrine Jeffers, a writer/performer, practicing nurse, and postdoctoral fellow in the UCLA National Clinician Scholars Program (Bromley et al., 2015), is the project's Principal Investigator. The goals of this new project are to increase understanding of individuals' experiences with depression as they navigate daily life and choose whether or not to seek mental health services, and to evaluate the impact of the participatory process of developing and performing the play through quantitative and qualitative methods. This project represents a next phase of development of the media/arts program to more fully realize a participatory stakeholder generation of art with intentional collaborative evaluation of impact of the experience for developers, performers, and audience. Consistent with CPPR, the long-term goal of this project and the program is to further build stakeholder and community capacity for promoting health equity for underresourced communities and to have policy impact.

Overall, we found it feasible and compelling to use a participatory framework to encourage stakeholder-generated art to address mental health stigma, with active participation of patient, social network, community, provider and other partners in creating, advising and performing a range of art forms. With limited evaluation resources, except for two formal research projects, we nevertheless observed that these events stimulated community members, providers, and patients to share their own stories of recovery, resiliency, resources, and activity in the arts. These events have a value in and of themselves as works of art and personal experience, which we hope to more formally demonstrate in the future.

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Leveraging Mobile Technologies to Improve Mental Health in Underserved Populations: Lessons Learned From Latino Immigrants and Homeless Populations

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MOBILE PHONES and Internet connectivity have become a necessity in modern society. Although in the early days of the Internet, high-priced entry points such as computers and broadband connections contributed to a "digital divide" between those with and without access, the development of low-cost Internet connected devices such as smartphones has led to more pervasive availability. When the Pew Research Center started tracking Internet usage in early 2000, only half of American adults were online. Since then that number has grown to over 90% (Pew Research Center,

2017). However, groups access the Internet in different ways. While most people have broadband access at home, racial minorities, older adults, rural residents, and those with lower levels of education and income are more likely to use smartphones as their primary, and often only, access point to the Internet (Smith, 2015). Beyond Internet connectivity, mobile phones adoption is driven by their usefulness for a variety of tasks. They are used for communicating with others (phone, email, messaging, social networks), and accessing financial information, jobs, and health resources.

Because these technologies connect people to invaluable information, they can be leveraged to intervene for improving mental health (Aguilera, Bruehlman-Senecal, Liu, & Bravin, 2017). This article will review some ways that mobile phones can be used to improve mental health with an emphasis on two underserved populations: Latino immigrants and homeless youth.

Recent years have demonstrated the potential of mobile phone technologies to provide mental health services more broadly. From text messaging interventions (Aguilera et al., 2017) to mobile apps (Pratap et al., 2017) to artificial intelligence–powered chatbots (Fitzpatrick, Darcy, & Vierhile, 2017), we have seen considerable innovation in new modes of intervention delivery and new types of interventions powered by technology. Technology has also demonstrated potential to improve identification and assessment of mental health. Google and the National Alliance on Mental Illness (NAMI) recently collaborated on efforts to provide depression and posttraumatic stress disorder screening to individuals

entering related terms into Google searches. Research demonstrates that passive assessment of mental health issues is possible through social media (e.g., Instagram—Reece & Danforth, 2017; Facebook—Schwartz et al., 2014) or smartphone sensors (Mohr, Zhang, & Schueller, 2017).

However, despite all the potential of technology to overcome issues present in our current mental health service system, issues such as stigma and limited access to underserved populations with high need still present problems. Stigma associated with mental health diagnoses and interventions is well documented, especially toward mental health treatment. This stigma can be higher among immigrant and low-income populations (Corrigan, 2004). The personal, private, and convenient nature of mobile phones make those mediums an ideal way to introduce mental health information and intervention. For example, Price, Davidson, Andrews, and Ruggiero (2013) found that underserved populations that are less likely to access in-person services were equally likely to engage in online interventions. Leveraging ubiquitous mobile devices to deliver mental health may reduce barriers such as stigma (Price et al., 2013), inflexible work schedules, transportation, childcare issues (Alvidrez & Azocar, 1999), and other factors that contribute to disparities in mental health service utilization.

Technology alone will not solve barriers to receiving quality mental health care. Instead, if mobile health technologies are to provide useful mental health resources for underserved populations, then they need to be designed to address their needs and preferences and be responsive or useful to the contexts where they are interested to receive care. We review some considerations of mobile health technologies generally to address mental health needs of underserved populations and discuss two particular underserved populations— Latino immigrants and homeless individuals—as illustrations intended to highlight considerations in the development, evaluation, and implementation of interventions using mobile health technologies.

mHealth for Spanish-Speaking Latinos With Depression

Although mobile health intervention development has exploded in recent years, development of mobile health tools does not always occur with diverse communities. According to the U.S. Census, there are 40 million Spanish speakers in the U.S. Latinos in the U.S. report significantly lower utilization of mental health services relative to need compared to their White counterparts, with those disparities increasing in recent years (Cook, Trinh, Li, Hou, & Progovac, 2016). When services are received, engagement (attendance and homework completion) tends to be low (Aguilera, Bruehlman-Senecal, Liu, & Bravin, 2017). Latino adults also report the very high utilization (94%) of mobile devices for accessing the Internet with younger and more educated subsegments utilizing mobile Internet at the highest rates (Brown, López, & Lopez, 2016). Despite the large population and high engagement with mobile phones, there are very few mHealth apps targeting mental health in Spanish. Only one study that we found has tested the feasibility of a mobile app for depression among Spanish speakers (Pratap et al., 2017) and another reported on the willingness of women to utilize apps for perinatal depression (Osma, Barrera, & Ramphos, 2016). There is a tremendous need to develop mHealth tools for mental health in Spanish.

Our group has utilized text messaging to improve the reach and quality of mental health interventions for Latino immigrants from low-income backgrounds and with low levels of educational attainment. HealthySMS is a text messaging platform that was developed with and for low-income populations (mostly Spanish speakers) to deliver a text-messaging-based adjunct to group cognitive behavioral therapy (GCBT) for the treatment of depression in a public sector primary-care clinic. The text-messaging-based adjunct was designed to enhance patients' mood-state awareness, improve CBT skill practice, increase therapy attendance, and help clinicians better track patient progress. Patients receiving this adjunct were sent daily text messages prompting them to report their mood on a 1 (*worst mood*) to 9 (*best mood*) scale, as well as daily psychoeducational messages that reinforced the concepts taught in GCBT. Patients were also sent weekly text-based reminders to attend therapy, and could opt in to receive daily reminders to take prescribed medications. Clinicians reviewed graphical representations of patients' daily mood data with patients during weekly GCBT sessions, allowing clinicians to assess patients' mood over the prior week, and talk with patients about how they could apply the strategies taught in therapy to cope with low mood.

Early feasibility and acceptability pilot research of the HealthySMS system demonstrates that patients reported overall positive experiences using texting as an adjunct to GCBT for depression (Aguilera & Berridge, 2014; Aguilera & Muñoz, 2011). In responding to open-ended questions regarding what they found helpful about the text messages, over half of patients spontaneously reported that the messages prompted self-reflection and mood-state awareness. For example, one English-speaking patient wrote: "They (the messages) made me stop and think for a moment about how I was feeling and why I was having those feelings. My life is so crazy, I need a reminder to think about how I feel." Similarly, a majority of patients also reported that the messages made them feel cared for, and closer to their therapist and the therapy group. For example, one Spanish-speaking patient indicated that the texting program "makes you feel like someone is concerned about you" (Aguilera & Berridge). In an earlier, smaller pilot, most patients (80%) also reported that the text messages encouraged them to attend therapy (Aguilera & Muñoz). Patients in this study respond to the text messages at an acceptably high rate, responding on average to 65% of the messages received over a 2–4 month period (Aguilera & Muñoz).

A recent clinical trial provides evidence that this text-messaging adjunct to GCBT increases psychotherapy attendance and reduces therapy dropout relative to stand-alone GCBT (Aguilera, Bruehlman-Senecal, Demasi, & Avila, 2017). Patients in this trial were low-income Spanish-speaking Latinos who were assigned to receive either standard GCBT for depression (control condition; $n = 40$) or the same treatment with the addition of the text-messaging adjunct described above ($n = 45$). Intent-to-treat analyses demonstrated that patients assigned to the text-messaging adjunct condition stayed in therapy significantly longer (median of 13.5 weeks before dropping out) than patients assigned to the control condition (median of 3 weeks before dropping out). Patients assigned to the text-messaging adjunct also generally attended a greater number of therapy sessions (median = 6 session) than patients assigned to the control (median = 2.5 sessions). The text-messaging adjunct did not lead to significantly higher reductions in depressive symptoms as both conditions experienced significant decreases in depressive symptom severity over the course of treatment. A larger sample would likely be needed to detect a potential condi-

tion difference in depressive symptoms or a longer study could investigate if the text-messaging adjunct might lead to more sustained benefits. Including text messaging might better reinforce how activities outside of the sessions can aid recovery and could potentially encourage people to engage in positive self-management behaviors in the period after treatment. Despite the shortcomings of the study, these findings provide promising evidence that text-based adjuncts to psychotherapy may promote sustained engagement with efficacious treatments for depression among Latino immigrants.

Data collected through HealthySMS has also proved useful in predicting clinically meaningful outcomes, including depressive symptom severity and weekly GCBT attendance. Average weekly mood ratings, measured via text, were found to reliably predict depressive symptom severity as assessed by the Patient Health Questionnaire (PHQ-9) within a sample of 33 depressed patients (Aguilera, Schueller, & Leykin, 2015). This finding suggests that text-based mood ratings may serve as an efficient proxy measure for depressive symptom severity, potentially reducing the need to administer the full PHQ-9 during therapy, a measure that can be clinically burdensome to administer and difficult to comprehend for patients with low literacy. Daily mood ratings have also been found to prospectively predict patients' likelihood of attending upcoming therapy sessions (Bruehlman-Senecal, Aguilera, & Schueller, 2017). In a sample of 56 depressed patients, patients who reported a more positive mood the day before a scheduled therapy session were significantly more likely to attend therapy the next day, even after controlling for their prior attendance history. These findings indicate that daily mood ratings can be used to predict and potentially prevent costly therapy appointment no-shows, allowing clinics to strategically time outreach to patients who need additional support to stay engaged. Given the benefits of regular therapy attendance, and the costs associated with early termination, this finding has high clinical utility. Taken together, these results underscore the value of the text messaging adjunct and the development with and for underserved and Spanish speaking populations.

Mobile Mental Health for Homeless Young Adults

Individuals experiencing homelessness are a high-need yet low-availability population when it comes to mental health services. Estimates consistently find that homeless individuals have rates of mental disorders 2 to 3 times higher than their housed peers (Quimby et al., 2002). Mental health issues are both a cause and consequence of homelessness, especially in young adults where homelessness often results from "aging out" of child welfare services (Fowler, Toro, & Miles, 2011). Indeed, nearly a quarter of children who leave the foster care system will experience homelessness within 2 years (Fowler, Toro, & Miles, 2009).

Unfortunately, homeless individuals receive mental health resources at extremely low rates, with estimates below 10% in most instances (De Rosa et al., 1999). Given the insufficiency of access to care, the most common setting for treatment tends to be emergency rooms when health needs can no longer be ignored (Ensign & Bell, 2004). This often results in treatment for acute issues such as substance use or serious mental illness but less care for common mental health problems, such as depression and anxiety. Just like their housed peers, however, common mental health issues are the primary mental health complaints among homeless individuals (Rohde, Noell, Ochs, & Seeley, 2001; Whitbeck, 2011).

Fortunately, evidence-based practices validated in other settings appear to be useful for homeless individuals. For example, a few studies have demonstrated that cognitive-behavioral therapy delivered in shelters can lead to significant decreases in depression and other mental health problems and improvements in self-efficacy (Hyun, Chung, & Lee, 2005; Taylor, Stuttaford, & Vostanis, 2007). However, although the treatments themselves are effective, there are considerable barriers to engagement. In one study, only treatment completers displayed significant benefits, and over half of the young adults who began treatment discontinued after the first session (Taylor et al., 2007). Thus, evidence-based practices must be provided in ways that are appropriate and acceptable for this population and the settings in which they come into contact with health resources.

While access to health care services is much lower than the general population, homeless individuals have a level of access to mobile technologies comparable to the general population. The adoption of specific technologies (e.g., feature phones as opposed to smartphones) are sometimes below current rates in some specific contexts, but the overall rates of ownership and use of devices is quite comparable. One-fourth of homeless individuals report using the Internet for more than an hour a day (most often accessed via smartphone devices; Rice & Barman-Adhikari, 2014; Rice, Monro, Barman-Adhikari, & Young, 2010). Estimates of smartphone ownership among homeless individuals ranges from 44% to 62% (McInnes, Li, & Hogan, 2013; Post et al., 2013), and individuals ages 18 to 29 account for the top end of that range (Rice, Lee, & Taitt, 2011).

Despite the high potential of mobile mental health interventions to be useful for homeless individuals, few attempts have been made to develop programs specifically for this population, and the research literature is completely lacking. In a system requiring low-cost interventions that can be used on-the-go without trained mental health specialists, mobile health interventions could promote a standard of care that could significantly advance mental health treatment in this population and setting.

In Chicago, we have been trying to leverage the affordances of technologies to develop a novel form of mental health services specifically designed for the needs of homeless young adults (Karnik, Glover, Boley, Schueller, & Zalta, 2017). The program was developed with stakeholder input from homeless young adults (Adkins et al., 2017), as well as close collaboration with the shelter system in which it would be deployed. Through focus groups we learned that homeless individuals, especially young adults, have frequently had negative experiences with mental health care and thus have low levels of trust in mental health professionals. Furthermore, depression, anxiety, and "stress" were indicated as chief concerns among different mental health issues. A major issue that emerged for these young adults was wanting to feel a sense of autonomy in their lives generally and, as a result, in the mental health treatment as well. We heard repeated stories of people feeling like their voices were not heard, which resulted in prescriptions of medications or treatment plans that did not address their needs. Additionally, logistical problems emerged. For example, travel to therapy appointments when even bus fare was a significant financial strain made it practical impossible to engage in traditional services.

Based on this input, we created a smartphone-delivered mental health program tailored to the needs of homeless young adults. The program consists of a combination of mental health apps and telephone

and text message support provided by a clinical psychologists. The apps leverage some products already developed and evaluated through Northwestern's Center for Behavioral Intervention Technologies such as the IntelliCare suite (Lattie et al., 2016; Mohr et al., 2017), as well as an app specifically designed for this population and project, Pocket Helper. Pocket Helper provides a daily tip supporting coping skills, which are the focus of the program, and a daily survey that feeds information back to the supporting clinical psychologist. The human support is based on concepts of "remote hovering" (Ben-Zeev, Kaiser, & Krzos, 2014) as well as the Efficiency Model of Support for Behavioral Intervention Technologies that emphasizes the importance of addressing goals of one's interaction with the technology (Schueller, Tomasino, & Mohr, 2017). Although the pilot program is still ongoing, several lessons have emerged from this early work.

First, the participants are accepting of this form of services and willing to engage with the program. We have had high rates of engagement with over half of the participants completing all of their telephone sessions. However, the highest rated aspect of the program is not the telephone support, ability to text message a provider, or the interactive mobile apps, but the simple tips that people receive on a daily basis. Last, although the participants enjoy the ability to connect with a provider via technology, they still would prefer to establish the connection through a face-to-face meeting. This suggests that "blended care" models that have become increasingly popular ways to integrate digital resources into mental health treatment abroad require further consideration in the United States. The idea that technologies might come to "replace" mental health providers is probably less likely in the near term than better learning how technologies can support providers. As such, technology might help create a form of market segmentation or fit into stepped-care models (i.e., some people receiving low-intensity treatments), but we should be thinking more deeply about technology plus humans rather than technology only serving as a stand-alone product.

Conclusions and Recommendations

It is crucial to identify populations with the highest need relative to available resources when developing and testing mental health interventions to achieve the maximum public health impact. Mobile health interventions often do not reach the populations that are most affected by mental health problems. Nor are they developed with and for those least able to access care within the current system. In the U.S., vulnerable populations (e.g., economically disadvantaged, racial and ethnic minorities, uninsured, low-income children, elderly, homeless, etc.) frequently receive their care in safety net or nontraditional settings, where cutting-edge interventions such as new mobile technologies are not likely to be designed or developed, and are only available many years after use within higher-resourced systems (Regenstein, Huang, & Cummings, 2005). This significant translational gap presents problems in achieving health equity and increases the likelihood that these interventions, when actually implemented in underserved settings, will ultimately fail with respect to sustained patient engagement because they were not built with these types of systems and populations in mind. It is more likely that mobile interventions will be widely accessible and easy to use if they are designed and tested with diverse patients from the outset (Mohr, Weingardt, et al., 2017; Sarkar et al., 2016).

Designing technology with and for underserved populations requires an understanding of their specific needs, capabilities, and motivations to achieve desired health outcomes. Mobile phone interventions are most likely to be engaging when they are integrated into existing services that people utilize and when technology can be easily integrating into their daily activities and routines. This may require developing a range of technology-based interventions from unsupported stand-alone interventions to interventions integrating important human relationships (e.g., clinical, social, family, etc.). Furthermore, we need to understand people's preferences. Some people might view mobile mental health interventions as an undesirable alternative to face-to-face care (Rennick-Egglestone et al., 2016).

In the service of creating effective and efficient mHealth mental health interventions that can be responsive to people's needs, it is helpful to consider a continuum of possibilities for such interventions to enter clinical care. Muñoz (2017) presented such a continuum consisting of traditional services augmented by digital tools, guided interventions that could involve low-touch human involvement, and automated interventions that involve no human touch. This continuum of options might exist both within and between interventions; and ensuring the availability of human support when desired, either remotely or face-to-face, might be an important future direction to tailoring interventions for diverse groups.

Reflecting on our two cases, there are still barriers to developing and implementing mHealth interventions for underserved populations. For example, older and less literate patients have a more difficult time engaging in mobile technology interventions because they tend to use and rely on smartphones less often and because they may have difficulty engaging in concepts that are largely delivered by text. Among homeless youth, some key barriers are lack of technology infrastructure (e.g., although smartphones are pervasive, WiFi and phone service are not), difficulties in promoting their awareness of such services and keeping them connected with them, and ensuring products represent the diversity of this group in terms of ethnic background and sexual orientation. These barriers are not insurmountable but should be viewed as design challenges to be addressed. Although leveraging mobile technology interventions for underserved populations is not always easy, we are confident that the efforts are worthwhile given the high level of need in these vulnerable and stigmatized populations.

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Child Sexual Abuse: Stigmatization of Victims and Suggestions for Clinicians

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CHILD SEXUAL ABUSE (CSA) occurs frequently, with one recent review suggesting that approximately 1 in 10 children will experience sexual abuse before age 18 (Townsend & Rheingold, 2013). Victims of CSA are at risk for developing a range of psychological and behavioral problems, including depression, anxiety, posttraumatic stress disorder (PTSD), suicidal thoughts and behavior, substance abuse, high-risk and inappropriate sexual behavior, and other conduct problems (Maniglio, 2009; Tyler, 2002). However, not all children experience these short- and long-term effects and many factors influence the heterogeneity of response to CSA (Kendall-Tackett, Williams, & Finkelhor, 1993; Putnam, 2003). Stigma, defined as "a mark of disgrace associated with a particular circumstance, quality, or person" (Oxford English Dictionary, 2017), can

play an important role in victims' recovery (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996). As such, the purpose of this paper is to critically review the literature on how survivors of CSA are currently stigmatized, identify the consequences of such stigma, and make suggestions for clinicians working with CSA victims and their families.

Youth who experience sexual abuse often face stigma from others. Due to the stigma around victimization, some youth delay their disclosure and some never tell (Fontes & Plummer, 2010; Gagnier & Collin-Vézina, 2016). Estimates vary, however, as studies show that the majority of children who experience sexual abuse do not tell someone during childhood (London, Bruck, Ceci, & Shuman, 2005; Lyon & Ahren, 2011). Many survivors identify shame and embarrassment as a

primary reason for delayed disclosure (Anderson, Martin, Mullen, Romans, & Herbison, 1993; Fleming, 1997). Stigmatization of sexual abuse victims also discourages open communication between family members about the abuse and discourages open communication about the problem of CSA in the community. Stigma can also influence a youth's own perception of self-blame, shame, and guilt (Finkelhor & Browne, 1985; Karakurt & Silver, 2014) and can lead to feelings of isolation (Finkelhor & Araji, 1986). The effects of stigma may continue into adulthood. Coffey and colleagues (1996) found that stigma mediated the relationship between sexual victimization in childhood and adult psychological distress in women. Another study showed that the relationship between childhood sexual abuse and the use of avoidant coping strategies following an adult sexual assault was mediated by feelings of stigma (Gibson & Leitenberg, 2001). Overall, a review of the limited literature suggests that more research is still needed to better understand the stigma CSA victims experience. Relative to other widely studied topics in the CSA literature, the dearth of studies on stigma likely associates with the complex-

ity of the issue as well as the methodological difficulties of conducting research on stigma associated with CSA. Broadly, stigma may include the following interrelated areas, which we explore in detail below: (a) the label of "abuse victim," (b) stereotyping youth based on their abuse history, and (c) blaming the victim for the abuse.

CSA Victim Label

The label of "child sexual abuse victim" can have significant implications for the youth's recovery (Holguin & Hansen, 2003). This label may impact children directly or it may indirectly affect children through the way nonoffending caregivers, teachers, professionals, and peers interact with the youth. As described below, the media's portrayal of victims may also contribute to how youth who experience sexual abuse are perceived.

Research has shown that labeling a person can sometimes encourage that individual to behave in ways that emulate the expected aspects of the label, a concept commonly termed *self-fulfilling prophecy* (e.g., Madon, Jussim, & Eccles, 1997). Past research on self-fulfilling prophecies with children has primarily examined educational labels within the classroom. Experimental and naturalistic studies show that labels and expectancies can influence students' academic achievement and behavior, such that the child is fulfilling the expectation of the label (Madon et al., 1997; Rosenthal & Jacobson, 1968; Rosenthal & Rubin, 1978). Building on this, research has investigated the role of mental health diagnostic labels on patient behavior. Link (1987) and Link, Cullen, Struening, Shrout, and Dohrenwend (1989) confirmed the theory that patients may fear rejection from others based on their mental illness diagnosis, which can lead to further dysfunction and isolation. It has been posited that children who hold negative expectations for themselves due to being sexually abused may be at risk for engaging in a self-fulfilling prophecy (Holguin & Hansen, 2003). For example, because the label "sexual abuse victim" is so commonly associated with negative outcomes (e.g., PTSD, depression), this label may act to maintain and possibly exacerbate the child's symptomology. In this example, children hold negative expectations for themselves. In addition, negative expectations may also come from outside sources, such as the child's family, teachers, and friends (Kouyoumdjian, Perry, & Hansen, 2005), which

could serve to reinforce the child's own beliefs. Therefore, it is important to also study the effect of the CSA label in the context of the child's environment.

A similar principle in psychology is *stereotype threat*, the concern of confirming a self-relevant negative stereotype (Steele, 1997). This concern can decrease an individual's performance, ultimately confirming the stereotype. Research has shown that stereotype threat affects children (e.g., Muzzatti & Agnoli, 2007; Neuville & Croizet, 2007; Tomasetto, Alparone, & Cadinu, 2011). One study found that first and third graders knew about the stereotype that those from low socioeconomic backgrounds have lower intellectual abilities and the children from a low socioeconomic background performed more poorly on a cognitive exam when tested in an evaluative context under stereotype threat (Désert, Préaux, & Jund, 2009). Tomasetto et al. (2011) showed that, overall, among girls in kindergarten through second grade, math performance was impaired when tested under stereotype threat. However, they found that stereotype threat did not decrease girls' math performance if their mothers reported a strong rejection to the stereotype that girls are worse at math (Tomasetto et al.).

While there have not been any specific studies using children who have experienced sexual abuse, it is theorized that the principle of stereotype threat may apply to this population. Research could examine CSA victim functioning in a variety of areas under a stereotype threat condition (e.g., CSA victims are permanently damaged, exhibit significant emotional and behaviorial problems, do worse in school, developmentally regress) and under a no-threat control condition to examine the role this may play on child and adult behavior. This research could also act as an intervention or outlet for educating adults as well as children about negative expectancies. Particularly, given the results of Tomasetto et al. (2011) that mothers' beliefs influenced the effect of stereotype threat on their daughters, the study could potentially assess the children's parents' perceptions of CSA victims and explore if this mediates the effects of stereotype threat. Though labels serve a function in identifying and treating individuals in need, labels may also have detrimental effects for children who experience sexual abuse. More research is needed to clearly understand this relationship.

In addition to the potential effect that the CSA victim label has directly on youth,

this label can also influence how other people, including nonoffending caregivers, teachers, professionals, and peers, interact with the youth. Some individuals believe that sexually victimized youth are, as a consequence, marred or damaged, will develop overwhelming emotional and behavioral problems, or will perpetrate on other youth (Cyr et al., 2016; Holguin & Hansen, 2003). Particularly, following their child's sexual abuse disclosure, many nonoffending caregivers experience significant distress (Cyr et al.; Elliot & Carnes, 2001), fear their child will never be the same, and hold negative expectations for the child's emotional and behavioral well-being (Holguin & Hansen; Kouyoumdjian et al., 2005). However, the heterogeneity of response to CSA shows that many factors influence outcomes and an adult's expectation that a child will experience negative symptomology may actually influence the development of those symptoms (Kouyoumdjian et al.) or serve to maintain or exacerbate the child's symptomology (Briggs, Hubbs-Tait, Culp, & Blankemeyer, 1995; Browne & Finkelhor, 1986; Holguin & Hansen; Kouyoumdjian, Perry, & Hansen, 2009). Researchers have aimed to better understand caregivers' perceptions and expectations of the impact of sexual abuse on their child following disclosure (Kouyoumdjian et al., 2009; Meidlinger, West, Hubel, & Hansen, 2012). Practitioners may find it valuable to assess and address nonoffending caregivers' expectations in treatment to improve child and family outcomes. Preliminary research has found that parental depression predicts negative expectations of their sexually abused child (Theimer et al., 2017), suggesting that it may be beneficial for treatment providers to concurrently address parent expectations as well as depression.

While research is limited, the CSA label may also negatively influence teachers' expectations, opinions, and interactions with the child (Bromfield, Bromfield, & Weiss, 1988; Holguin & Hansen, 2003; Kouyoumdjian et al., 2005). Using a sample of middle and high school educators, Bromfield et al. (1988) found that teachers reported that they would be less likely to encourage a child to keep trying following failure on a puzzle task when that child was described as having a history of sexual abuse. Teachers also predicted that the CSA-labeled child would have less success in the future compared to the nonlabeled child. These expectations and behaviors may unintentionally negatively impact CSA survivors' school functioning. Given that children sometimes initially disclose

sexual abuse to teachers and that, in 2015, education personnel were the most likely source of maltreatment reports to child protection agencies (U.S. Department of Health and Human Services, 2017), this may be a particularly relevant area of further research. It may also highlight the importance of examining this topic through a bioecological framework and studying the significant systems outside of the child and family. Additionally, professionals who commonly work with sexually abused youth, such as social workers, therapists or counselors, physicians, and police officers, also tend to have lowered expectations for children's outcomes, which can impact how professionals interact with these children (Holguin & Hansen, 2003; Holm, Holguin, & Hansen, 2002). Moreover, from the authors' experience and as noted in the literature (e.g., Goodman-Delahunty, Martschuk & Cossins, 2017; Holguin & Hansen), among adult populations (e.g., potential jurors) and professionals there is some level of misinformation about children's demeanor and development of symptomology following CSA. For example, some professionals believe that most children will develop severe PTSD symptomology or experience developmental regression in response to the abuse. Furthermore, some may doubt the child's disclosure if the child does not show any internalizing or externalizing symptoms commonly associated with CSA. Providing accurate and up-to-date information about CSA to professionals who encounter children daily could reduce misconceptions and positively influence how they interact with victimized youth.

While addressed much less in the research literature, clinical experience suggests that some youth have significant negative interactions with peers following disclosure. This may be especially relevant for adolescents, given the increased influence of their peer support network. It is unclear whether these negative interactions with peers specifically associate with the CSA label or other confounding factors (e.g., the circumstance of the abuse, the alleged offender); thus, more research is needed. Still, it is important to comprehensively include the youth's peers and friends as potential sources of negative expectations and as individuals who have the potential for influencing victim recovery (Holguin & Hansen, 2003).

Media coverage and the media's portrayal of CSA may play an important role in how people view those labeled as sexual abuse victims (Holguin & Hansen, 2003).

For example, it is common for extreme and severe cases of child sexual abuse to be covered in the media. Severe abuse is more commonly associated with the development of significant mental health symptoms, such as PTSD, depression, and suicidal ideation (Kendall-Tackett et al., 1993). Therefore, these publicized cases may inform people's expectations of sexual abuse victims. Dorfman, Mejia, Cheyne, and Gonzalez (2011) analyzed U.S. news coverage of child sexual abuse and found that the most common story involved the arrests and trials of offenders. This coverage does not represent most CSA cases given that only 29% of cases result in an arrest and many incidents are never reported to police (Snyder, 2000).

Overall, placing the label "CSA victim" directly on a child can have detrimental effects due to the negative connotations many hold. However, little is known about the scholarly use of the term "CSA victims" within the scientific literature when referring to a group of individuals who have experienced sexual abuse in childhood. Interestingly, researchers' use of the term "victims" compared to "survivors" in scientific work has been studied within female adult sexual assault populations. Hockett and Saucier (2015) found differences in research that used "victims" compared to "survivors," such that those who used "survivors" presented a more balanced representation of the consequences associated with adult sexual assault. Currently, there is a dearth of research on the use of these terms with child populations. Widely cited and well-regarded publications within the CSA scholarship use both terms, consistent with the current paper. Examination of this terminology could be an important area of future research.

CSA Victim Stereotyping

Some youth who are sexually abused encounter negative stereotypes based on aspects of their abuse. Though interrelated with the "abuse victim" label described above, the stereotypes victims face represent a unique aspect of stigmatization. While the "abuse victim" label focuses on negative expectancies for sexually abused youth on an individual level, victim stereotyping centers on how victims are typecast based on characteristics of the abuse. Broadly, stereotypes are oversimplified ideas about a particular group. They act as a cognitive shortcut and allow people to make quicker decisions. However, they are not always accurate. Among female sexual

abuse victims, adolescents may be especially likely to be stereotyped. There is a common belief that adolescent girls who wear revealing clothing are asking to be sexually abused (Bell, Kuriloff, & Lottes, 1994; Collings, 1997). This can lead to victim blaming and shaming. Particularly, differences in cultural norms may affect the stereotypes and stigmatization youth face. For example, cultures that value female modesty and virginity may stereotype female victims as blemished (Böhm, 2017; Fontes & Plummer, 2010). Additionally, the status of men and women in the society can associate with stereotypes. In some cultures, female victims may be believed to have played a role in tempting or provoking the sexual encounter and males may be perceived as being unable to control their sexual urges (Böhm; Fontes & Plummer). These cultural influences may act as a significant deterrent for victim disclosure and associate with feelings of shame and guilt.

Male victims may face unique challenges and problems with stereotyping. Males are commonly believed to be more capable of physically resisting the abuse or escaping the abuse (Davies, Pollard, & Archer, 2001; Davies & Rogers, 2006), reflecting the gender stereotype that males must be strong and fight back when assaulted (Thompson & Pleck, 1986). If they do not fight back, they may be perceived as weak (Gagnier & Collin-Vézina, 2016). Across many cultures, male victims who are abused by male perpetrators may be perceived as gay (Davies et al., 2001; Rogers & Davies, 2007) and the fear of being perceived as gay might deter males from disclosing (Fontes & Plummer, 2010; Heru, 2001). Additionally, child sexual abuse committed by a female perpetrator is perceived to be less harmful (Broussard & Wagner, 1988; Esnard & Dumas, 2013; Maynard & Wiederman, 1997; Rogers & Davies, 2007), potentially devaluing the importance of treatment for these youth.

Media portrayals of CSA contribute to problematic stereotypes. A common media portrayal of sexual abuse is often that of a perverted adult stranger preying on children (Holguin & Hansen, 2003). This creates a challenge for victims and families whose offender does not fit this stereotype, such as abuse committed by a family member or a known juvenile—which are both significantly more common than sexual abuse committed by a stranger (Finkelhor & Shattuck, 2012). Additionally, television shows and movies sometimes romanticize relationships between high school students and their teachers,

even when the relationship constitutes sexual abuse under most laws. This perpetuates the stereotype that these relationships are not harmful or potentially not as harmful as other forms of sexual abuse. Overall, these stereotypes may have negative implications for appropriately supporting victims of CSA following disclosure.

CSA Victim Blaming

Another form of stigmatization youth who experience CSA face is victim blaming. Research shows that many disclosures are met with victim blame and believing the youth is culpable for the abuse can have significant negative consequences for the child (Ullman, 2003). For example, placing responsibility onto the child may prompt the youth to self-blame and internalize responsibility (Hunter, Goodwin, & Wilson, 1992). Victims also delay or avoid disclosure altogether due to the fear of being blamed. Delayed disclosure prevents immediate access to mental health services following sexual abuse, could place the youth at risk for subsequent and repeated abuse by the offender, and potentially places other children at risk for sexual abuse by the unreported offender (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003). Finally, when those close to the youth, such as parents and family members, blame the victim it may be expected that they also provide less overall support and compassion. Following CSA disclosure, parental support has been consistently associated with child adjustment; specifically, maternal support has been widely studied (Zajac, Ralston, & Smith, 2015). One aspect of caregiver support is taking the youth to therapeutic services. However, if parents perceive the child as blameworthy, they may be less likely to engage the child in these needed services.

Certain youth are more likely to be blamed. For example, research shows that people believe older victims (i.e., adolescents) to be more responsible for the sexual abuse compared to younger victims (e.g., Back & Lips, 1998; Rogers & Davies, 2007; Rogers, Josey, & Davies, 2007). Blame may be placed on older children at a higher frequency because adolescents are perceived to be less credible, less trustworthy, and less sexually naïve (Davies & Rogers, 2009, Rogers & Davies, 2007; Rogers et al., 2007). Additionally, older youth are believed to be more able to verbally and physically resist an abusive encounter from an adult compared to younger children (Maynard & Wiederman, 1997). Overall, the level of

victim resistance may affect attributions of blame. When children are described as encouraging the sexual encounter, they are deemed more blameworthy (Broussard & Wagner, 1988; Ford, Schindler, & Medway, 2001). Youth who do not resist the abuse and act passively also tend to be ascribed more blame than those who resist the abuse (Broussard & Wagner). Following disclosure, some CSA victims are asked the questions, "Did you fight back?" or "Did you say no?" which could reflect the proclivity to assign blame to children based on their level of resistance. Finally, while more research is needed, the number of abuse occurrences may associate with people attributing blame to the youth. One study found people attributed more blame to a victim who was abused five times by the same perpetrator compared to a victim who was abused once (Theimer & Hansen, 2017). This may reflect the perception that youth must actively do something to stop the abuse after the first incident (i.e., an immediate disclosure) to be considered blame free—and inaction may be associated with the assignment of blame to the victim. This is significant given that most children do not immediately disclose sexual abuse to a trusted and protective adult (Conte & Vaughan-Eden, 2018). It is possible that people are unfamiliar with the reasons why children do not tell about CSA, including the tricks offenders use to gain children's trust and keep victims from disclosing (Craven, Brown, & Gilchrist, 2006).

Overall, blaming the victim for the abuse increases the stigmatization youth feel. Fortunately, victim blaming is commonly addressed in the professional literature, shedding light on the negative implications blame has on survivors of CSA. Moreover, noncompeting theories attempt to explain why people assign responsibility to victims, including Lerner's (1980) just world theory and Shaver's (1970) defensive attribution theory. These research efforts foster a deeper understanding of blame attributions and promote the appropriate assignment of blame to the perpetrator.

Suggestions for Clinicians

Efforts must be made to reduce the stigmatization of CSA survivors. The following briefly describes suggestions for clinicians who work with youth and families who experience CSA. These suggestions are intended to help clinicians support victims and their families and help

disseminate accurate information about CSA.

1. Include nonoffending caregivers, siblings, and other close family members in intervention efforts and provide psychoeducation on (a) the heterogeneity of CSA outcomes and (b) the adverse consequences of the CSA label and having negative expectations for the child's functioning post disclosure. Holguin and Hansen (2003) described that "seeing, perceiving, and interacting with the child in a manner that is not characterized by lowered expectations due to the sexual abuse label may diminish a damaged child mentality and serve to protect the child from additional and exacerbated harm" (p. 664). Additionally, psychoeducation in this area could decrease the chances of a child conforming to a self-fulfilling prophecy or being negatively impacted by stereotype threat. Holguin and Hansen noted that "an environment that enhances rather than limits opportunities and increases motivation so that coping and resilient responses can be created minimizes the chances that a learned helplessness will be fostered" (p. 664). Clinicians should make efforts to assess victims' and family members' negative expectations, keeping in mind and concurrently addressing the factors which associate with having negative expectations (e.g., parent depression).

2. When working with youth and families, use person-first language. In psychoeducational and therapeutic efforts, specific examples of person-first language include phrases such as "children who experience sexual abuse," "kids who receive an unsafe touch," or "children who experience an unsafe situation." In doing this, practitioners can refrain from using the word "victim" as a label in conversations with the child and family. In treatment with youth, professionals may decide to primarily use the term "unsafe touch" when referring to the sexual abuse as well as any inappropriate sexual behavior or unwanted physical interaction. However, this term is not inclusive to all forms of sexual abuse, as not all sexually abusive encounters include a physical touch. Therefore, "unsafe situation" may be preferred in certain cases.

3. Correct inaccurate victim stereotypes made by children, family members, pro-

fessionals, and others. This may be particularly relevant for male victims and adolescent female victims. Clinicians must consider the family's cultural context when addressing victim stereotypes.

4. Help children understand that they are not at fault. In interventions with victims and family members, process and correct statements attributing blame to the child.

5. Provide interventions that focus on increasing factors contributing to resilience (e.g., parental support) and instilling hope in children and their families (Domhardt, Münzer, Fegert, & Goldbeck, 2015; Marriott, Hamilton-Giachritsis, & Harrop, 2014). While validating the distress children and family members may be experiencing, uncover the family's strengths and provide power and control back to the family through prevention efforts.

6. Utilize CSA literature and resources to inform practice. Particularly, clinicians may find it helpful to review research on the heterogeneity of response to CSA (Hubel et al., 2014; Maniglio, 2009; Putnam, 2003) and factors that reduce negative outcomes (e.g., Domhardt et al., 2015; Marriott et al., 2014). Additionally, providers can gain education through online and in-person training. For example, a trauma-focused cognitive-behavioral therapy (TF-CBT) web-based learning course is available at https://tfcbt2.musc.edu. Trainings may also be available at accredited Child Advocacy Centers (see http://www.nationalchildrensalliance.org to find a nearby center).

7. Educate and share research on CSA with other professionals, including that having negative expectancies for a child can influence recovery. Make efforts to inform professionals about the heterogeneity of response to CSA. Provide them with education on the factors that influence risk and resiliency. Promote that, with this knowledge, they could have a positive influence on children's recovery.

8. Many people feel uncomfortable broaching the topic of child sexual abuse; however, discussing the problem of CSA openly may decrease the stigmatization survivors feel, promote timely disclosures, and decrease isolation.

Learn about and share information on the prevention efforts and resources dedicated to bringing awareness to child sexual abuse. Promote victim and family resiliency in the professional and popular media. Read the National Children's Advocacy Center's (2017) position on spreading the message of "progress and hope" (p. 1). Get involved in public policy to advocate for victims and families.

Conclusion

Unfortunately, youth who experience sexual abuse often face stigma from others and this stigma may associate with negative outcomes for the child. Broadly, societal stigmatization of sexual abuse victims deters open communication about the problem of CSA in the community. It may also discourage open and supportive communication between nonoffending family members and the child after sexual abuse is disclosed. A number of interrelated factors contribute to the stigmatization of victims. Stigmatization can involve the label of "sexual abuse victim," which holds many negative connotations. This label can affect children directly or indirectly through the way others interact with the youth. Stigma also includes stereotyping victims based on their abuse history. For example, adolescent female victims and male victims may be especially likely to be negatively stereotyped. Finally, stigmatization includes blaming the youth for the abuse, which has been shown to associate with negative outcomes. Unlike other aspects of CSA stigma, victim blaming has been widely studied in the related literature. Overall, the media may play a potential role in society's perception of youth who experience sexual abuse. Clinicians working with CSA survivors should include nonoffending family members in treatment efforts to reduce negative expectations, correct erroneous stereotypes, and correct attributions of blame toward the victim. Additionally, informed clinicians can share research on the factors that influence risk and resiliency with others and become involved in public policy as an advocate for children who experience sexual abuse and their families.

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Stigma and Treatment Engagement Among Veterans Living With HIV: Recommendations for Research, Intervention, and Policy

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IN 1985, THE VETERAN'S HEALTH Administration (VHA) developed a National AIDS Program to develop a formal policy regarding the HIV/AIDS epidemic. In the three decades since its founding, the program (now titled the VHA National HIV Program) has developed and implemented guidelines for the diagnosis and treatment of Veterans Living with HIV (VLHIV), as well as the education of providers and veterans about HIV prevention, testing, and treatment. These guidelines have been continuously updated as the field's knowledge of the etiology and treatment of HIV grows and as the VHA itself evolves. In their 2014 policy statement, the VHA National HIV Program requires patients treated for HIV infection within their system to be provided "patient-centered, state-of-the-art diagnosis, care, and treatment that reflects their individual value and goals" (VHA, 2014, p. 2).[1] The most recent available esti-mates report that over 26,000 VLHIV currently receive HIV treatment within the VHA, making the organization the largest provider of HIV treatment in the U.S. (VHA, 2014).

Currently, the VHA is nationally recognized as a leader in engaging VLHIVs in care and providing high-quality, comprehensive treatment. When compared to the general population of people living with HIV (PLHIV) in the U.S., VLHIV were significantly more likely to be engaged in care (77% vs. 46%), have received antiretroviral therapy (73% vs. 43%), and have suppressed viral loads (65% vs. 35%; Backus, et al., 2015). Although these rates are undoubtedly influenced by the more com-

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[1] A more recent directive related to HIV has been transmitted by the VHA (Directive 1113, issues 5/5/15). This, however, was less broad in scope and specifically updates the VHA policies surrounding HIV testing.

prehensive medical coverage available to individuals eligible for VHA benefits, there are other factors that may contribute to the VHA's relative success. Among these factors is the integrated nature of care within VHA, specifically the integration of primary care, specialty medical services, and mental health treatment. High levels of service integration are an explicit goal of the VHA, particularly with regard to complex and serious medical conditions such as HIV.

It is well documented that prevalence rates of mental health problems are higher among individuals with HIV and that this relationship is bi-directional; that is, individuals with mental health problems are at greater risk for contracting HIV and PLHIV are at greater risk for developing mental health problems (e.g., Nanni, Caruso, Mitchell, Meggiolaro, & Grassi, 2015). The presence of comorbid mental health problems is associated with a number of negative outcomes with respect to HIV, including reduced adherence to treatment (Gonzalez, Batchelder, Psaros, & Safren, 2011), increased sexual risk behaviors (i.e., condomless anal sex; Bouhnik et al., 2006), increased risk of HIV transmission (Sikkema et al., 2010), and enhanced disease progression (Hartzell, Janke, & Weintrob, 2008). Thus, the need for concurrent medical and mental health services for PLHIV is high both for individuals and to help stem the spread of the virus.

Despite the relatively greater availability and integration of mental health services within the VHA compared to many other health care systems, several barriers to care still remain. Some of these barriers exist for all veterans seeking care regardless of HIV diagnosis. For example, many VA hospitals remain underfunded and understaffed and as such waiting times for treatment can be lengthy. For example, access to care in the VA has been criticized and further exacerbated by a deliberate cover-up at the Phoenix VA, which was at the center of the crisis. In response, VA has released an innovative online tool to promote transparency about wait times and quality measures (https://www.accesstocare.va.gov/Healthcare/Timeliness) that veterans can use to understand care at their local facilities. As of 10/1/2017, 91.9% of patients were seen within 30 days, and 97% of referrals to specialty care were resolved within 7 days (i.e., typically scheduled within 30 days or referred to non-VA care in the community). However, certain positions in many VA hospitals remain understaffed and, consequently, waiting times for treat-ment may be an ongoing issue. Additionally, services can be difficult to access for those who live in rural areas and in urban centers far from a VA facility with an HIV clinic. However, unique barriers exist for VLHIV and co-occurring mental health problems. Primary among these is stigma. HIV and mental health problems are highly stigmatized conditions and many dealing with these issues possess other stigmatized identities (e.g., racial, ethnic, sexual, or gender minority identities; history of drug use). Several aspects inherent in active-duty military service and military policies may serve to exacerbate these stigmas, creating further difficulty for veterans. The focus of the present article is the impact of stigma on how VLHIV and co-occurring mental health problems access and engage in care, and various steps that can be taken to address these issues.

Conceptualizing and Addressing HIV Stigma

Stigma has been broadly defined as a societal phenomenon that begins with the labeling of a difference and then progresses through the following stages: the connection of that difference to negative stereotypes, the separation of those who are labeled from the rest of society ("us" versus "them"), and finally the stigmatized individual's loss of status (Link & Phelan, 2001). Decades of research have demonstrated that HIV-related stigma is associated with a host of negative mental health outcomes in PLHIV, increased HIV risk behavior, and decreased treatment adherence (Hatzenbuehler, O'Cleirigh, Mayer, Mimiaga, & Safren, 2011; Vanable, Carey, Blair, & Littlewood, 2006). Accordingly, HIV stigma reduction has emerged as a top priority of several global organizations dedicated to curbing the epidemic worldwide (e.g., Grossman & Stangl, 2013).

A systematic review of peer-reviewed publications detailing the outcomes of HIV stigma-reduction programs conducted worldwide from 2002–2013 found that the reach, complexity, and quality of the interventions enacted improved over the period (Stangl, Lloyd, Brady, Holland, & Baral, 2013). Most studies were conducted in Asia and Southern Africa; targeted students, health care workers, and people with HIV; and used information-based and skills-building approaches. Approximately 80% of the studies reported statistically significant reductions in all of their outcome measures. Promisingly, the review found that although the majority of interventions were at the individual level, increasing efforts to intervene at the interpersonal, community, organizational, and public policy levels were noticeable. This is especially important given that theoretical frameworks of HIV stigma are increasingly emphasizing that it is a social process that must be understood in relationship to power and domination (Parker & Aggleton, 2003). However, the review also highlighted many notable limitations of the existing studies, including the lack of multifaceted interventions, behavioral and biomedical outcomes, and focus on intersecting identities.

The need for addressing intersecting identities when working to reduce HIV stigma is critical as virtually all of the risk factors associated with acquiring HIV are heavily stigmatized in and of themselves. These include stigmatized demographic profiles (e.g., racial and ethnic minority status, sexual and gender minority status, low socioeconomic status), as well as stigmatized behaviors (e.g., intravenous drug use, sex work, unprotected sex). Thus, most PLHIV contend with intersecting (or layered) stigmas that are often complex to conceptualize but are essential for understanding how stigma affects individuals (Reidpath & Chan, 2005). Although research on intersecting stigmas is increasing, rarely have the unique contributions of active-duty military service and veteran status been considered.

Unique Contributions of the Military Experience to HIV Stigma

Veterans' experience with HIV screening and treatment is likely influenced by their experience while on active duty in the military, particularly for sexual and gender minority (SGM) personnel. Attitudes toward HIV testing and treatment in this subpopulation must be understood in the context of "Don't Ask, Don't Tell" (DADT), the policy under which openly gay or bisexual men and women were banned from the military from 1994 to 2011. Approximately 13,000 service members were discharged from the military under DADT (Burks, 2011). Considering that military physicians and psychologists are not bound by the same confidentiality constraints as civilian providers, many active-duty personnel avoided getting tested or treated for HIV or sought such services at civilian health centers (Smith, 2008). Lack of confidentiality and privacy also likely interfered with reporting incidents of sexual harassment and assault and

may have contributed to increased instances of such abuse (Burks). Victimization during military service and the lack of a supportive structure in which it could be reported likely contribute to less help seeking and greater trust issues among these individuals postdischarge, manifesting in lack of engagement with medical and mental health care. Additionally, DADT significantly stymied research on sexual orientation as well as HIV and other sexually transmitted infections among military personnel, which likely served to maintain stigma (Burks).

Older veterans were affected by what may have been even harsher policies in the pre-DADT era. Until 1942, sexually active men who have sex with men (MSM) could be prosecuted under Articles of War, and celibate homosexual or bisexual men could be given a "blue discharge," which separated them from the military and precluded certain benefits including access to the GI Bill and VA Healthcare. In 1947, blue discharges were replaced with "undesirable discharge" for those men found to have a homosexual or bisexual orientation, while those who engaged in same-sex behavior were "dishonorably discharged." The Crittenden Report, which found that homosexuals in the military posed no security risk, was written in 1957, but was suppressed and not released until a court order approximately 20 years later. Thus, regardless of service era, sexual minority veterans endured harsh policies that may have shaped their willingness to access and engage in treatment.

The recent proposed ban on transgender service members stigmatizes those transgender current and future veterans who have served. Although a federal judge blocked the ban in October 2017, it is uncertain when and whether it may be implemented and the proposal in and of itself devalues the contributions of transgender service members (see Green, 2017, for more information). Transgender people, particularly transgender women, are at elevated risk for HIV, and already experience great stigma generally (CDC, 2017). Therefore, transgender veterans living with HIV are particularly vulnerable to stigma and the host of accompanying negative outcomes.

Several other stigma-related factors not explicitly tied to sexual orientation may further interfere with HIV treatment engagement and health outcomes among active-duty military personnel and veterans. For example, research suggests that having a history of a vast array of adverse childhood experiences associated with stigma (e.g., childhood sexual abuse, severe poverty) are more common among military personnel than civilians (Blosnich, Dichter, Cerulli, Batten, & Bossarte, 2014) and are related to increased incidences of HIV (Fang, Chuang, & Lee, 2016). Additionally, the experience of military sexual trauma (MST), a highly stigmatizing experience, is associated with increased HIV risk (Suris & Lind, 2008). Furthermore, simply being diagnosed with a medical or mental health condition is a source of stigma among active-duty military personnel due to fear that such diagnosis will lead to them being deemed unfit for service and subsequently discharged. As such, reluctance to be screened and treated for various medical and mental health concerns is common.

Addressing HIV Stigma Within the VHA: Current Practices and Recommendations

VHA Directive 1304 (transmitted in November 2014) outlines the organization's priorities for addressing the needs of veterans with HIV. Although the reduction of stigma is not explicitly listed among the priorities, two highly related goals are included. First, the Directive emphasizes the need for the reduction of disparities among at-risk groups of veterans, including those who identify as sexual, gender, racial, and ethnic minorities. In order to increase treatment engagement and improve treatment outcomes among these populations, issues of stigma will undoubtedly need to be addressed. Second, the Directive underscores the need for mental health and substance use services to be integrated into HIV care. Increased access to such services will likely have a significant impact on reducing stigma-related barriers among VLHIV. The remaining priorities—earlier diagnosis, improved access to care, integration of HIV and primary care, and ongoing prevention services for VLHIV—also may indirectly serve to reduce stigma by encouraging greater knowledge and commitment to diagnosing and treating HIV among VHA personnel. Additionally, making HIV testing routine for all veterans may serve to reduce HIV stigma among the broader veteran population.

Although the priorities included in Directive 1304 are undoubtedly important goals to improving care among veterans living with HIV, further progress may be possible through research initiatives, clinical interventions, and policy revisions.

Although the VHA is increasingly focused on reducing health disparities and services for sexual and gender minorities has increased substantially since the repeal of DADT, the literature regarding the unique contributions of military experience to HIV stigma, diagnosis, and treatment remains scarce. First, qualitative methods (e.g., open-ended interviews, focus groups) are likely to be vital for identifying the unique barriers veterans with HIV face in accessing care within the VHA system. For example, does the co-location model that many VA hospitals have adopted for centralizing all medical and mental health care for veterans with HIV assist them as intended or does it make them feel segregated? Second, enhanced service utilization tracking and outcome monitoring has the potential to provide a more nuanced understanding of the type and dose of mental health and supportive services that are optimal for improving treatment engagement and outcome. Such data could shed light on questions such as whether concurrent CBT increases treatment adherence among VLHIV who are also diagnosed with depression. The synthesis of this qualitative and quantitative data can be used to identify which additional services may be required.

There is also great opportunity to implement empirically supported clinical interventions aimed at reducing stigma, increasing treatment adherence, and improving mental health within VHA HIV clinics. Mental health providers working in such clinics could be trained in interventions such as cognitive-behavioral therapy for adherence and depression (CBT-AD; Safren et al., 2012), which has shown to be more effective than treatment as usual for improving treatment adherence and mood among PLHIV, and Effective Skills to Empower Effective Men (ESTEEM; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015), a cognitive-behavioral intervention that addresses minority stress processes in gay and bisexual men and has been shown to reduce risky sexual behavior and mental health symptoms. Even if the funding, personnel, and infrastructure to conduct large-scale randomized control trials of such interventions are not available, quality improvement projects and smaller scale studies have the potential to provide a wealth of useful information.

It may also be necessary to revise existing policies and enact new policies within the VHA to adequately address HIV stigma. The VHA may consider explicitly

prioritizing HIV stigma reduction and adopting related empirically supported practices that have been effective within other organizations and health care settings. Additionally, the deleterious impact of policies like DADT, the currently blocked ban on transgender individuals serving in the military, and experiences like MST may need to be addressed more directly in order to reengage VLHIV. In that seeking care within the VHA is not something a subset of veterans is willing to do, the VHA may also consider partnering with high-quality care providers in the community where VLHIV can alternatively opt to receive HIV care. It is important, however, that discussions surrounding changes to policy and new initiatives be true to the tenets of the Patient-Centered Care Initiative and include the active input of affected veterans.

Conclusion

In recent years, the VHA has emerged as a national leader in the diagnosis and treatment of HIV. VHA policy emphasizes the need for addressing comorbid mental health problems and reducing disparities among disadvantaged populations. Despite this, HIV stigma remains a pervasive issue that prevents many veterans from being screened and receiving treatment. Although programs to reduce HIV stigma are being implemented and evaluated worldwide, there are likely to be unique needs for veterans that are not fully addressed by these programs. Research initiatives, clinical interventions, and policy shifts that address both broad issues related to HIV stigma alongside the unique needs of VLHIV have the potential to further improve treatment engagement and outcomes in this population.

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Bisexual Individuals' Experiences With Changing Their Self-Identified Sexual Orientation: The Roles of Partner Gender and Pressure From Partners

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SEXUAL MINORITY INDIVIDUALS are at increased risk for negative health outcomes relative to heterosexual individuals (Meyer, 2003), and accumulating evidence indicates that bisexual individuals experience the greatest burden (for a review, see Feinstein & Dyar, 2017). These health disparities are due, in large part, to stigma-related stressors (e.g., discrimination; Meyer), and bisexual individuals experience unique stressors that gay/lesbian individuals do not, such as "dual-sourced discrimination" (i.e., discrimination from both heterosexual and gay/lesbian individuals; Brewster & Moradi, 2010; Mohr & Rochlen, 1999). There is some evidence that bisexual individuals also experience unique stressors in the context of their romantic relationships, such as pressure from their partners to change their self-identified sexual orientation to reflect the gender pairing of their current relationship (e.g., to identify as gay/lesbian while in a same-gender relationship or heterosexual while in a different-gender relationship). However, little is known about this unique stressor. To address this, the current study examined bisexual individuals' experiences with changing their self-identified sexual orientation because of the gender of their partner and pressure from their partner.

The Impact of Stigma on Willingness to Date a Bisexual Partner

Heterosexual and gay/lesbian individuals both report negative attitudes toward bisexual individuals (de Bruin & Arndt, 2010; Eliason, 1997; Mohr & Rochlen, 1999; Mulick & Wright, 2002; Yost & Thomas, 2012). These negative attitudes reflect the stereotypes that bisexuality is not a stable sexual orientation (e.g., it is a temporary or transitional identity) and that bisexual individuals are not suitable romantic relationship partners (e.g., they are promiscuous and unfaithful; Brewster & Moradi, 2010; Mohr & Rochlen). For example, bisexual individuals are perceived as less likely to be monogamous than heterosexual individuals and more likely to transmit an STD to a partner than heterosexual and gay/lesbian individuals (Spalding & Peplau, 1997), and bisexual men are viewed as more confused, less trustworthy, less inclined toward monogamy, and less able to maintain a long-term relationship than heterosexual and gay men (Zivony & Lobel, 2014). Armstrong and Reissing (2014) found that men and women both endorsed concerns about dating a bisexual partner (e.g., that they would not be able to fulfill the bisexual partner's sexual needs, that the bisexual partner would cheat on them), and these concerns were most pronounced for committed relationships compared to casual sex and dating.

This bias against bisexual individuals as potential relationship partners often goes beyond negative attitudes and extends to an unwillingness to have sex with or to date a bisexual partner. For example, Eliason (1997) found that most heterosexual individuals reported that they were somewhat or very unlikely to have sex with a bisexual partner, and Mohr and Rochlen (1999) found that nearly one-third of gay/lesbian individuals reported that they were unwilling to date a bisexual partner. Feinstein, Dyar, Bhatia, Latack, and Davila (2014) also found that willingness to be in a relationship with a bisexual partner was lower than willingness to have sex with or to date a bisexual partner, suggesting that some people are able to overlook their concerns about bisexual partners when it comes to casual sex and dating, but not when it comes to serious or committed relationships. This is not surprising, given that bisexual individuals are stereotyped as being promiscuous, unfaithful, and unable to maintain monogamous relationships (Brewster & Moradi, 2010; Mohr & Rochlen), all of which are more relevant concerns for serious/committed relationships compared to casual ones. Bisexual individuals themselves have also described being rejected as potential partners because of their sexual orientation, noting that people have rejected them because of stereotypical expectations as well as negative past experiences with bisexual partners (Li, Dobinson, Scheim, & Ross, 2013). In sum, bisexual individuals face unique challenges related to dating, especially when it comes to serious/committed relationships.

Ongoing Challenges for Bisexual Individuals in Relationships

Bisexual individuals can also experience challenges related to their sexual orientation after entering into relationships. For example, in qualitative studies, bisexual individuals have described experiences in which their partners have invalidated their identities and put them down for being bisexual (Bostwick & Hequembourg, 2014; Hequembourg & Brallier, 2009; Ross, Dobinson, & Eady, 2010). Bisexual women have also described experiencing pressure from their partners to change their self-identified sexual orientation to reflect the gender pairing of their current relationship or because their partner was opposed to dating someone who identified as bisexual (Bostwick & Hequembourg). Further, bisexual women noted that attempts to resist pressure to change their self-identified sexual orientation were often perceived as reflecting stubborness or a lack of committment to the relationship (Bostwick & Hequembourg).

Several potential explanations for this pressure have been proposed. Ochs (1996) suggested that a partner who maintains their bisexual identity while in a relationship can be perceived as holding onto the possibility of having a relationship with a partner of a different gender. Ochs also suggested that gay/lesbian individuals may be especially concerned that a bisexual partner will leave them for a different-gender partner to gain the privileges afforded to people who are, or who are assumed to be, heterosexual. However, while being in a different-gender relation-

ship can afford certain privileges, it can also present challenges for bisexual individuals. For example, bisexual individuals in different-gender relationships are often assumed to be heterosexual (Ross et al., 2010) and bisexual women with different-gender partners report higher levels of stigma-related stress (e.g., binegative discrimination) and negative mental health outcomes (e.g., depression, binge drinking) compared to bisexual individuals with same-gender partners (Dyar, Feinstein, & London, 2014; Molina et al., 2015). Therefore, bisexual individuals can experience stigma-related stress regardless of the gender of their partner. Steinman (2001) also suggested that people prefer for their partners to match their own sexual orientation, because of their personal investment in their identity. Of note, both scholars proposed that lesbian women may be more likely than gay men to reject bisexual

Table 1: Demographics

Age (M, SD)	27.2 (9.9)
Sexual Identity	
Bisexual	70.3%
Queer	11.0%
Pansexual	12.8%
Other	5.9%
Gender	
Cisgender male	26.7%
Cisgender female	53.7%
Transgender	2.3%
Genderqueer	9.0%
Other	8.3%
Race/Ethnicity	
Caucasian/White	82.1%
Latino/Hispanic	4.8%
African American/Caribbean American/Black	2.3%
South Asian	1.8%
Middle Eastern	1.0%
Native American/First Nations	.8%
East Asian	.5%
Biracial/Multiracial	5.1%
Other	1.8%
Country of Residence	
United States	72.0%
Canada	7.6%
United Kingdom	8.8%
Australia	1.8%
Germany	2.1%
Other	7.7%

Note. For self-identified sexual orientation, "other" included: lesbian, omnisexual, heterosexual, mostly lesbian, mostly gay, mostly heterosexual, and other.

individuals as potential partners, because of their strong community bonds and the politicized nature of lesbian identity (e.g., connections with feminism and antipatriarchy).

The Current Study

Despite qualitative evidence that some bisexual women experience pressure from their partners to change their self-identified sexual orientation, little is known about this experience. For example, given that the qualitative evidence came from a sample of 10 bisexual women (Bostwick & Hequembourg, 2014), it is unknown how common these experiences are among bisexual individuals, including bisexual men and transgender/nonbinary individuals. To address this, we conducted an exploratory study of bisexual individuals' experiences with changing their self-identified sexual orientation because of the gender of their partner and pressure from their partner. Additionally, to better understand these experiences, we examined their associations with other stigma-related stressors. We hypothesized that bisexual individuals who had changed their self-identified sexual orientation because of their partner's gender would report higher levels of other stigma-related stressors, including discrimination, internalized stigma, acceptance concerns, difficulty developing a positive bisexual identity, and uncertainty about which sexual orientation label best reflects their attractions and behavior compared to those who had not changed their self-identified sexual orientation because of their partner's gender. Similarly, we hypothesized that bisexual individuals who had experienced pressure from their partners to change their self-identified sexual orientation would also report higher levels of other stigma-related stressors compared to those who had not experienced pressure from their partners to change their self-identified sexual orientation. To our knowledge, this is the first quantitative study to examine these experiences.

Method

Procedure

Data were collected as part of an Internet-based survey focused on sexual identity, minority stress, and relationship experiences among individuals attracted to more than one gender. Participants were recruited from Facebook groups and online listservs for LGB individuals and required to meet the following inclusion

criteria to participate: report being at least 18 years old, attracted to more than one gender, and able to read English. Participants provided informed consent, completed a series of questionnaires, and were offered the opportunity to enter a raffle for one of six $50 gift cards. The questionnaires (described below) were administered in the following fixed order: (1) demographics; (2) experiences with changing one's self-identified sexual orientation; (3) binegative discrimination; (4) internalized binegativity; and (5) acceptance concerns, sexual identity uncertainty, and difficulty developing a positive bisexual identity.

Participants

A total of 397 individuals who reported attractions to more than one gender completed the survey. Most identified as bisexual (70.3%), followed by pansexual (12.8%), queer (11.0%), and other sexual orientations (5.9%). Additionally, most identified as cisgender women (i.e., assigned female at birth and currently identified as female; 53.7%), followed by cisgender men (i.e., assigned male at birth and currently identified as male; 26.7%), and other genders (e.g., transgender, nonbinary; 19.6%). Additional demographics are reported in Table 1. Of note, most participants were White and from the United States and other English-speaking countries.

Measures

Demographics. Participants were asked to report their age, self-identified sexual orientation, gender identity, sex assigned at birth, race/ethnicity, and country of residence. Response options and descriptive statistics are presented in Table 1.

Experiences with changing one's self-identified sexual orientation. Participants were asked, "Have you ever identified with another sexual identity/orientation because of the gender of your relationship partner?" Response options included: (1) No; (2) Yes, I identified as heterosexual while in a different-gender relationship; and (3) Yes, I identified as lesbian/gay while in a same-gender relationship. Participants could select more than one response option, and responses were dichotomized to represent whether or not participants had ever changed their self-identified sexual orientation because of their partner's gender (0 = no, 1 = yes). Those who endorsed this experience were also asked: "Did you experience any pressure from your relationship partner to

Table 2. Associations Between Changes in Self-Identified Sexual Orientation Because of the Gender of One's Partner and Stigma-Related Stressors

	Omnibus	ANCOVA		No Change		Change	
Outcome	df	F	p	M	SE	M	SE
ABES-H Instability	1, 386	2.79	.10	2.67	.07	2.89	.11
ABES-LG Instability	1, 386	2.39	.12	2.53	.08	2.75	.12
ABES-H Sexual Irresponsibility	1, 385	1.05	.31	2.09	.07	2.21	.10
ABES-LG Sexual Irresponsibility	1, 385	.24	.62	1.94	.06	1.99	.10
ABES-H Hostility	1, 384	.29	.59	2.05	.05	2.10	.09
ABES-LG Hostility	1, 384	.18	.67	1.89	.06	1.85	.09
Internalized Binegativity	1, 385	5.13	.08	2.15	.08	2.39	.12
Internalized Bi-Illegitimacy	1, 385	5.16	.02	1.16	.03	1.27	.04
Sexual Identity Uncertainty	1, 385	18.06	< .001	1.92	.07	2.43	.10
Acceptance Concerns	1, 385	11.21	.001	3.36	.07	3.81	.12
Difficult Process	1, 385	17.36	< .001	3.36	.09	4.03	.14

Notes. ABES = Anti-Bisexual Experiences Scale; H = heterosexual; LG = lesbian/gay; means represent marginal means adjusting for participant age and gender.

Table 3. Associations Between Pressure From One's Partner to Change One's Self-Identified Sexual Orientation and Stigma-Related Stressors

	ANCOVA			Change in Identity without Pressure		Change in Identity with Pressure	
Outcome	df	F	p	M	SE	M	SE
ABES-H Instability	1, 108	5.99	.02	2.72	.16	3.24	.18
ABES-LG Instability	1, 108	3.50	.06	2.67	.18	3.13	.20
ABES-H Sexual Irresponsibility	1, 108	4.12	.04	2.14	.14	2.53	.16
ABES-LG Sexual Irresponsibility	1, 108	1.17	.28	2.01	.15	2.22	.16
ABES-H Hostility	1, 107	6.77	.01	1.97	.12	2.36	.12
ABES-LG Hostility	1, 107	.28	.60	1.81	.13	1.90	.14
Internalized Binegativity	1, 108	.08	.78	2.31	.20	2.38	.22
Internalized Bi-Illegitimacy	1, 108	3.68	.06	1.20	.08	1.40	.09
Sexual Identity Uncertainty	1, 108	.50	.48	2.36	.17	2.53	.19
Acceptance Concerns	1, 108	4.02	.05	3.54	.15	3.95	.17
Difficult Process	1, 108	2.10	.15	3.80	.19	4.16	.20

Notes. ABES = Anti-Bisexual Experiences Scale; H = heterosexual; LG = lesbian/gay; means represent marginal means adjusting for participant age and gender.

identify in this way?" (0 = no, 1 = yes). Participants who had changed their self-identified sexual orientation because of their partner's gender in more than one relationship were instructed to consider their most recent experience.

Binegative discrimination. The Anti-Bisexual Experiences Scale (Brewster & Moradi, 2010) was used to assess binegative discrimination. It includes 17 items, each administered twice—once referring to experiences with heterosexual individuals and once referencing experiences with lesbian/gay (LG) individuals. There are three subscales: (1) experiences in which people assume that bisexuality is not a stable sexual orientation (sexual orientation instability, 8-items; e.g., "People have acted as if bisexuality is 'just a phase' I am going through"); (2) experiences in which people assume that bisexual individuals are sexually irresponsible (sexual irresponsibility, 4-items, e.g., "People have treated me as if I am obsessed with sex because I am bisex-

ual"); and (3) experiences of hostility (hostility, 5-items; e.g., "People have not wanted to be my friend because I identify as bisexual"). Items were rated on a 6-point scale (1 = never, 6 = almost all the time) and subscale scores were computed by averaging item responses. Means, standard deviations, and Cronbach's alphas for each subscale were as follows: sexual orientation instability (from heterosexual individuals: $M = 2.75$, $SD = 1.20$, $\alpha = .94$; from LG individuals: $M = 2.60$, $SD = 1.30$, $\alpha = .95$); sexual irresponsibility (from heterosexual individuals: $M = 2.08$, $SD = 1.07$, $\alpha = .81$; from LG individuals: $M = 1.92$, $SD = 1.03$, $\alpha = .81$); and hostility (from heterosexual individuals: $M = 2.02$, $SD = .90$, $\alpha = .85$; from LG individuals: $M = 1.86$, $SD = 1.00$, $\alpha = .87$).

Internalized binegativity. The Bisexual Identity Inventory (Paul, Smith, Mohr, & Ross, 2014) was used to assess internalized binegativity. The 8-item "illegitimacy of bisexuality" subscale reflects internalization of the attitude that bisexuality is not a legitimate sexual orientation (e.g., "I think that being bisexual is just a temporary identity"; $M = 1.20$, $SD = .42$, $\alpha = .78$). The 5-item "internalized binegativity" subscale reflects a negative affective response to being bisexual (e.g., "It's unfair that I'm attracted to men and women"; $M = 2.24$, $SD = 1.25$, $\alpha = .82$). Items were rated on a scale of 1 (*strongly disagree*) to 7 (*strongly agree*) and subscale scores were computed by averaging item responses.

Acceptance concerns, sexual identity uncertainty, and difficulty developing a positive bisexual identity. The Lesbian, Gay, and Bisexual Identity Scale (Mohr & Kendra, 2011) was used to assess acceptance concerns, sexual identity uncertainty, and difficulty developing a positive bisexual identity. All references to "LGB" were changed to "bisexual." The 3-item "acceptance concerns" subscale reflects concerns about being accepted because of one's bisexual identity (e.g., "I often wonder whether others judge me for my sexual orientation"; $M = 3.51$, $SD = 1.22$, $\alpha = .79$). The 4-item "sexual identity uncertainty" subscale reflects uncertainty regarding which sexual identity label most accurately describes one's attractions and behavior (e.g., "I can't decide whether I am bisexual or homosexual"; $M = 2.06$, $SD = 1.10$, $\alpha = .85$). The 3-item "difficult process" subscale reflects difficulty developing a positive bisexual identity (e.g., "Admitting to myself that I'm bisexual has been a very slow process"; $M = 3.56$, $SD = 1.45$, $\alpha = .80$). Each item was rated on a scale of 1 (*strongly disagree*) to 7 (*strongly agree*) and subscale scores were computed by averaging item responses.

Data Analyses

Analyses were conducted using SPSS Version 24. Less than 1% of the data were missing and they were handled using pairwise deletion. First, we examined the proportion of participants who had ever changed their self-identified sexual orientation because of their partner's gender. Second, we used a chi-squared test and follow-up z-tests to examine whether this proportion differed based on participant gender. Third, we used analysis of covariance (ANCOVA) and follow-up pairwise comparisons of marginal means to examine whether levels of other stigma-related stressors differed based on whether or not participants had ever changed their self-identified sexual orientation because of their partner's gender (adjusting for participant age and gender). Finally, in the subset of participants who endorsed changing their self-identified sexual orientation because of their partner's gender, we examined the proportion who had experienced pressure from their partner to do so, whether this differed based on gender, and whether levels of other stigma-related stressors differed based on whether or not participants had experienced pressure from their partner.

Results

Changes in Self-Identified Sexual Orientation Because of the Gender of One's Partner

Approximately one-third of participants ($n = 116$, 29.2%) reported that they had ever changed their self-identified sexual orientation because of their partner's gender. Of those 116 participants, 72 (62.1%) reported that they had identified as heterosexual while in a different-gender relationship, 34 (29.3%) reported that they had identified as gay/lesbian while in a same-gender relationship, and 10 (8.6%) reported that they had done both. There was a significant gender difference, $\chi2 [2] = 9.26$, $p = .01$, which indicated that cisgender women were more likely than transgender/nonbinary individuals to have ever changed their self-identified sexual orientation because of their partner's gender (cisgender women: $n = 74$, 34.7%; transgender/nonbinary individuals: $n = 13$,

16.7%). Neither group differed from cisgender men ($n = 29$, 27.4%). Compared to those who had not changed their self-identified sexual orientation because of their partner's gender, those who had reported higher levels of several stigma-related stressors (see Table 2), including internalized illegitimacy of bisexuality, acceptance concerns, sexual identity uncertainty, and difficulty developing a positive bisexual identity. There was also a trend toward them reporting higher levels of internalized binegativity.

Pressure From One's Partner to Change One's Self-Identified Sexual Orientation

Of those who had ever changed their self-identified sexual orientation because of their partner's gender ($n = 116$, but 3 did not answer the follow-up question), 43 (38.1%) reported that they had experienced pressure from their partner to do so, and this proportion did not differ based on participant gender, $\chi2 [2] = 3.45$, $p = .18$. Compared to those who had not experienced pressure from their partners, those who had reported higher levels of several stigma-related stressors (see Table 3), including all three binegative experiences from heterosexual individuals (sexual orientation instability, sexual irresponsibility, and hostility) and acceptance concerns. There were also trends toward them reporting higher levels of binegative experiences from LG individuals (sexual orientation instability) and internalized illegitimacy of bisexuality.

Discussion

The goal of the current study was to broaden our understanding of bisexual individuals' experiences with changing their self-identified sexual orientation in the context of romantic relationships. To our knowledge, this was the first quantitative study to examine this experience. Previously, a small qualitative study of 10 bisexual women found that some bisexual women had experienced pressure from their partners to change their self-identified sexual orientation to reflect the gender pairing of their current relationship (Bostwick & Hequembourg, 2014). Our findings add to this literature by demonstrating that 29.2% of the bisexual individuals in our sample had changed their self-identified sexual orientation because of the gender of their partner, of whom 38.1% had experienced pressure from their partner to do so. Therefore, 10.8% of our sample had experienced pressure from a partner to change

their self-identified sexual orientation.

Changing one's self-identified sexual orientation in and of itself should not be pathologized. In fact, it is a relatively common experience. For example, in a longitudinal study of a nationally representative sample, 12% of young adults (ages 18–26) reported a different self-identified sexual orientation 7 years later, 70% of whom became more same-sex oriented (Everett, 2015). Further, self-identified sexual orientation can continue to evolve after initially adopting a nonheterosexual identity. Rosario and colleagues found that 28% of sexual minority youth (ages 14–21) reported a different self-identified sexual orientation across four time points (prior to baseline, baseline, 6 months later, and 12 months later; Rosario, Schrimshaw, Hunter, & Braun, 2006). Similarly, Diamond (2005) found that 32% of nonheterosexual women (ages 18–25) reported both lesbian and nonlesbian identities over 8 years, and Everett and colleagues found that 25%–26% of nonheterosexual women (ages 18–82) reported a different self-identified sexual orientation 4 to 5 years later and again 7 years later (Everett, Talley, Hughes, Wilsnack, & Johnson, 2016). There are diverse motivations for changing one's self-identified sexual orientation, including experiencing fluctuations in attractions and contextual changes across development (e.g., new relationships; Diamond, 2008; Peplau, Sparling, Conley, & Veniegas, 1999). However, someone can also be motivated to change their self-identified sexual orientation because of stigma (e.g., discrimination), and pressure from one's partner represents a unique form of discrimination affecting some bisexual individuals. Although speculative, pressure from partners to change one's self-identified sexual orientation may help explain previous findings that relationship involvement is associated with increased anxiety (Feinstein, Latack, Bhatia, Davila, & Eaton, 2016) and psychological distress (Whitton, Dyar, Newcomb, & Mustanski, in press) for bisexual individuals, but not for gay/lesbian individuals. The extent to which changes in self-identified sexual orientation are motivated by different factors (e.g., fluctuations in attractions, stigma) remains an empirical question.

Of note, more bisexual individuals had changed their self-identified sexual orientation to heterosexual while in a different-gender relationship than to gay/lesbian while in a same-gender relationship. This is likely due, in part, to different-gender relationships being more common than same-gender relationships among bisexual individuals (Pew Research Center, 2013). However, it is also possible that it may be more challenging to maintain one's bisexual identity while in a different-gender relationship compared to a same-gender relationship. Previous research has demonstrated that bisexual women with male partners are less open about their sexual orientation, experience more binegative discrimination, and report more depression, binge drinking, and alcohol-related consequences compared to bisexual women with female partners (Dyar et al., 2014; Molina et al., 2015). Therefore, the unique challenges facing bisexual individuals with different-gender partners may lead to them being more likely to change their self-identified sexual orientation while in a relationship. It will be important for future research to examine the different motivations that bisexual individuals have for changing their self-identified sexual orientation in the context of different types of relationships.

We also found that cisgender women were most likely to have changed their self-identified sexual orientation because of their partner's gender (34.7%), while transgender/nonbinary individuals were least likely (16.7%). These findings may reflect sexual fluidity being more common among women than men (i.e., women are more likely than men to experience changes in their sexual attractions, behaviors, and identities; Diamond, 2016). Additionally, women are more likely than men to engage in accommodative behaviors in relationships (Schoenfeld, Bredow, & Huston, 2012). Therefore, it is also possible that changing one's self-identified sexual orientation because of the gender of one's partner reflects a unique form of accommodation among cisgender bisexual women. In regard to transgender/nonbinary individuals, it is possible that they are less influenced by societal pressure to change their bisexual identity compared to cisgender individuals, because they are more accustomed to belonging to a stigmatized social group due to their minority gender identity. If our findings are replicated, it will be important for future research to examine why cisgender women are more likely to change their self-identified sexual orientation because of their partner's gender, despite not being more likely to experience pressure from their partner to do so.

In regard to other stigma-related stressors, we found that bisexual individuals who had changed their sexual orientation because of their partner's gender reported more internalization of the belief that bisexuality is an illegitimate sexual orientation, acceptance concerns, sexual identity uncertainty, and difficulty developing a positive bisexual identity. Although speculative, these stigma-related constructs may reflect motivations for changing one's self-identified sexual orientation while in a relationship. We specifically asked participants if they had ever changed their self-identified sexual orientation *because of the gender of their partner*, but it is possible that such changes were also motivated by having internalizing negative beliefs about bisexuality, concerns about being accepted by others, uncertainty about the sexual identity label that most accurately describes one's attractions and behavior, and struggling to accept one's own bisexuality. It will be important for future research to examine the extent to which each of these concerns influences decisions to change how one identifies.

Finally, we found that having experienced pressure from one's partner to change one's self-identified sexual orientation was associated with having experienced more binegative discrimination, especially from heterosexual individuals. Although our measure of binegative discrimination distinguished between experiences with heterosexual and gay/lesbian individuals, it did not distinguish between experiences with different types of people (e.g., strangers, family members, romantic partners). It is possible that participants who endorsed having experienced pressure from their partner to change their self-identified sexual orientation and binegative discrimination were reporting on binegative discrimination from their partner. However, it is also possible that these findings reflect a pattern wherein some bisexual individuals experience binegative discrimination from their partners and other people. We also found that those who had experienced pressure from their partners to change their self-identified sexual orientation reported more concerns about being accepted and a trend toward more internalization of the belief that bisexuality is an illegitimate sexual orientation. It is possible that experiencing pressure from one's partner to change one's self-identified sexual orientation contributes to bisexual individuals being more concerned about whether or not people accept them for being bisexual and internalizing the belief that bisexuality is an illegitimate sexual orientation.

The current findings highlight the need for structural interventions to reduce bisexual stigma at the population level.

Until attitudes toward bisexual individuals improve, clinicians are tasked with helping their bisexual clients to cope with stigma-related stressors and their consequences for mental health and relationship functioning. It is important for clinicians to recognize that bisexual individuals can experience unique challenges related to finding partners and after entering into relationships. Therefore, interventions that address stigma-related stress need to consider discrimination and rejection from diverse sources, including current relationship partners. That said, it is also important that clinicians do not pathologize changes in one's self-identified sexual orientation. If a client is experiencing pressure from their partner to change their self-identification, then the clinician could help them explore their feelings about being pressured to do so, the pros and cons of changing their self-identification (if they are considering it), and the implications of changing their self-identification (e.g., for their sense of self, relationship, and community involvement).

The decision to change one's self-identified sexual orientation, regardless of the motivating force, is a personal decision. As such, we do not believe that there is a single "right" decision that applies to everyone who is considering doing so. Instead, we believe that clinicians can help their clients to understand their thought processes and emotional experiences in an effort to make a decision that is in line with their personal values and goals. Depending on the individual client's goals, specific evidence-based interventions may be useful as well. For example, if a client is experiencing pressure from their partner to change their self-identified sexual orientation and it is contributing to feelings of depression or to internalizing negative beliefs about bisexuality, then cognitive-behavioral interventions guided by minority stress theory may be useful (for an example, see Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015). If the client wants help resisting pressure from their partner, regardless of whether or not they want to maintain the relationship, then they may benefit from communication skills training (e.g., learning how to communicate their feelings in an effective manner). Again, if a client is considering changing their self-identified sexual orientation because of the gender of their partner or because of pressure from their partner, then we encourage clinicians to focus on helping the client to understand their experience and work toward their individual goals, rather than assuming that

there is a "right" decision in such a situation.

The current findings should be considered in light of several limitations. First, although we specifically asked whether participants had ever changed their self-identified sexual orientation *because of their partner's gender,* it is possible that there were diverse motivations that influenced their decision. It will be important for future research to examine these motivations in order to understand their consequences on relationship satisfaction and well-being. Second, our sample was not a representative sample of bisexual/non-monosexual individuals. All of our participants were affiliated with an LGB-oriented organization listserv or Facebook group and elected to participate in a research study advertised to bisexual/nonmonosexual individuals. Further, most of our participants identified as White and were from the United States and other English-speaking countries. Therefore, research is needed with more diverse and representative samples of bisexual/nonmonosexual individuals. Third, although we examined gender differences in bisexual individuals' experiences with changing their self-identified sexual orientation, it is possible that other demographic characteristics (e.g., age, generational cohort) also influence these experiences. For example, there is some evidence that societal attitudes toward bisexual individuals have shifted from negative to more neutral, and that younger individuals have more positive attitudes toward bisexual individuals (Dodge et al., 2016). As such, younger generations of bisexual individuals may be less likely to experience pressure from their partners to change their self-identified sexual orientations. However, younger individuals are also more likely to identify as bisexual (Copen, Chandra, & Febo-Vazquez, 2016; Pew Research Center, 2013), and this increased visibility may lead to more opportunities to experience this unique stigma-related stressor. It will be important for future research to examine the extent to which age, generational cohort, and other demographic characteristics influence these experiences. Finally, given our cross-sectional design, we do not know if changes in self-identified sexual orientation preceded or followed other stigma-related stressors. Longitudinal research is needed to better understand the direction of these associations. Limitations notwithstanding, to our knowledge, the current study was the first quantitative study of bisexual indivduals' experiences

with changing their self-identified sexual orientation in the context of a relationship. Therefore, findings shed light on a unique experience that warrants attention in future research in order to understand the unique stigma-related stressors facing bisexual individuals and their consequences.

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Stigma Change and Behavior Therapy 20 Years Later

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TWENTY YEARS AGO, I edited a series of papers for another of ABCT's journals, *Cognitive and Behavioral Practice*, addressing cognitive behavioral strategies for erasing the stigma of mental illness (Corrigan, 1998a). A lot has happened since then. Most large Western countries launched nationwide antistigma programs including beyondblue in Australia, Opening Minds in Canada, and Time to Change in the UK. The Substance Abuse and Mental Health Administration (SAMHSA) supported a consensus panel of the National Academy of Science (NAS) to summarize existing research on stigma in order to inform future antistigma programs in the U.S. The NAS (2016) report in many ways reflects the status of research on stigma and stigma change. This special issue of *the Behavior Therapist* provides me with a chance to look back at where we have come over the past two decades as well as forward for promising directions.

What Is Stigma?

Understanding the object of stigma has evolved significantly over the past 20 years. Early research focused on the stigma of "mental illness" per se without unpacking the complex ways in which mental illness is understood (Farina, 1981; Link, Cullen, Frank, & Wozniak, 1987). Articles in this issue show how the object of stigma has evolved. Papers herein describe nuanced issues such as the harm caused by stigma related to child sexual abuse (Theimer & Hansen, 2018; this issue) or intersectionality with bisexual orientation (Feinstein, Dyar, Davila & Jabbour, 2018; this issue). The NAS (2016) panel was charged with describing the stigma of "behavioral health," SAMHSA's way of grouping mental illness with substance use disorder (SUD). The panel concluded that research on the stigma of SUD was exponentially less than that of mental illness. Hence, we summarized the literature of SUD stigma, seeking to extend directions for research using theory and methods from the mental illness research (Corrigan et al., 2017a, 2017b). One conclusion was that SUD, unlike mental illness, stigma seems to be socially and legally sanctioned (Corrigan, Schomerus, & Smelson, 2017). For example, both civil and criminal law permits discrimination against people with SUD, but not mental illness. Public health campaigns often use disrespectful images of people with SUDs to dissuade children from picking up abuse habits.

Another paper in this special issue shows stigma research has grown from a narrow focus on mental illness to concerns about stigma in other health conditions such as HIV-AIDS (LeBeau & Bailey, 2018; this issue). In this light, the American Psychological Association launched its quarterly journal, *Stigma and Health*. Now in its third volume, areas of frequent research in addition to mental health include weight concerns, HIV-AIDS, and sexual orientation intersectionality. The broader enterprise of stigma change grows as we learn how stigma varies with different experiences.

How Do We Remedy Stigma?

In the 1998 special issue of *Cognitive and Behavioral Practice*, I ended my chapter by opining on the role of behavior therapy in stigma change (Corrigan, 1998b). I said behavior therapy is fundamentally a change enterprise in which discrete interventions are used to strategically better a person's life. Distinguished behaviorists have extended the potential of behaviorism from one-on-one therapeutic exchange to societal change. B. F. Skinner (1948) provocatively described *Walden Two*, an idyllic community based on learning theory and operant psychology. More humbly, Cyril Franks (1984) called for behavior therapists to join the ranks of advocates, innovators, and planners to have broad effect on a person's problems. Franks called for environmental change that complements personal efforts.

Behavioral therapists use a "practitioners' criterion" for judging value of specific interventions. Does research, according to the practitioner criterion, suggest that an innovative approach to CBT leads to meaningful improvement in client-therapist exchange and, more important, better outcomes for these clients? More basic research on psychopathology is valued according to the practitioners' criterion when it informs and advances innovative approaches. Stigma research is driven by the "advocates' criterion" (Corrigan, 2018). In this light, descriptive research is important when it provides insights into effective ways to challenge stigma. More important, research on antistigma strategies is beneficial when advocates are able to incorporate findings into their armamentarium for effective stigma change.

Schultz's (2018; this issue) review in this special issue echoes a major theme in the NAS (2016) report. Stigma change efforts need to proceed with caution. Framing mental illness as a brain disorder makes stigma worse, at least in adults (Kvaale, Haslam, & Gottdiener, 2013). While it may decrease blame, it also diminishes the extent to which the public believes people recover. Mental illness is hardwired in. "You may look okay now, but how do I know you won't flip out later?" Other examples emerged in the research literature. Efforts to reduce stigma by focusing on appropriate words are mostly feckless (Corrigan, 2014). Some advocates believe, for example, that the public is better served by replacing words like *schizophrenia* with *Bleuler's syndrome* (George, 2012). Several East Asian countries—Japan, Korea, and Singapore—have actually changed words for schizophrenia into less stigmatizing variants in their language. Word changes in these countries led to many studies on its impact on stigma with two emerging trends (Lasalvia, Penta, Sartorius, & Henderson, 2015). First, word change has no real impact on the general population. Whether it's called schizophrenia or Bleuler's Syndrome, "those people are different than me and they are dangerous." Word change, however, does seem to have an effect on providers similar to the impact of the American Psychiatric Association's release of the DSM-5.0 in 2013. Providers quickly learned which terms were in (e.g., *autism spectrum disorder*) and which were out (*Asperger's Disorder*) so they could accurately complete billing codes. I am unaware of evidence that learning new terms led to decreased stigma in any group.

Stigma change is prone to unintended consequences because of mistakes that occur from progressive zeal (Corrigan, 2018). The stigma of mental illness is fundamentally social injustice, which motivates progressives to action. The world has stirring examples of civil rights heroes—Martin Luther King, Jr., Mahatma

Gandhi—that inspire us. As a result, progressives charge into battle often with naïveté. Education is an especially seductive way for Westerners to right social wrongs. We believe myths about a stigmatized group are easily corrected by facts that counter it. Summaries of research on education, however, show it has very limited effects from pre- to posttest (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012). Any benefits that do arise immediately after education seem to disappear at subsequent follow-up (Corrigan, Michaels, & Morris, 2015).

I do not believe, however, that stigma change programs should be left to the social scientists. We would still be waiting for the wisdom of recovery if not for eloquent advocacy of people with lived experience. Instead, advocates need to marry the good intentions of progressivism with evidence of effectiveness to promote approaches that matter.

If word change and education are not effective approaches to stigma, what are? One effective approach to stigma is contact. Members of the general public who have contact with people with mental illness as peers will show diminished stigma (Couture & Penn, 2003). The contact hypothesis harkens back to the 1950s when Gordon Allport (1954) said that intergroup exchange was the most effective way to decrease conflict between social groups. White people's prejudice against Black people decreases when the two groups interact in everyday, real-world exchanges. Men oppress women less when the two genders work together towards "commonly defined" goals. There is, however, a notable difference between the stigmatizing experiences of people with mental illness and those of people of color, what Goffman (1963) calls *discredited versus discreditable marks*. The stigma of race and gender is discredited based on obvious marks: skin color and body features. The stigma of mental illness is discreditable: it is essentially hidden. Members of the public can easily identify who in a crowd is likely to be harmed by racism because of skin color. Not so mental illness. In fact, the stigma of mental illness is in some ways similar to that experienced by the LGBTQ community. Let me digress to assure the reader I am not saying LGBTQ is a mental illness. This assertion was among the most egregious of modern psychiatry. However, the experience of LGBTQ individuals being in the closet to avoid the shame imposed upon them by ignorant society is similar to that of people with mental illness. Research

recurrently shows that having to conceal one's mental health experiences—to be in the psychiatric closet—has horrible effects narrowly on one's health and wellness, more broadly on the pursuit of all life goals (Corrigan et al., 2010).

The LGBTQ community began to dismantle homophobia when courageous individuals came out by disclosing not only the downside of gay discrimination but, equally important, the pride of their daily lives. Similar advantages may await people with mental illness. A "mad" community has already coalesced to tackle the prejudice and discrimination wrought by labels related to mental illness (Corrigan, Kosyluk, & Rüsch, 2017). Their kind of disclosure, their public face, is what yields the kind of contact that challenges mental illness stigma. Disclosure also has benefits for people in the closet with mental illness. Strategically deciding when and how to disclose aspects of one's journey with mental illness and corresponding recovery can replace the shame of mental illness with empowerment (Corrigan, Rüsch, & Scior, in press). Still, decisions to disclose should not be made lightly. Any benefits need to be clearly considered against risks. The Honest, Open, Proud program is a peer-led strategy that helps people weigh costs and benefits of disclosing and then learn how to do so should they decide. Results of three randomized trials show its impact on decreasing stigma stress and related depression (Corrigan et al., 2015; Mulfinger et al., 2017; Rüsch et al., 2014).

Moving Forward Another 20 Years

Research is beginning to identify principles for effective stigma change, grounding them in contact and disclosure. As elsewhere in behavior therapy, program developers are posing innovative approaches that complement or otherwise extend the effects of existing evidence-based approaches. The goal of APA's Stigma and Health is to provide a forum for rigorous investigations that elucidate the impact of stigma on health conditions and, more important, suggest effective ways to lessen its impact. Community-based participatory research (CBPR) is essential to this effort (Corrigan & Shapiro, 2010). Mango et al.'s (2018; this issue) paper nicely highlights the role of CBPR in developing arts programs meant to replace stigma with empowerment. CBPR emerged out of public health efforts to assure that science meant to impact a community reflects the priorities of that com-

munity. Our research team has moved into programs that address ethnic health disparities in the health care system serving those with serious mental illness (Corrigan et al., 2017; Corrigan et al., in press). We have developed and tested a peer navigator program for African Americans and for Latinxs with serious mental illness. The research team is mostly White, many living in the Chicago suburbs. The only way for programs to be developed and evaluated that meet the needs of the Black or Latinx community is for people from the community to lead the effort.

Hence, the only way to meaningfully develop and evaluate programs meant to decrease stigma is for people from that community to own the process. This means that programs tackling the stigma of mental illness need to be led by people with mental illness. This can be a surprising message for everyone else. If we are not out as a person with lived experience, then our role is as ally. I write this article as a straight male. I am hugely in support of LGBTQ rights. But my role is relegated to ally. Regarding mental illness, this means people with lived experience of mental illness set the agenda and I, as ally, ask where I can help. This can also be surprising news for professionals, especially for psychiatrists and psychologists who have inordinate power in mental health care matters. Our effective place in the stigma battle is either to come out with our own story of recovery, or settle back comfortably into the role of ally.

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Meagan Henry
Ross Jacobucci
Meredith Landy
Clarisa Markel
Elisabeth Markman

Willa Marquis
Kristin Niel
Camilla Nonterah
Sarah Orban
Kelly Peck
Errol Philip
Andrea Pihlaskari
Emily Rooney
Miriam Rowan
Rebecca Schovitz
Jesse Spiegel
Jennifer Stefanik
Colleen Stiles-Shields
Eehwa Ung
Reanna (Sara) Whiting

New Professional 2
Courtney Agorsor
Fernando Alessandri
Kimberly Arditte Hall
Diana Bennett
Rachel Cover
Inga Curry
Corion Duran
Carolyn Ha
Lina Haji
Nora Hope
Karen Jennings
Alissa Jerud
Ashley Knapp
Carrie Massura
Larissa McGarrity
Amy Mikolajewski
Alexandra Perloe
Meredith Ronan
Tyler Sasser
Kathryn Seay
Anna Smalling
Angela Walden
Claire Weaver
Julie Yeterian

New Professional 3
Megan Avery
Gretchen Bandoli
Caroline Barry
Dana Beall Brown
Nicole Campbell
David Contrada
Christy Dutcher
Nancy Fader
Aaron Fischer
Rachel Foster
Christie Gardner
Margaret Lena
  Gustafson

Jennifer Hames
Kathryn Hecht
Eyal Kalanthroff
Emily Lattie
Tyler Mason
Tina Mayes
Aubrey Moe
Jan Mooney
Jose Moreno
Kentaro Nakajima
Naomi Pollock
Emily Prather
Katherine Rose
Lindsay Schnetzer
Marieke Toffolo
Julia Wong
Elizabeth Wrape

Postbaccalaureate
Katrina Aberizk
Yesenia Aguilar Silvan
Christopher Albright
Sydney Baker
Henry Behan
Talia Berson
Vivian Byeon
Corinne Carlton
Gia Chodzen
Matthew Clayton
Giselle Costales
Eliza Davidson
Callah Davis
Brett Davis
Dulce Diaz
Caroline Dress
Ashley Eddy
Olivia Eilers
Connie Fee
Amanda Ferrante
Schuyler Fox
Theresa Gladstone
Katherine Gnall
Aishwarya Gosai
Garo Green
Christina Harris
Carolyn Helps
Alexandra Hernandez-
  Vallant
Esther Howe
Andrew Huckins-Noss
Zohaib Jessani
Madeline Johnson
Clara Johnson
Diane Keister
Brittany Klimek
Susan Kusmierski

Joseph Levy
Elizabeth Mahon
Carolyn Marsh
Rachel Maskin
Mary McNamara
Noelle Mendez
Chantelle Miller
Zahra Mousavi
Alice Mullin
Haruka Notsu
Heidi Ojalehto
Andrew Orapallo
Alyson Randall
Elizabeth Rangel
Meghan Reilly
Laura Saldana
Eva Schonfeld
Katie Scopelliti
Rana Sebak
Ana Sheehan
Ye Sung
Melanie Tran
Marta Trevino
Michelle Truong
Alison Tuck
Patrick Turner
Fayth Walbridge
Madison Walker
Rachel Walsh
Kaylin Wesley
Amelia Yang
Chanel Zhan
Rachel Zukerman

Student
Deah Abbott
Dylan Abrams
Laura Acosta
Ileana Acosta
Colin Adamo
Eguono Akpoduado
Damla Ece Aksen
Jaclyn Aldrich
Ezdehar Alsahow
Olivia Altamirano
Michelle Alto
Pooja Amatya
Stephanie Amaya
Sarah Anderson
Felicia Andresen
Emily Bailey
Nichole Baker
Nicole Baldwin
Shelby Bandel
Kimberly Barajas
Lara Barbir

Sarah Barnes
Abigail Barthel
Brooke Bartlett
Zoey Bass
Brian Bauer
Maya Beach
Alexis Beale
Julia Belfer
Ilana Berman
Natalie Bernal
Bradley Bloomfield
Lauren Bochicchio
Pranav Bolla
William Booker
Brianna Borri
Marissa Bowfield
Melanie Boyac
Charlotte Brill
Kimberley Brown
Casey Brown
Spencer Brown
Briana Brownlow
Alexandra Buccelli
Christopher Buck
Levenae Buggs
Evan Burke
Jordan Burko Macatee
Rachel Butler
Benjamin Calebs
Venessa Candanoza
Mary Carey
Caitlyn Carey
Emily Carol
Janet Carrier
Chelsea Carson
Chelsea Carter
Elizabeth Casline
Rebeca Castellanos
Hailey Caudle
Ian Cero
Charlie Champion
Cindy Chang
Christina
  Chaturanyakoon
Lindsey Chesus
Jason Chung
Kelsey Clark
Kelsi Clayson
Kristen Clouthier
Liza Cohen
Aleta Cohn
Richard Cole
Alexis Collins
Matthew Cook
Molly Cory
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Melissa Craw
Ruifeng Cui
Allison Cunning
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Alessandro D`Amico
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Hannah Dahms
Kelsey Dailey
Katharine Daniel
Alexandra Danlag
Benjamin Darnell
Samuel Davis
Elizabeth Demeusy
Josue Deslauriers
Alexandra Dick
Michael Dolezal
Megan Dorenkamp
Rae Drach
Yeelen Edwards
To`Meisha Edwards
Ryan Egan
Sarah Ehlke
Daniel Elledge
Robyn Ellis
Damian Elson
Dana Ergas
Jasper Estabillo
Troy Fangmeier
Chelsea Feller
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  Rosenfield
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Alfonso Floyd, Jr.
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Whitney Fosco
Michael Friedman
Madelyn Frumkin
Shannon Gair
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Cristina Garcia
Julia Garza
Alexandra Gasbarro
Emily Gawlik
Alexandria
  Georgadarellis
Holly George
Rachel Gernert
Nadav Gerson
Dorothy (Dottie) Gill
Katrina Goines
Rachel Goldman
Julia Goldmark
Aliza Goldstein

Ronella Gollman
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Svetlana Goncharenko
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Michael Gramlich
Tiffany Graves
Judge Graves
Rebecca Greco
Jordan Gregory
Sabrina Gretkierewicz
Jason Grossman
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Robert Guiles
Angela Guy
Lydia hackenberg
Lauren Hammond
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Emily Hanau
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Casey Harris
Christina Harrison
James Haws
Nicole Hayes
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Madeline Herman
Kate Herts
Kiley Hiett
Paige Hildreth
Jaryd Hiser
Hilary Hoagwood
Ethan Hoffman
Hannah Holbrook
Kristyne Hong
Judy Hong
Sarah Horvath
Kristene Hossepian
Jacqueline Howard
AnnMarie Huet
Maryam Huseini
Marina Ibarra
Kelsey Irvin
Paymon Jalali
Jesslyn Jamison
Brittany Jaso
Gracie Jenkins
Chris Jillard
Hallie Jordan
Vanessa Kalach
Raksha Kandlur
Sungha Kang
Demetra Keith
Thomas Kelly
Carisha Kelsey
Samantha Kempker
Candice Kennedy
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Hyoun Kim
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Jamie Kirkpatrick
Patrycja Klimek
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Amanda Korff
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Laura Kurzius
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Taylor Landis
Brittany Lang
Melissa Latham
Thien-An Le
Amy Lee
Han Na Lee
Nicole Legg
Madison Lenox
Rebecca Lieberman
Jessica Llewelyn-
  Williams
Faith Logan
Susanna Lopez
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Kristen Luchene
Berta Luis Sanchez
Ariadne Lyon
Mollie Lyon
Robert Lyons
Melanie Maddox
Kera Mallard
Debesh Mallik
Sybil Mallonee
Melyssa Mandelbaum
Madeline Marks
Shelby Martin
William Martin
Andrea Martinez-
  Abrego
Onkar Marway
Austen Taylor Matro
Nichole Mazzulo
Hayden Mbroh
Kenneth McClure
Matison McCool
Katherine McDermott
Tyler McFayden
Kathryn McGill
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Alexandria Miller
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Katya Naman
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Tommy Ho-Yee Ng
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Kristin O'Brien
Cliodhna O'Connor
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Raul Palacios
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Briauna Paul
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Carolyn Ponting
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Aubrie Potteiger
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Olivia Preston
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Megan Pruitt
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Brittany Quimby
Ana Rabasco
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Kristy Rendler
Lauren Rentschler
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William Sasiela
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Ulysses Savage
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Jesus Schink
Sandra Schlicker
Simone Schriger
David Schuberth
Lily Schwartz
Daniela Scotto
Jed Seltzer
Stefanie Sequeira
Jonathan Shalom
Brittany Sherrill
Samantha Sherwood
Lyndsey Shimazu
Meghan Shippe
Atara Siegel
Karina Silva
Soleana Silva
Chelsy Simmons
Jordan Skalisky
Abigail Skeens
Alexis Smith
Alyssa Smyth
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Cody Solesbee
Zachary Soulliard
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Leigh Spivey
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Fiona Thomas
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Claire Trainor
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Sam Worrall
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Li Wei Yuan
Katherine Zambrana
Anna-Carlotta Zarski
Lauren Zimmerman
Samantha Zohr
Zupa Zupin
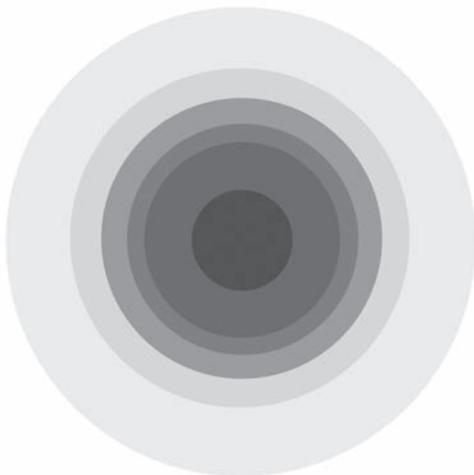
ABCT in DC

52nd Annual Convention
November 15–18, 2018

April is ABCT election month!

VOTING
electronic
ABCT

Full Members, New Member Professionals, and Fellows:

Remember to cast your electronic vote!

If we do not have your email in our system, then we mailed you a paper ballot. If you did not receive voting materials, please contact Dakota McPherson: DMcPherson@abct.org

This year's candidates:

President

Martin Antony

Representative-at-Large

Jeffrey Goodie

Shireen Rizvi

David Tolin

Secretary Treasurer

Jessica Cronce

Sandra Pimentel

ABCT Leadership and Elections Committee:
David Pantalone, *Chair*
Patricia DiBartolo and Kristen Lindgren, *Members*

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