Understanding the impact of stigma on people with mental illness

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Many people with serious mental illness are challenged doubly. On one hand, they struggle with the symptoms and disabilities that result from the disease. On the other, they are challenged by the stereotypes and prejudice that result from misconceptions about mental illness. As a result of both, people with mental illness are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people. Although research has gone far to understand the impact of the disease, it has only recently begun to explain stigma in mental illness. Much work yet needs to be done to fully understand the breadth and scope of prejudice against people with mental illness. Fortunately, social psychologists and sociologists have been studying phenomena related to stigma in other minority groups for several decades. In this paper, we integrate research specific to mental illness stigma with the more general body of research on stereotypes and prejudice to provide a brief overview of issues in the area.

The impact of stigma is twofold, as outlined in Table 1. Public stigma is the reaction that the general population has to people with mental illness. Self-stigma is the prejudice which people with mental illness turn against themselves. Both public and self-stigma may be understood in terms of three components: stereotypes, prejudice, and discrimination. Social psychologists view stereotypes as especially efficient, social knowledge structures that are learned by most members of a social group (1-3). Stereotypes are considered “social” because they represent collectively agreed upon notions of groups of persons. They are “efficient” because people can quickly generate impressions and expectations of individuals who belong to a stereotyped group (4).

Prejudice, which is fundamentally a cognitive and affective response, leads to discrimination, the behavioral reaction (9). Prejudice that yields anger can lead to hostile behavior (e.g., physically harming a minority group) (10). In terms of mental illness, angry prejudice may lead to withholding help or replacing health care with services provided by the criminal justice system (11). Fear leads to avoidance; e.g., employers do not want persons with mental illness nearby so they do not hire them (12). Alternatively, prejudice turned inward leads to self-discrimination. Research suggests self-stigma and fear of rejection by others lead many persons to not pursuing life opportunities for themselves (13,14). The remainder of this paper further develops examples of public and self-stigma. In the process, we summarize research on ways of changing the impact of public and self-stigma.

**PUBLIC STIGMA**

Stigmas about mental illness seem to be widely endorsed by the general public in the Western world. Studies suggest that the majority of citizens in the United States (13,15-17) and many Western European nations (18-21) have stigmatizing attitudes about mental illness. Furthermore, stigmatizing views about mental illness are not limited to uninformed members of the general public; even well-trained professionals from most mental health disciplines subscribe to stereotypes about mental illness (22-25).

Stigma seems to be less evident in Asian and African countries (26), though it is unclear whether this finding represents a cultural sphere that does not promote stigma or a dearth of research in these societies. The available research indicates that, while attitudes toward mental illness vary among non-Western cultures (26,27), the stigma of...
mental illness may be less severe than in
Western cultures. Fabrega (26) suggests that
the lack of differentiation between psychi-
atriac and non-psychiatric illness in the three
great non-Western medical traditions is an
important factor. While the potential for
stigmatization of psychiatric illness certainly
exists in non-Western cultures, it seems to
primarily attach to the more chronic forms
of illness that fail to respond to traditional
treatments. Notably, stigma seems almost
nonexistent in Islamic societies (26-28).
Cross-cultural examinations of the concepts,
experiences, and responses to mental illness
are clearly needed.

Several themes describe misconceptions
about mental illness and corresponding stig-
matizing attitudes. Media analyses of film
and print have identified three: people with
mental illness are homicidal maniacs who
need to be feared; they have childlike per-
ceptions of the world that should be mar-
veled; or they are responsible for their illness
because they have weak character (29-32).
Results of two independent factor analyses
of the survey responses of more than 2000
English and American citizens parallel these
findings (19,33):
a) fear and exclusion: persons with severe
mental illness should be feared and, there-
fore, be kept out of most communities;
b) authoritarianism: persons with severe
mental illness are irresponsible, so life deci-
sions should be made by others;
c) benevolence: persons with severe mental
illness are childlike and need to be cared for.

Although stigmatizing attitudes are not
limited to mental illness, the public seems to
disapprove persons with psychiatric disabili-
ties significantly more than persons with
related conditions such as physical illness
(34-36). Severe mental illness has been
likened to drug addiction, prostitution, and
criminality (37,38). Unlike physical disabili-
ties, persons with mental illness are per-
ceived by the public to be in control of their
disabilities and responsible for causing them
(34,36). Furthermore, research respondents are
less likely to pity persons with mental illness, instead reacting to psy-
chiatric disability with anger and believing
that help is not deserved (35,36,39).

The behavioral impact (or discrimina-
tion) that results from public stigma may
take four forms: withholding help, avoid-
ance, coercive treatment, and segregated
institutions. Previous studies have shown
that the public will withhold help to some
minority groups because of corresponding
stigma (36,40). A more extreme form of this
behavior is social avoidance, where the pub-
lic strives to not interact with people with
mental illness altogether. The 1996 General
Social Survey (GSS), in which the Mac
Arthur Mental Health Module was adminis-
tered to a probability sample of 1444 adults
in the United States, found that more than a
half of respondents are unwilling to: spend
an evening socializing, work next to, or have
a family member marry a person with men-
tal illness (41). Social avoidance is not just
self-report; it is also a reality. Research has
shown that stigma has a deleterious impact
on obtaining good jobs (13,42-44) and leas-
ing safe housing (45-47).

Discrimination can also appear in public
opinion about how to treat people with men-
tal illness. For example, though recent stud-
ies have been unable to demonstrate the
effectiveness of mandatory treatment
(48,49), more than 40% of the 1996 GSS
sample agreed that people with schizophre-
nia should be forced into treatment (50).
Additionally, the public endorses segregation
in institutions as the best service for people
with serious psychiatric disorders (19,51).

STRATEGIES FOR CHANGING
PUBLIC STIGMA

Change strategies for public stigma have
been grouped into three approaches:
protest, education, and contact (12). Groups
protest inaccurate and hostile representa-
tions of mental illness as a way to challenge
the stigmas they represent. These efforts
send two messages. To the media: STOP
reporting inaccurate representations of men-
tal illness. To the public: STOP believing neg-
ative views about mental illness. Wahl (32)
believes citizens are encountering far fewer
sanctioned examples of stigma and stereo-
types because of protest efforts. Anecdotal
evidence suggests that protest campaigns
have been effective in getting stigmatizing
images of mental illness withdrawn. There is,
however, little empirical research on the psy-
chological impact of protest campaigns on
stigma and discrimination, suggesting an
important direction for future research.

Protest is a reactive strategy; it attempts to
diminish negative attitudes about mental ill-
ness, but fails to promote more positive atti-
dudes that are supported by facts. Education
provides information so that the public can
make more informed decisions about men-
tal illness. This approach to changing stigma
has been most thoroughly examined by
investigators. Research, for example, has
suggested that persons who evince a better
understanding of mental illness are less like-
ly to endorse stigma and discrimination
(17,19,52). Hence, the strategic provision of
information about mental illness seems to
lessen negative stereotypes. Several studies
have shown that participation in education
programs on mental illness led to improved
attitudes about persons with these problems
(22,53-56). Education programs are effec-
tive for a wide variety of participants, includ-
ing college undergraduates, graduate stu-
dents, adolescents, community residents,
and persons with mental illness.

Stigma is further diminished when mem-
bers of the general public meet persons with
mental illness who are able to hold down jobs
or live as good neighbors in the community.
Research has shown an inverse relationship
between having contact with a person with
mental illness and endorsing psychiatric stig-
ma (54,57). Hence, opportunities for the
public to meet persons with severe mental ill-
ness may discount stigma. Interpersonal con-
tact is further enhanced when the general
public is able to regularly interact with people
with mental illness as peers.

SELF-STIGMA

One might think that people with psychi-
atriac disability, living in a society that widely
endorses stigmatizing ideas, will internalize
these ideas and believe that they are less val-
ded because of their psychiatric disorder.
Self-esteem suffers, as does confidence in
one’s future (7,58,59). Given this research,
models of self-stigma need to account for the deleterious effects of prejudice on an individual’s conception of him or herself. However, research also suggests that, instead of being diminished by the stigma, many persons become righteously angry because of the prejudice that they have experienced (60-62). This kind of reaction empowers people to change their roles in the mental health system, becoming more active participants in their treatment plan and often pushing for improvements in the quality of services (63).

Low self-esteem versus righteous anger describes a fundamental paradox in self-stigma (64). Models that explain the experience of self-stigma need to account for some persons whose sense of self is harmed by social stigma versus others who are energized by, and forcefully react to, the injustice. And there is yet a third group that needs to be considered in describing the impact of stigma on the self. The sense of self for many persons with mental illness is neither hurt, nor energized, by social stigma, instead showing a seeming indifference to it altogether.

We propose a situational model that explains this paradox, arguing that an individual with mental illness may experience diminished self-esteem/self-efficacy, righteous anger, or relative indifference depending on the parameters of the situation (64). Important factors that affect a situational response to stigma include collective representations that are primed in that situation, the person’s perception of the legitimacy of stigma in the situation, and the person’s identification with the larger group of individuals with mental illness. This model has eventual implications for ways in which persons with mental illness might cope with self-stigma as well as identification of policies that promote environments in which stigma festers.

CONCLUSIONS

Researchers are beginning to apply what social psychologists have learned about prejudice and stereotypes in general to the stigma related to mental illness. We have made progress in understanding the dimensions of mental illness stigma, and the processes by which public stereotypes are translated into discriminatory behavior. At the same time, we are beginning to develop models of self-stigma, which is a more complex phenomenon than originally assumed. The models developed thus far need to be tested on various sub-populations, including different ethnic groups and power-holders (legislators, judges, police officers, health care providers, employers, landlords). We are also learning about stigma change strategies. Contact in particular seems to be effective for changing individual attitudes. Researchers need to examine whether changes resulting from anti-stigma interventions are maintained over time.

All of the research discussed in this paper examines stigma at the individual psychological level. For the most part, these studies have ignored the fact that stigma is inherent in the social structures that make up society. Stigma is evident in the way laws, social services, and the justice system are structured as well as ways in which resources are allocated. Research that focuses on the social structures that maintain stigma and strategies for changing them is sorely needed.

References

Corrigan and Watson have written an excellent overview on the impact of stigma on the lives of persons with severe mental illness (SMI). In this commentary, we would like to expand on one aspect of that article, namely strategies for reducing stigma toward persons with SMI.

Corrigan and Watson have identified three approaches for reducing stigma: protest, education, and contact. Although these approaches have promise, they are not without weaknesses. A potential disadvantage of using protest (i.e., telling the public to stop believing negative views about mental illness) is that it may actually increase, rather than decrease stigma. In fact, research has shown that instructing individuals to ignore or suppress negative thoughts and attitudes towards a particular group can have paradoxical rebound effects; stigma will be augmented rather than reduced (1).

To examine this issue with respect to psychiatric stigma, we instructed participants to either suppress or not to suppress their stereotypes of persons with SMI and evaluated the effects on stigma-related attitudes and behaviors (2). The results showed that suppression instructions did reduce negative attitudes, but did not impact behavior toward persons with SMI, and that the paradoxical rebound effects did not occur. This suggests that stereotype suppression may have modest, although limited effects, on psychiatric stigma.

There is evidence that individuals who possess more information about mental illness are less stigmatizing than individuals who are misinformed about mental illness (3). This suggests that providing individuals with factual information about SMI, in particular regarding dangerousness and SMI, would reduce stigmatization. We have generally found support for this hypothesis.

Information regarding the residential context of persons with SMI (i.e., that they may live in supervised housing) (4), and the relationship between dangerousness and SMI (5), were both associated with reduced stigmatization to persons with SMI in general and to a hypothetical individual with SMI. However, the positive effects of factual information on psychiatric stigma were attenuated when subjects had to rate their reactions to actual persons with SMI (6). Thus, factual information regarding SMI may be more effective in reducing stigma toward persons with SMI in general, than toward specific individuals.

Finally, there is convincing evidence that increased contact with persons with SMI is associated with lower stigma (7). However, there are a number of problems that plague work in this area. First, many studies have examined the effects of previous self-reported contact on stigma, rather than how contact changes stigma prospectively (7). In those studies in which direct contact was measured, the manipulation often took place in the context of contrived laboratory situations or as part of a course and/or training program. Scant attention has been placed on how direct interpersonal contact affects stigma during ongoing naturalistic relationships. Second, the mechanism(s) underlying stigma reduction, as a function of contact, are unknown. In other words, how does contact reduce stigma? Two theories have been proposed for this. According to the recategorization theory (8), contact with an out-group member results in changes in out-group member classification, from ‘them’ to ‘us’ relationships.