

Dimensions of Folk Psychiatry

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This article presents a social–cognitive model of laypeople’s thinking about mental disorder, dubbed “folk psychiatry.” The author proposes that there are 4 dimensions along which laypeople conceptualize mental disorders and that these dimensions have distinct cognitive underpinnings. Pathologizing represents the judgment that a form of behavior or experience is abnormal or deviant and reflects availability and simulation heuristics, internal attribution, and reification. Moralizing—the judgment that individuals are morally accountable for their abnormality—reflects a form of intentional explanation grounded in everyday folk psychology. Medicalizing represents the judgment that abnormality has a somatic basis and reflects an essentialist mode of thinking. Psychologizing—ascribing abnormality to psychological dysfunction—reflects an emergent form of mentalistic explanation that is neither essentialist nor intentional. Implications for psychiatric stigma and for cross-cultural variations in understandings of the psychiatric domain are discussed.

How mental disorder should be conceptualized is a pressing question within the mental health professions. Theorists vigorously debate how it should be defined and dispute the definitions embodied in psychiatric classifications. Less attention has been paid to how laypeople understand mental disorders. Although professional understandings guide treatment, theory, research, and policy, lay conceptions also have important consequences. The public’s help-seeking decisions and attitudes toward sufferers are driven by beliefs about the nature of disorder, and discrepancies between lay and professional conceptions interfere with treatment, especially when these conceptions originate in different cultural contexts. “Folk psychology” has emerged as a focus of study (D’Andrade, 1995), but “folk psychiatry” might also deserve careful investigation.

But how should laypeople’s concepts of mental disorder be approached? Perhaps they are simply pale reflections of professional concepts, filtered through the media and hence shallow, incomplete, and outdated. This view underpins studies of “mental health literacy” (Jorm, 2000): The public’s literacy is high when its beliefs

about the forms, causes, and treatments of mental disorder correspond to professional knowledge. Although unquestionably important, this view has clear limitations. First, it presents lay concepts of disorder as purely inductive phenomena accruing through exposure to expert knowledge. It leaves little room for the possibility that laypeople actively construct their understandings of disorder, guided by the broader understandings of human nature and deviancy that circulate within a culture. Second, the literacy view sees lay conceptions as declarative knowledge alone, when they surely call on particular cognitive processes and modes. Third, this view presents laypeople’s concepts from the standpoint of expert knowledge rather than in their own terms. Lay concepts of disorder become deficient approximations to professional knowledge, making folk psychiatry seem derivative and granting expert knowledge a questionable taken-for-granted status.

In this article, I develop a social–cognitive account of folk psychiatry that takes a more expansive view of lay concepts of mental disorder. It recognizes the active and theory-guided nature of concept acquisition and representation, the indispensability of culture, and the intimate links between lay concepts and particular social–cognitive processes. It represents a view of lay concepts that allows them to be understood without primary reference to expert knowledge, and with the recognition that

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lay thinking about mental disorder may be saturated with and constructed from lay theories.

My fundamental argument is that lay understandings of mental disorders can be captured within four dimensions. These dimensions are not mutually exclusive alternatives, and particular phenomena are represented along each dimension more or less independently. Each dimension of folk psychiatry has a public or cultural aspect, and each is associated with distinct cognitive processes and modes. In this article, the public and cognitive aspects are discussed, relevant research is integrated, and implications of the folk psychiatry model for psychiatric stigma and for cultural variations in understandings of mental disorder are drawn out. Baldly stated, I argue that “pathologizing” occurs when a particular form of behavior or experience is judged to be deviant or abnormal. Pathologized behaviors and experiences are represented along three further dimensions, each with a distinct explanatory framework. “Moralizing” abnormality involves judging it to be under the person’s intentional control, and thus attributing it to a reproachable perversity or weakness of will. “Medicalizing” abnormality involves attributing it to a bodily aberration, conceptualized as a causal essence. “Psychologizing” abnormality, finally, involves explaining it with causal reference to psychological disturbances—mentalistic but not fully intentional—manifest in psychological dysfunction, emotional distress, or intrapsychic conflict.

Pathologizing

Mental disorder cannot be ascribed unless a form of behavior or experience is judged to be abnormal, aberrant, or deviant. This pathologizing judgment is quite fundamental, but it is agnostic about the causal basis of the abnormality. Determining a phenomenon to be abnormal does not commit one to a particular explanatory framework and is therefore preliminary to explanation. Indeed, special explanatory efforts are mustered when behavior is judged to be deviant.

Pathologizing appears in several guises in the professional discourse. Statistical abnormality is often invoked as a criterion for deciding whether a phenomenon is disordered. For example, Ausubel (1961, p. 72) defined mental illness as “gross deviation from a designated

range of desirable behavioral variability.” Within the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition; *DSM-IV*; American Psychiatric Association, 1994, p. xxi), abnormality is captured differently, as behavior that is not “merely an expectable or culturally sanctioned response to a particular event.” In this sense, pathologizing reflects a judgment that a normative expectation for behavior has been breached. In either case, to pathologize is to judge behavior or experience to deviate from norms—statistical or social—without presuming an explanation for the deviation.

Pathologizing has been a focus of attention in critical studies of psychiatric classification. Many writers note how the psychiatric domain has expanded over the past century to encompass forms of behavior that were previously understood quite differently. Successive editions of the *DSM* have become more differentiated and have broadened horizontally into qualitatively new forms of abnormality and vertically into milder variants of recognized conditions. Thus, it has been argued that the *DSM* wrongly pathologizes many normal psychological variations (Kutchins & Kirk, 1997) and inflates the estimated prevalence of disorder in the community (Horwitz, 2002). However, judgments of abnormality are not restricted to professionals but constitute a fundamental dimension of folk psychiatry. The cognitive processes that underpin these judgments are complex and appear to have at least four components: judgments of infrequency and incomprehensibility, internal attribution, and perceptions of entitativity. Deviant phenomena are seen as inhering in rare, refractory, and reified types of people.

Judgments of Infrequency

Judging behavior to be deviant may simply involve assessing its familiarity by comparing it with stored knowledge. Psychological phenomena will be judged to be abnormal when they are unfamiliar, deviating from mental representations of typical recalled behavior and experience. Perceived infrequency is commonly based on unavailability to recall (Tversky & Kahneman, 1973) in this manner.

Failure of Causal Explanation

Simple judgments of infrequency or unfamiliarity are not the only cognitive processes that may underlie pathologizing. Deviance will be attributed to phenomena that are difficult to comprehend as well as being rare or discrepant from norms. Pathologizing should therefore occur to the degree that behavior eludes explanation. Ahn, Novick, and Kim (2003) have shown that supplying a plausible explanation for a deviant behavior reduces judgments of its abnormality. This finding is consistent with Kahneman and Tversky's (1982) simulation heuristic, according to which the ease of constructing a causal scenario to explain an event is used to gauge the event's likelihood. Understanding behavior makes it more normal by giving it explanatory coherence, and conversely failing to understand it makes it abnormal.

Internal Attribution

Pathologizing behavior or experience tends to imply that the locus of its causality is to be found within the person, even if that cause is currently opaque. The vast literature on attribution theory describes the conditions under which such internal attributions are made, and these conditions appear to be of direct relevance to judgments of abnormality. Kelley (1967), for example, proposed that internal attributions are favored when "consensus" and "distinctiveness" information is lacking and "consistency" information is present. Thus, if a person behaves in a way that differs from how others behave in a particular situation, behaves in the same fashion in other situations, and behaves consistently in the situation over time, the cause of the behavior is attributed to the person. Internal attribution should therefore be triggered when behavior is statistically deviant, especially when it is expressed in a situationally and temporally stable fashion. Pathologizing therefore involves a judgment of deviance accompanied by an inference that the cause of this deviance is internal to the deviant person. Consistent with this view, Blanton and Christie (2003) showed that behavior that violates normative expectations is perceived to be particularly identity defining.

Entitativity

Internal attribution locates the cause of deviance in the deviant individual. However, pathologizing judgments also involve social categorization. I propose that groups of people who are judged to engage in deviant behavior tend to be perceived as coherent entities and that this perception of "entitativity" (Campbell, 1958; Hamilton & Sherman, 1996) is one cognitive component of pathologizing. Entitativity represents the perception that a group is meaningful and homogeneous and mirrors the sociological concept of "reification" (Haslam, Rothschild, & Ernst, 2004).

Several considerations link perceived entitativity to pathologizing. First, minority groups are usually seen to have high entitativity (Brewer & Harasty, 1996), so perceived abnormality should promote it. Second, entitativity is associated with the attribution of shared dispositions to group members (Yzerbyt, Rogier, & Fiske, 1998), so it should be associated with internal attribution. Third, stigmatized and threatening social categories tend to be perceived as entitative (Abelson, Dasgupta, Park, & Banaji, 1998; Haslam, Rothschild & Ernst, 2000), and people with mental disorders represent one such category (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). These factors conspire to make it likely that deviant individuals will be judged to belong to reified categories.

In sum, I argue that several cognitive processes combine to yield a representation of behavior or experience as rare, expectation violating, difficult to understand, internally caused, and indicative of reified kinds of people. Because it involves failure to understand deviance, pathologizing creates an explanatory gap. The three remaining dimensions of the folk psychiatry model represent alternative explanatory frameworks for filling it, and without their explanatory content no judgment of mental disorder will occur. Pathologizing is therefore logically prior to these dimensions and at a somewhat different level of analysis.

Moralizing

One possible response to deviant behavior is to evaluate it as a morally repugnant violation of communal standards and prescriptive norms.

Norm violations can be interpreted in directly moral terms as depravity, but also secularly as criminality or religiously as sin. People who engage in socially disapproved behavior are judged to deserve correction, coercion, punishment, or moral reproach. The history of psychiatry is rife with conditions that have become accepted as mental disorders only after a long period of being considered forms of immorality (Conrad & Schneider, 1980). Substance abuse, addiction, homosexuality, and psychopathy have followed this trajectory, passing from immorality into disorder, and in the case of homosexuality passing out of the latter by a process of normalization (i.e., depathologizing). For some phenomena (e.g., deviant sexualities and violent criminality), there remains a degree of professional ambivalence between moral and psychiatric stances.

Moralizing has important societal and cultural dimensions and cannot be reduced to its cognitive aspects. Nevertheless, moral cognition is a fundamental component of social thinking, rooted in commonsense folk psychology. A basic assumption of folk psychology (D'Andrade, 1995; Malle, 1999) is that acts derive from intentions, which themselves derive from reasons, and that reasons are consciously considered beliefs and desires. According to this folk model of the mind, the presence or absence of intention is fundamentally important for evaluating behavior, especially in moral cognition. As Malle (1999, p. 45) noted, "reason explanations foster praise and blame via the assumptions of agency and responsibility." Unintentional behavior is not held to be blameworthy, and factors that reduce intentionality—sickness, coercion, strong emotion, immaturity—mitigate blame. Norm violation without suitable mitigation will therefore be interpreted in morally saturated intentional terms: The actor has wicked intentions (i.e., perversity) or lacks the ability or desire to restrain them (i.e., weakness of will or intemperance).

Attribution theorists have made a similar point using causal rather than intentional language. Weiner, Perry, and Magnusson (1988) showed that mental or behavioral stigmata are more negatively evaluated than physically based stigmata as a result of differences in their perceived controllability. Behavioral deviance was moralized because it was attributed to causes that the afflicted person could—and

hence should—control. Intentional control again looms large in the moral evaluation of deviance, although by the present account "controllability" is not a matter of attributed causes, as attribution theory supposes, but of ascribed reasons. Framing the perceived controllability of deviance in terms of reasons and intentionality rather than internal causation brings out the elements of responsibility and moral accountability that distinguish the moralizing stance.

If moralizing reflects processes of everyday reason- and intention-based folk psychology, we may speculate about the kinds of deviance that are most likely to be moralized. Forms of deviance that involve behavior perceived to be voluntary should be most moralized. Deviance that involves experiences (e.g., hallucinations), bodily states (e.g., somatic complaints), or reflexive behaviors (e.g., vomiting) should be less moralized. Intentional behaviors that involve consumption should be highly moralized, because their purposiveness is especially salient. Thus, addiction, sexual deviation, and stealing should be more moralized than phobic avoidance or compulsive hand washing.

Medicalizing

Moralizing represents deviance as intentional behavior. Medicalizing takes a somewhat antithetical stance, representing it as the product of somatic aberrations outside the person's control and thus akin to disease. The historical decline of moralizing to a large extent gave way to this view of deviance as sickness (Conrad & Schneider, 1980). Biomedical understandings of mental disorder dominate contemporary psychiatry, which increasingly seeks the causes of disorder in biochemistry, neurophysiology, and genes and advocates somatic treatment.

The medicalization of deviance has been understood primarily as a historical and cultural process, but it also has an important cognitive dimension that is best described as an essentialist mode of thinking. Cognitively, medicalizing represents deviance as the outward expression of a fixed and identity-determining pathological essence. It reflects an ontological assumption that forms of deviance are discrete "natural kinds" (Kripke, 1980) rooted in specific bodily aberrations. The centrality of essentialist thinking to biomedicine has often been noted. McHugh and Slavney (1998) described the dis-

ease model of mental disorder as the “ontological” approach because it postulates objective latent categories. Fábrega (1997) used the same term to account for biomedical assumptions about the specific etiology, invariance, biological basis, and universality of psychiatric phenomena. Luhrmann (2000) ascribed these assumptions to a view of disorders as natural kinds, which Zachar (2000) and Haslam (2000, 2002b) challenged.

Social psychologists and anthropologists have recently come to recognize essentialist social thinking among laypeople. Rothbart and Taylor (1992) argued that people often misconstrue human groups as natural kinds, treating socially constructed groupings as if they were timeless, inalterable, and inductively potent. Hirschfeld (1996) and Gil-White (2001) obtained experimental and ethnographic evidence for essentialist cognition about race and ethnicity, differing over whether it represents an extension of “folk biological” intuitions into the social domain or an abstract mode of construal that can be applied in many domains. Haslam, Rothschild, and Ernst (2000, 2002) proposed that natural kind thinking involves beliefs that a social category has a sharp boundary, defining properties, a natural basis, historical invariance, and immutable membership. They found that people differentiate among social categories along a coherent natural kind dimension that also captures individual differences in beliefs about particular categories.

Essentialist lay thinking about psychiatric categories has also been examined. Haslam and Ernst (2002) demonstrated the existence of a coherent natural kind view of mental disorders: When participants were given information consistent with an essentialist view of a mental disorder, they drew a variety of additional essentialist inferences about it. Led to believe that a disorder had a biological basis, for instance, they inferred that it was a discrete and historically invariant category with defining properties. Similarly, Haslam (2002a) found that the elements of essentialist thinking formed a unified dimension in laypeople’s beliefs about depression. These studies support the view that essentialist thinking is a coherent cognitive mode within folk psychiatry.

By this account, laypeople’s medicalization of mental disorder is not simply an internalization of the biomedical view of deviance; it also

reflects the externalization of a distinct cognitive modality. Biomedicine is one culturally elaborated form of explanation that resonates with essentialist, natural kind thinking. To medicalize is to express a basic folk ontology that may have evolved to make sense of the natural world. This mode of thinking may in some ways misrepresent the professional discourse of biomedicine. Biomedical explanations do not invariably invoke specific etiologies, immutable conditions, or sharply bounded diagnostic entities, and the history of Western medicine contains long periods of decidedly antessentialist thinking (e.g., Canguilhem, 1989). Nevertheless, I argue that laypeople’s medicalizing tends to take an essentialist form, in part a simplifying distortion of biomedical thought and in part the expression of an inbuilt mode of thinking about human variation.

Psychologizing

The emergence of psychology as a discipline and as a basis for understanding mental disorder is a historically recent phenomenon. In less than a century, psychological discourse has saturated Western cultures, carrying with it new ways of understanding self, society, and deviance. However, interpreting deviance psychologically is not simply a free-floating cultural habit but has a demonstrated bearing on patterns of clinical presentation. Across and within cultures, people differ in their tendencies to manifest distress in psychological or somatic idioms (Robbins & Kirmayer, 1991).

How psychologizing should be characterized cognitively is not obvious. First, any unifying properties that it might have are obscured by the diverse forms of explanation that occur in different psychological traditions. Second, psychologizing would seem to be closely related to the cognitive mode associated with moralizing; psychological and intentional explanation both make reference to mental states and processes. Nevertheless, psychologizing and moralizing are importantly different. Moralizing rests on folk psychology, with its currency of beliefs, desires, and intentions. Although these concepts play a role in formal psychological explanation, qualitatively different concepts are usually favored. Fundamentally, folk psychology involves explanation in terms of reasons, whereas

psychologizing involves explanation in terms of causes.

The reason–cause distinction has a long philosophical history and has been resurrected by Malle as a way of examining laypeople’s behavioral explanations. According to Malle (1999, p. 27), reasons are “agents’ mental states whose content they considered and in light of which they formed an intention to act.” Behavior-generating factors that do not meet these criteria are “causes,” and Malle demonstrated that laypeople link causal explanations with unintentional behavior: Causes are believed to generate behavior without mediation by intentions. This distinction between cause- and reason-based folk explanation is different from and irreducible to the internal versus external or person versus situation distinctions that have driven research on causal attribution.

Psychologizing, I argue, reflects social explanation that is mentalistic but causal, which distinguishes it cognitively from moralizing. In several respects, psychological explanation explains behavior with reference to psychological causes and therefore understands it as less than fully intentional. First, in place of intentional concepts, psychological explanations often invoke mechanistic and functional concepts (e.g., dysfunctions). Second, psychological explanations sometimes redescribe intentional concepts in ways that reduce implied intentionality (e.g., belief becomes “schema” and desire becomes “motive”). Third, whereas intentional explanation implies that people are aware of their reasons (Malle’s “subjectivity rule”), psychological explanation often refers to causal influences that operate outside of awareness. Fourth, reasons ascribed in intentional folk explanation are assumed to rationally support actions (Malle’s “rationality rule”), whereas psychological explanation often challenges rationality. Fifth, psychological explanation often refers to the causal history of the person’s reasons for action. Causal history factors (e.g., personality traits and social learning experiences) “offer the context, background, and origins of reasons” (Malle, 1999, p. 32) and appear to be cognized differently than reason explanations. Because people are not understood to be aware of such factors, explanations that invoke them are at least partially causal rather than straightforwardly intentional. Finally, psychological explanation often traffics in emotion, a concept

that sits uneasily with intentional explanation in folk psychology (D’Andrade, 1995). It is believed to have a causal relation to intentions, but also direct links to unintentional expressive and reflexive behavior and to somatic processes.

These considerations—psychological explanation’s deployment of mechanistic, functional, nonconscious, nonrational, causal–historical, and emotional concepts—support the argument that psychologizing differs from intentional explanation largely by its focus on causes rather than reasons. Thus, psychologizing resembles moralizing in its explanatory focus on mental states but differs in construing these states as causes. Similarly, psychologizing resembles medicalizing in attributing causes rather than reasons but differs in representing these causes as mental rather than somatic. Understandings of deviance are often represented in a polarized way, stretched between medicalized disease and moralized character flaw, but the folk psychiatry model suggests that an additional dimension is required.

Are the Dimensions Exhaustive?

The four dimensions of folk psychiatry afford a schema for understanding lay thinking about deviance. The proposed attributes, cognitive bases, cues, and exemplifying conditions of each dimension are summarized in Table 1. However, it could be objected that these dimensions are not exhaustive. Stress and spiritual causes of mental disorder could be raised as additional explanatory modes. However, stress, as a nonspecific term for environmental demands, could be understood in terms of moralizing (i.e., as a force overwhelming weak characters), medicalizing (i.e., as the trigger of immanent aberration), or pathologizing (i.e., as an external factor mitigating perceived deviance). Spiritual explanations of mental disorder (e.g., possession) can also be assimilated to existing dimensions. Kirmayer, Fletcher, and Boothroyd (1997), for example, found that Inuit ascriptions of deviant behavior to spirits or demons were very strongly associated with judged immorality. Alternatively, spiritual explanations could reflect the essentialist mode of thought. Boyer (1993) described how, in an African context, spiritual figures can be understood as a “pseudonatural kind” through the imputation of a spiritual essence. In a similar vein, Keil, Levin,

Table 1
Summary of the Four Dimensions of Folk Psychiatry

Feature	Pathologizing	Moralizing	Medicalizing	Psychologizing
Ascribed properties	Rarity Deviance Incomprehensibility	Controllability Wickedness	Biological causation Uncontrollability Discreteness Immutability	Intrapsychic disturbance or impairment
Cognitive mode	Internal attribution Reification	Intentional folk psychology	Psychological essentialism	Mentalistic causation
Cues	Unfamiliarity Causal opacity	Deviant voluntary behavior Social norm violation	Somatic features Unpredictable transformations	Unintentional behavior Distress Deviant experience
Evaluative response	Aversion	Anger Blame	Pity Avoidance	Reduced blame
Exemplary conditions	Gender identity disorder Delusional disorder	Antisocial personality disorder Substance abuse	Alzheimer's dementia Retardation	Major depression Posttraumatic stress disorder

Richman, and Gutheil (1999) presented supernatural explanations of illness in traditional societies as attempts to “fill in” explanatory gaps left by a lack of concrete biological knowledge. Spiritual explanations of mental disorder might therefore represent a special case of moralizing or medicalizing.

Evidence for the Four Dimensions

The four-dimensional model of folk psychiatry has received empirical support in studies of lay concepts of mental disorder in four countries. In all of these studies, my colleagues and I presented people with paragraph-length descriptions of multiple conditions, some of them *DSM-IV* disorders and others outside the *DSM-IV*'s margins (e.g., neurological disorders, bad habits, problems in living, and criminal behaviors). Participants judged whether the conditions were mental disorders and rated their agreement with items representing criteria proposed in definitions of mental disorder (e.g., “These people are experiencing a malfunction of a normal psychological capacity or mechanism”). By this means, we could assess the breadth of participants' concepts of mental disorders (i.e., the range of conditions judged to be disorders), the correlation of their concepts with the professional (*DSM-IV*) definition, the conditions that best exemplified their concepts, the criteria they used in making their mental disorder judgments, and the structure of their beliefs about disorders.

Haslam and Giosan (2002) investigated the concept of disorder among American undergraduates, who rated 68 conditions on 15 criteria. Three factors underpinned these ratings and powerfully predicted judgments of mental disorder across the conditions. One factor, corresponding to pathologizing, distinguished conditions along a dimension that involved perceived rarity, difference in kind from normality, incomprehensibility, and not being a normative response to life circumstances. It was best exemplified by pedophilia, gender identity disorder, and delusional disorder. Criteria including the presence of emotional distress, impaired ability to cope with life demands, and the inferred presence of a malfunctioning psychological mechanism or intrapsychic conflict loaded on another factor, corresponding to psychologizing. This factor was best exemplified by conditions such as major depressive, dissociative identity, and panic disorders. A third factor was bipolar: One pole represented conditions as controllable forms of socially deviant behavior, conflicts between the person and society, flawed character, or irrationality, and the other portrayed conditions as biologically based. This factor therefore contrasted moralizing and medicalizing. The most moralized conditions included antisocial personality disorder, and the most medicalized included Alzheimer's dementia and hyperthyroidism.

Giosan, Glovsky, and Haslam (2001) replicated this study using translated measures in Brazil and Romania. Similar dimensions

emerged, again capturing a very large proportion of the variance in judgments of mental disorder. Comparable dimensions emerged in studies of lay concepts of childhood disorders conducted in Australia (Giummarra & Haslam, 2003) and in a study of Brazilian sojourners in New York (Glovsky & Haslam, 2003). In that study, higher levels of American acculturation were associated with greater tendencies to understand “*distúrbio mental*” in psychologizing and moralizing ways. Versions of three of the dimensions—labeled somatic, psychological, and normalizing (the reverse of pathologizing)—emerged in a Canadian study of attributions for somatic complaints (Robbins & Kirmayer, 1991). Thus, international research supports the existence and generality of the proposed cognitive dimensions.

Finally, a recent study directly supported the proposed cognitive bases of three of the dimensions. Levi and Haslam (in press) had participants write free explanations for five conditions hypothesized to exemplify moralized, medicalized, and psychologized disorders. Explanations were coded for Malle’s (1999) three modes of folk explanation (causes, reasons, and causal history of reasons). All folk psychiatry model predictions were supported. A hypothetically moralized mental disorder (antisocial personality disorder) and a socially deviant nondisorder (assaultiveness) were more likely than a hypothetically medicalized disorder (Alzheimer’s dementia), a nonpsychiatric disease (Parkinsonism), and a hypothetically psychologized disorder (major depressive disorder) to obtain reason explanations. The medicalized mental disorder and the disease were most likely to receive cause explanations. The hypothetically psychologized disorder received more causal history explanations than the others, and the mental disorders were more psychologized than the nondisorders. Explanation types were only weakly correlated with attributional dimensions (e.g., controllability), supporting their distinctness.

Implications for Public Attitudes Toward Mental Disorder

If the folk psychiatry model is to be useful, it should illuminate other aspects of laypeople’s responses toward mental disorder, such as their

attitudes. Mental disorder is the enduring focus of stigma, with sufferers perceived to be dangerous, unpredictable, and dirty (e.g., Link et al., 1999). The folk psychiatry dimensions might clarify the psychological basis of stigma and suggest paths to its reduction. Theorists and researchers have often linked it to the moralizing dimension by showing correlations between controllability attributions and rejecting attitudes toward numerous stigmata, including mental disorders, obesity, and homosexuality. Weiner et al. (1988), for example, found that people with mental illness are often judged to be responsible for their deviant behavior. The apparent link between moralizing and stigma has prompted destigmatization campaigns to challenge the ascription of character weakness to the mentally ill, substituting a medicalized view of mental disorder as the uncontrollable outcome of a somatic cause, no different in kind from diabetes.

Research suggests that a medicalized understanding of disorder is no panacea for stigma, however. Read and Harré (2001) found that people who attributed mental disorder to biogenetic causes tended to hold more negative attitudes toward it, and Mehta and Farina (1997) showed that confederates who disclosed a psychiatric problem were blamed less but treated more harshly when the problem was described as being of biological rather than psychosocial origin. Similarly, Walker and Read (2002) found that a biomedical explanation of a psychotic man’s condition increased perceptions of his dangerousness and unpredictability.

Several pathways may lead from medicalizing to stigma. Medicalizing may trigger paternalistic responses linked to punitive control and encourage a view of the disordered as deeply and categorically different (Read & Harré, 2001). Attributing disorder to uncontrollable causes such as chemical aberrations may produce a perception that the disordered are unaccountable, irresponsible, and unpredictable and may produce a sense of vulnerability among the unaffected, as with infectious diseases. A medicalized self-understanding may also handicap sufferers, engendering a belief that they are incapable of ever functioning normally, a belief that may elicit pessimism and disengagement if also held by the lay public (Farina, Fisher, Getter, & Fischer, 1978).

These proposed links between medicalizing and stigma all reflect components of the essentialist mode of thought hypothesized to underpin medicalizing. Locating the disordered in a bounded category reflects the discreteness component, and pessimism over recovery reflects immutability. Perceived personal vulnerability and unpredictability may also rest on essentialist thinking, given Keil et al.'s (1999) claim that mental disorder is sometimes implicitly understood to be contaminating and Gelman and Hirschfeld's (1999, p. 434) claim that essentialist thinking is recruited "when the event being explained is unpredicted or causally anomalous with respect to other events in the same domain."

These links between essentialist thinking and stigma are speculative, but they are beginning to find an empirical footing. Essentialist thinking does not have a simple link to prejudice (cf. Allport, 1954), but some aspects of it may. Believing homosexuals and heterosexuals to be fundamentally different in kind is associated with antigay attitudes (Haslam et al., 2002; Hegarty & Pratto, 2001), and believing that people's attributes are fixed is associated with a greater tendency to make stereotype-based judgments (Levy, Stroessner, & Dweck, 1998). The apparent connections between medicalizing and stigma might reflect similar dynamics of prejudice in the psychiatric domain.

An important implication of this discussion is that medicalizing is not reducible to the attribution of uncontrollable causes for mental disorders. If medicalizing were simply the attribution of uncontrollability, then pity and helping should be elicited, and stigma reduction campaigns that assimilate mental disorder to disease should be effective. However, if medicalizing calls into play a set of evaluatively complex inferences—of discreteness, immutability, and unpredictability—then a less sanguine pattern of responses should arise, as research increasingly indicates.

One way of reconciling the evidence that moralizing and medicalizing are both associated with stigma is to consider that they may be associated with qualitatively distinct forms of aversion. Studying the qualitatively different emotional reactions to different forms of norm violation has been a focus of recent social psychology. Neuberg and Cottrell (2002), for example, catalogued people's differential reac-

tions to those who are perceived to be nonreciprocators or treacherous, or who advocate or symbolize values that conflict with social norms. Treachery and value conflict appear to be associated with moralizing, in that they are usually perceived to involve deliberate immoral conduct and elicit anger and moral reproach. Nonreciprocation may be more closely tied to medicalizing, in that deviance attributed to a physical aberration is judged to be fixed and disabling. This form of stigma is associated with avoidance rather than anger, a pattern observed in reactions toward physical disability. The avoidance of medicalized deviance can also be understood as a consequence of the essentialist belief that others are deeply and categorically different from oneself (Haslam et al., 2002; Hegarty & Pratto, 2001).

The relations between psychiatric stigma and the moralizing and medicalizing dimensions are clearly complex, involving distinct cognitive pathways and affective responses, and neither offers a simple antidote to stigma. The folk psychiatry model clarifies these subtleties, which the attributional analysis of controllability cannot, and it raises new questions that stigma research based on this analysis fails to address. In particular, how are pathologizing and psychologizing associated with stigma?

The role that pathologizing might play in psychiatric stigma has not been adequately considered to date. Being statistically deviant, violating expectations, being hard to comprehend, and having one's deviance internally attributed and reified should promote negative reactions. As Scheff (1999) argued, the disordered person's violation of normative expectations can engender fear, embarrassment, and ontological insecurity. Consistent with the role of pathologizing in stigma, greater familiarity with mental disorder is associated with more positive attitudes (Angermeyer & Matschinger, 1996). Pathologizing may therefore be an insufficiently appreciated determinant of stigma separate from moralizing, mentalizing, and controllability attributions. The role of psychologizing in stigma is unclear. It may be associated with benevolent attitudes and empathy, to the extent that mitigating intentionality attenuates blame and psychologizing foregrounds emotional distress. However, research is needed to untangle the distinctive associations of stigma with this and the other dimensions of the folk psychiatry

model. Studies will need to go beyond examination of causal attributions by investigating pathologizing and reason-based explanation, examine additional explanatory frameworks (i.e., psychologizing), and embed controllability attributions in broader frameworks of moral and essentialist thinking about deviance.

Cultural Variations in Concepts of Mental Disorder

Folk psychiatry might serve as a useful framework for making sense of cultural variations in lay concepts of mental disorder. There are important continuities and deep discontinuities in disorder concepts across cultures, and these could be mapped onto the four dimensions. Here I sketch four possible ways of mapping cross-cultural differences. First, the range of phenomena to which disorder concepts refer might differ quantitatively, although the dimensions themselves and their relation to disorder judgments are shared. Second, the relations between the dimensions and judgments of disorder may differ across cultures, although the dimensions are shared: Features of different dimensions underpin different disorder concepts. Third, the dimensions may have different interrelations in different cultures. Fourth, one or more dimensions may be importantly different or absent in a culture.

The first, quantitative form of cross-cultural difference is evident in Giosan et al.'s (2001) study of disorder concepts in the United States, Brazil, and Romania. The structure of the concept in the three countries was similar, with equivalent dimensions having similar relationships to disorder judgments, but Americans judged a greater range of conditions to be mental disorders than Brazilians or Romanians. The cultural basis of this difference was demonstrated by Glovsky and Haslam (2003), who showed that the number of conditions judged to be disorders by Brazilians residing in the United States correlated with their level of American acculturation. A related process of cultural change is evident in the United States over the past half century. A pioneering survey conducted by Star (1955) revealed that many psychiatric conditions were judged to be mental illnesses by small minorities of the population, whereas recent surveys (e.g., Link et al., 1999) show much higher rates.

The second form of cross-cultural variation in disorder concepts involves different associations between the folk psychiatry dimensions and disorder judgments. Even if the dimensions were universal, they might be differentially associated with the meaning of the concept. Some cultures might hold more medicalized and others more moralized understandings of disorder, for example. In this vein, Giosan et al. (2001) found that Romanians tended to hold a more medicalized understanding of mental disorders than Americans and Brazilians, whose concepts of disorder were relatively moralized.

The third and more qualitative form of cross-cultural variation involves differences in the interrelations of dimensions. One possible example involves medicalizing and moralizing. Rosenberg (1997) has argued that the opposition between moral and medical understandings of illness is a consequence of 19th-century advances in the explanation of disease, implying that moralizing and medicalizing stances toward mental disorder need not stand in polar contrast. This might be especially true in non-Western contexts wherein lay conceptions of disease are less influenced by Western medical history, and concepts of mental disorder might therefore reflect less antithetical understandings of the biomedical and the moral. Consistent with this possibility, in Giosan et al.'s (2001) Brazilian sample the medicalizing and moralizing dimensions were statistically unrelated, whereas they were opposed in a bipolar factor among Americans.

The fourth way in which culturally variant understandings of disorder might be represented within the folk psychiatry dimensions is the absence or radical distinctness of one or more dimensions. Notable here is psychologizing. Attributing behavioral deviance to psychological dysfunction, and attending to intrapsychic phenomena such as emotional distress and conflict, is an explanatory idiom that has grown steadily in the West over the past century. Consistent with this point, Giosan et al.'s (2001) American participants, relative to Brazilians and Romanians, judged more conditions to be disorders and based their judgments more on psychological criteria (e.g., distress, psychological malfunction, and intrapsychic conflict). Similarly, Glovsky and Haslam's (2003) Brazilian sojourners adopted a more intrapsychic concept of disorder with increasing American accultura-

tion. Psychologizing may represent an emergent form of explanation with cultural roots in recent Western history. Whereas pathologizing, medicalizing, and moralizing are arguably universal, psychologizing as a distinct cognitive dimension may be absent or rudimentary in traditional societies. Phenomena akin to those that exemplify mental disorder in the West may be attributed to bodily or spiritual causes or moral failure rather than to inferred psychological dysfunctions. A corresponding lack of a superordinate mental disorder concept might be expected alongside this attenuation of psychologizing.

Conclusion

Considered separately, the four dimensions proposed here are not original. The article's intended contribution, rather, is to assemble them into a coherent framework, theorize their cognitive underpinnings, and address them to laypeople's thinking. The dimensions offer a systematic framework for studying lay concepts of disorder, which have often been reductively examined as pale reflections of expert knowledge or within the cognitively impoverished framework of attribution theory. To be useful, the folk psychiatry model must demonstrate its capacity to illuminate lay concepts. Attempts to do so for psychiatric stigma and cross-cultural variations have been offered here, but ideally the dimensions should clarify additional phenomena such as historical shifts in public perceptions of deviance, patterns of psychological help seeking, the clinical presentations of mental disorders, and discrepancies between lay and professional understandings.

The theoretical proposals laid out in this article are tentative and well in advance of the available research. Further study may call into question the proposed dimensions and their capacity to account for lay thinking about mental disorders. Nevertheless, these proposals represent an attempt to disentangle and theorize phenomena that often have not been distinguished and explained in previous work.

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Received October 15, 2003

Revision received January 30, 2004

Accepted February 3, 2004 ■

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