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Dehumanization and mental health: clinical implications and future directions

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Research shows that people with mental health conditions experience dehumanization, and this is associated with states of emotional distress. Possible sources of meta-dehumanization include interpersonal interactions with members of society, professionals, and institutions, as well as negative portrayals in the news and media. Self-dehumanization may arise from the internalization of these meta-perceptions, interpersonal interactions, or the inherent nature of certain mental health conditions. This article reviews literature on meta- and self-dehumanization within clinical psychology, suggests directions for future research, and provides clinical implications for the field. We advocate for the consideration of self-dehumanization in existing therapies, the development of protocols designed for rehumanization, and the provision of more humanizing care by professionals and society.

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From human zoos to insane asylums, public and professional attitudes have demonstrated a historical lack of empathy for people with mental health conditions. While perceptions of mental health are evolving, people with mental health conditions are still viewed as lacking humanity, and therefore more likely to be treated in a manner that is antisocial, aggressive, and exclusionary [1•–4]. Here, we review empirical work around dehumanization within clinical psychology, from 2000 to 2022, and provide direction for research and clinical intervention. This work includes both meta- and self-dehumanization and their respective relevance within clinical psychology. As there are distinctions between various types of mental health conditions [1•], our commentary highlights people with psychosis and substance use disorder as examples of individuals particularly vulnerable to dehumanization [1•]. Additionally, we propose a novel association with extreme dehumanization: death by suicide. Our hopes are to provide further awareness of dehumanization within mental health and simultaneously steer conversation toward additional research and remedy.

Meta-dehumanization

Meta-dehumanization, the perception that oneself or one's identity is perceived as less than human by other people, is oftentimes a result of personal attributes or membership to a respective social group. In a multigroup study, surveying women, people with alcohol use disorder, and organizational employees, DeMoulin and colleagues [5] found that thwarted psychological needs (control/autonomy, belonging, and self-esteem) acted as antecedents for meta-dehumanization. This work suggests potential avenues of meta-dehumanization that may be of relevance to people with mental health difficulties [1•,6•]. If people do not feel they belong with others, are in control of their experience, or have sufficient self-esteem, this may lead to meta-dehumanization.

Boysen and colleagues asked participants to rate the humanity of people with various mental health conditions by diagnosis. People with mental health conditions were generally seen as less human than the 'American' control group. Furthermore, these perceptions were moderated by mental health condition and ethnicity — suggesting that those with diagnoses typically more 'othered', such as psychosis and substance use disorder, and those with minority ethnic identities, may be dehumanized to a greater extent [1•]. These perceptions may be related to negative portrayals of people with mental health conditions in the news and media (i.e. dangerous, violent, and unpredictable; [7,8]). Consequentially, societal stigma could impact interpersonal relationships (i.e. thwarted belonging), an empirically supported pathway toward meta-dehumanization [5].

Meta-dehumanization may also occur within the clinical context, from interactions with healthcare service providers, staff, and clinicians [9]. Unfortunately, research suggests that healthcare staff dehumanize psychiatric patients more so than general hospital patients [10•], perhaps suggesting additive dehumanizing experiences for those with mental health conditions. Experiential accounts suggest that people in clinical settings can feel like both an object that needs fixing, and a child lacking independence [11]. A review [9] highlighted deindividuating practices, impaired patient agency, dissimilarity, mechanization, empathy reduction, and moral disengagement as potential causes of clinical dehumanization. Vaes & Muratore [12] suggest this may serve a protective function for staff, and that dehumanization may reduce staff burnout. Nevertheless, the intention behind any form of dehumanization does not reduce its impact. Given that hospitals are a place for recovery, and that therapeutic relationships are a fundamental component, meta-dehumanization may disrupt quality care.

Furthermore, institutions such as psychiatric hospitals can be dehumanizing environments that may reinforce and exacerbate meta-dehumanization [13]. While they intend to provide care for service users, practices such as restraint, seclusion, sedation, and curtailing of freedoms are inherently dehumanizing experiences (i.e. loss of autonomy/control; [5]). There is critical understanding, relief, and pathways forward in accurate diagnostic feedback; however, if done poorly, assessments, diagnoses, and the focus on symptoms and medication rather than the person may also feel dehumanizing. It is no wonder, then, that interpersonal, medical, and institutional experiences of meta-dehumanization may result in negatively internalizing beliefs about one's humanity.

Self-dehumanization

Self-dehumanization is the perception that oneself is less than human. Fontesse and colleagues [14•] found that meta-dehumanization was related to anxiety, depression, and the maintenance of drinking habits in people with alcohol use disorder. However, importantly, these relationships were fully mediated by self-dehumanization, suggesting internalization of dehumanization (self-dehumanization) may better explain poor mental health outcomes than meta-dehumanization. This aligns with previous correlational research suggesting an association between self-dehumanization and anxiety, negative affect, and physical symptoms of distress [15].

Self-dehumanization may stem from the nature of mental health difficulties, cognitive perceptions, and social interactions [14•–16]. Additionally, continued experiences of meta-dehumanization may be internalized into one's self-concept, resulting in self-dehumanization [14•]. For some conditions, their nature may be inherently dehumanizing. In qualitative accounts, people with psychosis have articulated a variety of distressing experiences which give rise to self-dehumanization. These include a loss of personal agency [17], and hearing voices that deny independence and competence [18]. Difficulties can arise with social connection, where people with psychosis have reported feeling a lack of belonging with other people and seeing themselves as below others. A diminished sense of self, self-worth, and loss of trust in oneself also contributes to the feeling of self-dehumanization (Venus & Chadwick, unpublished). In people with alcohol use disorder, Fontesse and colleagues [14•] suggest that negative emotionality from self-dehumanization can lead to relapsing into binge drinking, potentially contributing to refueling the cycles of addiction. Taken together, these findings suggest that the nature of the mental health condition and self-dehumanizing perceptions may be in a cyclical battle, with each reinforcing the other.

Theoretical implications of dehumanization on mental health

Theories addressing stigma, hopelessness, connection, and dehumanization set a strong foundation to identify how self-dehumanization may impact mental health [1•,19–23]. The initial theoretical origins of stigma reference a reduction in humanness, suggesting one is taken from a 'whole' and 'usual' person and decreased to something less [22]. This sense of wholeness is also contingent upon our need for connection, the feelings of being 'human among humans' as we are 'much more simply human than otherwise' [23,24]. Nevertheless, individuals with mental health concerns have been classified to align with animalistic traits (e.g. underevolved) and mechanistic traits (e.g. lacking warmth and competence), both of which are seen as subcategories of dehumanization [1•,4]. Furthermore, these nominal associations have very real consequences — perpetuating avoidance from within the mental health system, impacting one's ability to socially connect to others, and to engage with society overall [21,25].

Theoretically, self-dehumanization could act as a conduit between thought and behavior. To highlight how this may impact extreme forms of self-dehumanization, we present a novel explanation from the lens of death by suicide. Suicide accounts for around 1.3% of global deaths [26]. Though death by suicide is less common than other causes of death, it creates considerable alarm due to its tragedy, scope of impact, and preventability. As preliminary evidence supports a relationship between dehumanization and suicidal thoughts and behaviors (Robison, under review), there is a critical need to framework how dehumanization fits into ideation to action theories. The Interpersonal Theory of Suicide (IPTS),

identifies how self-inflicted lethality occurs at the convergence of suicidal desire (i.e. perceived burden and thwarted belonging, both viewed as intractable by the individual) and one's ability to behaviorally enact fatal self-injury (i.e. capability for suicide [27,28]). Self-dehumanization has been shown to amplify a sense of 'otherness' and social isolation [29,30], which, when coupled with thoughts of death, could potentiate further disconnection from others. Although not yet empirically supported, feelings of inhumanity could spur the incorrect belief of one's inability to constructively contribute to society (e.g. perceived intelligence, self-sufficiency, and skill specialization), leading to the perception of burdensomeness (i.e. indicated through qualitative accounts [31]). Furthermore, self-perception of nonhumanness has been shown to decrease bodily value and/or sacredness and has been preliminarily related to self-harm [32,33]. We recognize the need for further research, nevertheless, self-dehumanization may prove to be a clinically promising leverage point within suicide research, acting as an intermediary between suicidal desire to suicidal action.

Clinical impact

Today, there are still underlying expectations in the controllability and responsibility of mental health conditions. Individuals are expected to take ownership by initiating treatment and managing their symptoms [19,34]. This becomes particularly challenging when the behaviors and concerns individuals seek to alleviate are further dehumanized and stigmatized based on their visibility (e.g. psychosis [1•,35,36]). Stigma creates feelings of inadequacy and guilt in connection with mental health conditions [37] and manifests in maladaptive behaviors such as treatment disengagement [38–41]. As these conditions are psychologically, biologically, and socially woven from the fabric of human existence [42], it is vital that novel factors, such as dehumanization, are researched to broaden our understanding and instigate intervention within mental health.

Future directions for research

To best address these concerns, we build upon the suggestions of prior researchers (c.f. [43]), identifying and discussing future avenues within clinical populations from a social, environmental, and contextual perspective. As such, the field must first turn toward the development and validation of scales assessing self-dehumanization, meta-dehumanization, and symptom-specific dehumanization. While prior work has begun these processes (c.f. [6•]), there is ample opportunity for a generalizable gold standard.

Once effectively measurable, research may then begin understanding the antecedents, consequences, protective factors, interactions, and the restorative effects of meta- and self-dehumanization. At large, organizational and environmental research around hospitals, research facilities, and treatment settings may aid in identifying the complex interplay of managerial, staff, and client meta- and self-dehumanization [44–46]. This may lead toward 'humanizing' certain elements of the care while simultaneously meeting the needs of service users.

Self-dehumanization research thus far has largely been correlational and conducted on people with specific mental health conditions [1•,3,14•,43]. However, to address issues related to causation, future research should consider longitudinal and experimental designs. This work should begin with the intentional consideration of individuals vulnerable to dehumanization, such as people with substance use disorder, psychosis, suicide risk, and personality disorders [1•]. Further, research should seek to understand how intersectionality (i.e. race, ethnicity, and gender), and the identity to multiple social groups who are vulnerable to dehumanization, impacts self- and meta-dehumanization. This may include people with mental health conditions who are also from a minority ethnic background, experiencing homelessness, or holding refugee status.

Moreover, identifying potential biological, cognitive, neurological, and sociological protective factors that discontinue the transference of meta- to self-dehumanization may be a useful avenue for understanding resilience in those with mental health conditions. Furthermore, future research should explore alternate pathways that may manifest self-dehumanization, such as interpersonal relationships, social isolation, distress, and suffering, as each of these may contribute to the development of both self-dehumanization and dehumanization of those with mental health conditions by others.

Finally, future research should seek to understand the impact of self-dehumanization on therapeutic outcomes. Does it have a mediating or moderating effect on changes in outcome measures? And does self-dehumanization predict attrition or engagement with mental health services? Research into the humanizing effects of different therapies may be beneficial, allowing for a more targeted approach to experiences of dehumanization.

Toward rehumanization

As dehumanization is the denial of humanity to people, rehumanization is the attempt to restore this sense of humanity. At a societal level, this may manifest as destigmatizing mental health conditions and integrating continued education within schools and workplaces. To prevent burnout of staff and dehumanization of service

users in healthcare settings, institutional efforts to repair staff well-being must be prioritized.

Individually, rehumanization aligns with the IPTS, in that positive social connection, contrasting thwarted belonging, as well as a sense of purposefulness and sacredness of life, remedying perception of burdensomeness, may provide a sense of interconnection toward humanity [27]. This effect has been seen thus far in forgiveness, with additional clinical benefits such as a reduction in desire toward self-injury [47•]. Therapeutically, doses of meaningful connection, including connection with healthcare providers, may be incorporated into pre-existing evidence-based treatment plans [10•]. Additionally, morals and value assessments provoke higher-order thinking, something that has been identified as uniquely human (see [20]). When appropriately validated and affirmed, these assessments may provoke clients to reflect further on how they already exhibit innately human traits [9,48].

Furthermore, therapeutic interventions cultivating self-compassion may offer support to people who feel dehumanized. Self-compassion comprises kindness to oneself, recognition of suffering as a human experience, and mindful awareness [49]. Its development could allow a more positive relationship to the self and build resilience against meta-dehumanization. Group-based mindfulness interventions have been suggested to have a humanizing potential [50], as they allow the individual to see themselves as a person independently of their distressing experiences and facilitate connection with a community of other people. Therapies such as Acceptance and Commitment Therapy and Dialectical Behavioral Therapy may be adapted to emphasize self-compassion, allowing people to relinquish self-dehumanizing beliefs they may hold. Acceptance of oneself, reframing of suffering, and connection to others may pave the way toward rehumanization while simultaneously reducing clinical distress.

Conclusion

We recognize that mental health symptoms, behaviors, and diagnoses often co-occur with one another. Within this context, we reiterate that incorporating 're-humanization' into evidence-based treatments would be minor modifications to treatment plans with potentially profound impacts on one's sense of self-worth and place in this world. Second, the benefits of feeling more human, and thereby further connected to society and others, may decrease secondary concerns when addressing primary presenting problems.

It is important to note that while therapies may aid in combating feelings of self-dehumanization, and equipping clients with tools for resiliency, this does not address the direct sources of dehumanization. We therefore must additionally consider how to address dehumanization on a macrolevel. From the clinical perspective, intentionality around rehumanization implementation must be that of an 'essence' — believing wholeheartedly that each individual is accepted, capable, equal, and a complex human being. This mindset must be adopted as well by graduate students, researchers, and medical practitioners at large.

Since it is near impossible to dismantle dehumanization entirely, it is important to consider how barriers in access to treatment further perpetuate historical contexts of marginalization and stigma around mental health. Individuals experiencing meta-dehumanization and successively self-dehumanization, may be further dehumanized in seeking treatment in their experiences of hopelessness and frustration. Therefore, healthcare systems must also consider how to decrease barriers in the accessibility, quality, inclusivity, and diversity of mental health and medical services. Our hope is that in modeling appropriate humanization at the systematic level, this may, in addition, spur societal change overall.

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CRediT authorship contribution statement

Tom A. Jenkins: Conceptualization, Writing – original draft, Writing – review & editing. **Morgan Robison**: Conceptualization, Writing – original draft, Writing – review & editing. **Thomas E. Joiner**: Writing – review & editing, Supervision. Both Tom A. Jenkins and Morgan Robison are co-first authors of the article.

Data Availability

No data was used for the research described in the article.

Conflict of interest statement

Nothing declared.

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1. • Boysen GA, Chicosky RL, Delmore EE: **Dehumanization of mental illness and the stereotype content model**. *Stigma Health* 2020, Advance online publication.

This paper highlights the widespread dehumanization of people with mental health conditions and demonstrates its relationship with stigma across three studies. The first finds that Americans dehumanize people with mental health conditions more than Mexican immigrants and Muslims. The second demonstrates that dehumanization occurs more severely for some mental health conditions than others. The third finds significant relationships between dehumanization and stigma measures.

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