Changing mental illness stigma as it exists in the real world

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Abstract
Persons with mental illness frequently encounter public stigma. This review seeks to clarify mental illness stigma and discuss methods for changing stigma in the real world. Following an overview of public stigma we discuss the main avenues recognised for changing stigma in the real world: protest, education and contact; and give examples of anti-stigma strategies in practice. Finally, we discuss the most effective method, contact, in greater detail through three different areas where anti-stigma efforts have been focused: disclosure, children, and patient-based programs. Anti-stigma programs that focus upon the most effective ways to diminish stigma will help bring about change in the stigmatising attitudes of the general public.

Mental illness stigma is a complex phenomenon that affects not only people with psychiatric disorders and their families, but also society as a whole. Efforts to further understand stigma and erase its impact should be informed by carefully conducted research in the same tradition of investigation that directs the study of mental health services and social phenomena. Here, the findings and implications of stigma research are discussed, with particular emphasis on the role of contact between individuals with mental illness and the general public as the best strategy for promoting the change of stigma in the real world.

Impact of stigma
Over the past two decades, research has begun to describe the problems produced by mental illness stigma, and develop strategies and techniques to diminish it. When attempting to understand the impact of mental illness stigma, researchers distinguish between self-stigma (the prejudice individuals turn against themselves because they are members of a stigmatised group), structural stigma (policies of private and governmental institutions that intentionally restrict opportunities of people with mental illness, and the policies of institutions that yield unintended consequences that hinder the options of people with mental illness), and public stigma (ways in which the public reacts to a group based upon stigma about that group (Corrigan, 2000; Corrigan, Markowitz & Watson, 2004; Corrigan & Watson, 2002). While all three levels of stigma deserve indepth investigation, this paper limits discussion to public stigma.

What is public stigma?
Social psychologists have framed the process of stigma in terms of four cognitive constructs: cues, stereotypes, prejudice, and discrimination. The process begins with the cues that signal subsequent prejudice and discrimination. Adopted by Goffman in 1963, the term “stigma” is from the Greeks, who defined it as a mark meant to publicly and prominently represent immoral status. Stigmas, therefore, are typically the marks that, when observed by a majority member, may lead to prejudice. Goffman noted that some stigmas are readily apparent and based on a physical sign such as skin colour (ethnicity cue), body shape (a cue for gender), or body size (a cue for obesity). Other stigmas are relatively hidden; for example, the public cannot generally tell who among a group of people falls into such stigmatised groups as gay men, members of religious minorities, and people with mental illness. Instead of an unequivocal physical cue, hidden
stigma is signalled by label or association (Link, Cullen, Frank, & Wozniak, 1987; Penn & Martin, 1998). Labels may be self-promoted ("I am mentally ill!") or given by others ("that person is mentally ill"). Hidden stigma can also be ascertained based on association; for example, observation of someone leaving a psychiatric clinic might lead to the assumption that the person is mentally ill.

Social psychologists view stereotypes as knowledge structures that are learned by most members of a cued social group (Augoustinos, Ahrens, & Innes, 1994; Esses, Haddock, & Zanna, 1994; Hilton & von Hippel, 1996; Judd & Park, 1993; Krueger, 1996; Mullen, Rozell, & Johnson, 1996). Stereotypes are especially efficient means of categorising information about social groups. 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 (Hamilton & Sherman, 1994).

Just because most people have knowledge of a set of stereotypes does not imply that they agree with them (Devine, 1989; Jussim, Nelson, Manis, & Soffin, 1995). For example, many persons can recall stereotypes about different racial groups but do not agree that the stereotypes are valid. People who are prejudiced, on the other hand, endorse these negative stereotypes ("That’s right! All persons with mental illness are violent!") and generate negative emotional reactions as a result ("They all scare me!") (Devine, 1988, 1989, 1995; Hilton & von Hippel, 1996; Krueger, 1996).

In contrast to stereotypes, which are beliefs, prejudicial attitudes involve an evaluative (generally negative) component (Allport, 1954; Eagly & Chaiken, 1993). Prejudice, which is fundamentally a cognitive and affective response, leads to discrimination, the behavioural reaction (Crocker, Major, & Steele, 1998). Discriminatory behaviour manifests itself as negative action against the outgroup or exclusively positive action for the ingroup. Outgroup discrimination for people with mental illness includes coercion (mandatory treatment or criminal justice responses based upon the belief that people with mental illness are not able to make competent life decisions), withholding help (choosing not to assist a person with mental illness because they are believed to be responsible for their lot in life), avoidance (common examples of social avoidance include landlords who do not lease to people with mental illness or employers who do not hire them) and segregation (actions that promote moving people away from their community into institutions where they can be treated or controlled) (Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003). These discriminatory behaviours can have an especially troublesome impact upon stigmatised groups, limiting the quality of life and opportunities for those diagnosed with mental illness. Employers, for example, are less likely to hire individuals labelled as mentally ill (Bordierri & Drehmer, 1986; Farina & Felner, 1973; Link, 1987), and landlords less likely to rent/lease housing to those labelled as mentally ill (Alisky & Iczkowski, 1990; Page, 1977, 1983).

**Strategies for changing public stigma**

Three approaches have been identified as diminishing aspects of the public stigma experienced by people with mental illness: protest, education, and contact. Groups protest inaccurate and hostile representations of mental illness as a way to challenge the stigmas they represent. These effects seek to send two messages. To the media: stop reporting inaccurate representations of mental illness. To the public: stop believing negative views about mental illness. It is an approach that works on two levels, economic (boycott of product) and moral (shame).

An economic boycott is the withdrawal or withholding of economic cooperation in the form of buying, selling, or handling of goods or services, often accompanied by efforts to induce others to do likewise. This may target the actual producer of the material, or affiliated distributors or advertisers. Moral protest programs present an ethically untenable position regarding a group (e.g., "Mentally ill patients should be institutionalised because they are incapable of caring for themselves.") followed by a rebuke against continuing these thoughts (e.g., "This is untrue. Shame on us for wanting to keep persons with mental illness away from their communities."). Two examples of protest in action are the motion picture titled *Crazy People* and the television show *Wonderland*.

In 1990, Paramount Pictures in the United States produced a full-length comedy starring Daryl Hannah and Dudley Moore called *Crazy People*. The newspaper and poster advertisements for *Crazy People* were patently offensive, including a picture of a cracked egg with hands and arms and the caption "Warning: Crazy people are coming" (Wahl, 1995). After pointed discussions with representatives of several advocacy groups, Paramount Pictures changed marketing strategies. The new advertisement had pictures of the film’s stars with the revised slogan "You wanna laugh tonight?".

The first episode of *Wonderland* depicted a person with mental illness shooting several police officers and stabbing a pregnant psychiatrist in the belly with a hypodermic needle. Advocacy groups targeted not only the show’s producers and ABC Television’s senior management, but encouraged communication
with companies that sponsored and advertised during the show. ABC television removed the show from the air after a few episodes. While these examples give anecdotal evidence of protest having impact upon the media, there is little empirical research on the psychological impact of protest campaigns on people's prejudice about mental illness.

Research has not shown that "just say no to negative stereotypes" efforts actually lead to a more enlightened view of mental illness. In fact, research suggests that protest may actually cause attitude rebound in the stigmatising beliefs of the public (Corrigan et al., 2001; Macrae, Bodenhausen, Milne, & Jetten, 1994). Instead of decreasing stigma, the public reaction to protest may be "don't tell me what to think" and negative attitudes worsen. Thus, while protest attempts to diminish negative attitudes about mental illness, it fails to promote more positive attitudes that are supported by facts.

Education attempts to effect change in stigma by challenging the myths of mental illness (e.g., people with mental illness are incapable of being productive members of the work world) with facts (most individuals who receive vocational rehabilitation for psychiatric disability will have a successful work world outcome). Several studies have shown that members of the general public who seem to be more knowledgeable about mental illness are less likely to endorse stigma and discrimination (Link & Cullen, 1986; Link et al., 1987; Roman & Floyd, 1981). For example, graduate students who participated in brief courses on mental illness showed improved attitudes about persons with psychiatric disabilities (Keane, 1991; Morrison, 1980; Morrison, Cocozza, & Vanderwyst, 1980; Morrison & Teta, 1980). Members of the general public also showed improved attitudes after completing short information sessions (Penn et al., 1994; Penn, Kommana, Mansfield, & Link, 1999; Thornton & Wahl, 1996) and semester-long courses on severe mental illness (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999).

These approaches of public education are very popular due to their ease of exportability to a wide audience. Past strategies have included public service announcements, books, movies, flyers and other audio-visual aids to dispel myths about mental illness and replace them with facts (Bookbinder, 1978; Pate, 1998; Smith, 1990). However, evidence suggests that the magnitude and duration of improvement of attitudes may be limited (Corrigan et al., 2001; Corrigan et al., 2002), and correlated to an individual's pre-education program knowledge (Holmes et al., 1999). As such, the effects of education programs reflect those who already agree with the message (Devine, 1995).

A third way to change public attitudes about mental illness is to facilitate interaction between citizens and persons with psychiatric disabilities. Contact with members of a stigmatised group has long been considered an effective means for reducing intergroup prejudice. Research on racial stereotypes has shown that persons randomly assigned to contact with a minority group member, versus no contact, have diminished prejudice toward that group (Desforges et al., 1991). Contact effects can be understood in context of familiarity. Familiarity from contact can be secondary and include prominent individuals within a society such as movie stars (such as actress Margo Kidder who disclosed her diagnosis of bi-polar disorder) or television personalities (such as U.S. newsman Mike Wallace who disclosed his diagnosis of major depression).

Research suggests, however, that contact and familiarity with "people just like me", who include neighbours, co-workers, family members and other people one regularly associates with and can relate to, can have a greater anti-stigma effect than when famous people disclose. Research shows that members of the general public who are more familiar with individuals with mental illness are less likely to endorse prejudicial attitudes (Holmes et al., 1999; Link & Cullen, 1986; Penn et al., 1994, 1999). As well, members of the general public who interact with a person with mental illness as part of an anti-stigma program show significant improvements in their attitudes, greater than protest, education or control conditions (Corrigan et al., 2001). A subsequent study has demonstrated that attitude change that results from contact is maintained over time and has related change in behaviour (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003).

Contact, however, is not without barriers. It is not especially exportable. Videos and other materials can be disseminated easily and quickly for educational programs. Contact requires a person with the courage to disclose his or her mental illness. Educational materials can be absorbed almost anywhere. Contact requires willing individuals to be identified and prepped for anti-stigma presentations, and specific situations identified for contact exposure.

Disclosure as the foundation of contact

One strategy to massively increase the power of contact on stigma is to encourage people with mental illness to publicly disclose their experiences. Epidemiological research suggests that as much as 20% of the adult population meets criteria for significant mental illnesses such as major depression, bi-polar disorder, schizophrenia and anxiety disorders (Kessler et al., 2001; Narrow, Rae, Robbins, &
Regier, 2002). Despite this, the general population is largely unaware of the number of people with psychiatric disorders because it is a largely hidden stigma. The public does not become aware that an individual has a psychiatric history until that person comes out with it (Goffman, 1963). The gay and lesbian community seems to have benefited from coming out, both as individuals and as a group. In a similar fashion, people with mental illness who publicly declare their experiences with psychiatric disorders and the mental health system may become a significant force in challenging stigma (Corrigan, 2003).

Apart from the potential benefits that could be realised, there are significant costs that must be considered when an individual is deciding to disclose his or her psychiatric history. These costs and benefits might mirror those experienced by gay men and lesbians. Perhaps the most sobering among the risks of coming out is bodily harm. The news media regularly reports on hate crimes based on sexual orientation, with the case of Matthew Shepard perhaps the best known. This 21-year-old gay man was beaten to death outside Laramie, Wyoming in 1998. Survey research has demonstrated the breadth of this violence: one study showed 41% of a sample of lesbians and gay men reported being the victim of a bias-related crime since the age of 16, and another 9.5% reported an attempted bias crime against them (Herek, Gillis, Cogan, & Glunt, 1997).

On one hand, there does not seem to be a facile comparison between these types of hate crimes and the experiences of people with mental illness. There is no body of evidence clearly suggesting that people with mental illness who disclose are frequently the victims of crime in retaliation for their mentally ill “lifestyle”. There are some advocates, however, who believe that violence against people with mental illness is more subtle in form (Chamberlin, 1998; Fischer & Ahern, 2000). This research suggests that the prescription of mandated treatments (e.g., involuntary commitments and mandated medications) is sometimes used against people with mental illness. Research has shown that some people with mental illness who have been the target of mandated or coercive treatment experience these treatments as harmful and abusive (Svensson & Hansson, 1994).

There are other examples of punitive consequences to disclosing a mental illness. Many members of the general public may choose to avoid people who have come out as having a mental illness, and such experiences of social disapproval may negatively affect the self-esteem of these people. Of greater concern is that this may translate into employment and housing discrimination against those who have disclosed their illness (Ragins & Cornwell, 2001). In the United States, a good example of the former has been a national debate regarding gay and lesbian teachers. Although specific statistics have been difficult to gather, mounting evidence suggests that many homosexual teachers suffer from employment discrimination (Jennings, 1994; Olson, 1997). A similar pattern has been found for people with mental illness; individuals who have disclosed their psychiatric condition are less likely to obtain or maintain jobs because of stigma (Corrigan & Watson, 2002).

Despite the stated disadvantages, research has clearly shown multiple advantages to disclosing one’s sexual orientation. Perhaps the most significant is the removal of the stress that results from no longer having to keep a secret on such an important part of one’s identity (Rosario, Hunter, Mageun, Gwadz, & Smith, 2001). Diminished stress leads to better relationships with one’s partner (Beals & Peplau, 2001) and improved job satisfaction (Day & Schoenrade, 1997, 2000). Moreover, people who have disclosed report greater support from their families (Kadishin, 2000). People with mental illness who disclose also are afforded some legal protections against violations of their rights through the Americans with Disabilities Act.

**Addressing stigma in children**

Many believe that if the cognitive processes of preschool and primary grade children could be influenced, prejudice about and discrimination towards people with mental illness might never develop or might be muted (Wahl, Wood, & Richards, 2002). Ideally, future generations of adults could be fostered for whom the stigma of mental illness is neither so prevalent nor egregious. Child-related stigma is described by a complex picture. Although research on mental illness stigma in children is not well developed, some possible parallels can be found in research on ethnic stigma. Of course, extrapolation of this research from ethnic groups to mental illness is limited. Further research needs to determine if these comparisons hold.

Research on ethnic stigma suggests that children as young as 3 are sensitive to cues that signal group differences, and are able to discriminate between blacks and whites, assign racial labels, and positively identify to which groups people belong (Aboud, 1988; Augustinos & Rosewarne, 2001). Those different from the group are perceived as being bad or in some other way negative. By 5 years of age, research suggests that children are knowledgeable about outgroup stereotypes (Aboud, 2003; Bar Tal, 1996; Katz & Kofkin, 1997; Teichmann, 2001).

Research on changing stigma in children has a rich history in schools. This body of research has largely focused on the stigma related to race and ethnicity. Like education for mental illness stigma reduction,
research on educational multicultural programs for reduction of bias and prejudice has been mixed with occasional positive findings (Litcher & Johnson, 1969) but frequent non-significant results (Litcher, Johnson, & Ryan, 1973; Weigel, Wiser & Cook, 1975; Yawkey, 1973).

The concept of contact for children, however, shows benefits for stigma reduction and change. Interpersonal contact between the public and members of the stigmatised group yields significant decrements in prejudice (Allport, 1954; Pettigrew & Tropp, 2000). School integration has provided a natural lab for testing the assumptions of the contact hypothesis. Daily interactions in classrooms seem to naturally facilitate five factors seen as necessary for optimal contact to diminish prejudice: (a) equal status between groups, where neither the majority nor minority group occupies a higher status or is in charge; (b) common goal, with both groups working toward the same ends; (c) no competition, with the tone of the contact being a joint effort, not competitive effort; (d) institutional support and sanctions for the interaction; and (e) moderate disconfirmation, because the benefits of contact are enhanced when it is with a person who moderately disconfirms the stereotypes about his or her group (Pettigrew & Tropp, 2000). Studies frequently show mixed findings or no differences (Schofield, 1995). Unfortunately, the promise of integrated education in terms of prejudice is not mirrored by the data.

Among children, friendship seems to be the key mediator in the contact effect in school. Research has shown that children who report a cross-race friendship at a young age are less likely to endorse stereotypes about that racial group (Ellison & Powers, 1994; Jackman & Crane, 1986; Patchen, 1983). While survey research has found that cross-race friendships may be the exception rather than the norm (Hallinan, 1982; Hallinan & Texiera, 1987; Patchen, 1983), other studies suggest that this trend has significantly improved in the past decade (Aboud & Mendelson, 1999; DuBois & Hirsch, 1990). Some educators have enhanced contact effects by building in specially created opportunities for individualised, positive interaction in the early grades (Miller, 1983; Patchen, 1983; Schofield, 1995). These findings suggest that contact effects are most likely to remediate prejudice towards people with mental illness when teachers opt to facilitate positive, friendship-building interactions among children with and without mental illness.

The threat of "coming out of the closet" once again becomes a key factor in realising this kind of contact. Decisions need to be made as to whether children with mental illness will disclose their group status in order to facilitate contact effects. This means that some parents of children with mental illness, who are rightfully concerned about their child's socialisation and education, must risk their child being stigmatised to attempt this kind of friendship building. Moreover, the mother and father must risk experiencing family stigma that suggests, for example, that bad parenting produced their child's mental illness (Corrigan & Miller, 2004).

A contact program in action: In Our Own Voice

An example of a contact based program to reduce stigma is the In Our Own Voice (IOOV) program. As mentioned above, the summary of social science literature suggests that contact between the public and people with mental illness may lead to significant improvements in stigmatising attitudes and behaviours of the public. The National Alliance for Mental Illness (NAMI) IOOV program represents a convergence of the research literature with the goals of advocates. Developed by consumers of mental health services, IOOV is a 90-min standardised program in which people with mental illness interact with an audience about their mental illness.

The elements of IOOV are designed to parallel social psychology research findings about effective components of contact programs that seek to decrease stigma (Allport, 1954; Stefan, 2001). Some of these include interaction, qualification and content. Contact is more effective when the public gets to interact and exchange ideas with the contact person through discussion (Gaertner, Rust, Dovidio, Bachman, & Anastasio, 1996). It is not enough to hear a presentation about mental illness by a person with mental illness. Further interaction through active discussion allows participants to ask questions, make observations and provide a foundation for challenging stigmatising myths and attitudes.

Goffman (1963) stated that mental illness is a hidden stigmatised group (i.e., the public cannot identify people with mental illness unless they self disclose), thus the contact person in IOOV has to qualify as a person with mental illness. This qualification is disclosed by the contact person discussing their specific psychiatric diagnosis (e.g., schizophrenia), relevant medical history and medications. Last, the content of the material includes important areas on which to focus, including information about recovery from mental illness (Corrigan & Watson, 2004). The content does not focus solely upon the symptoms of mental illness, but goes into the impact upon the individual's life, struggles with illness, and continuing process of recovery from mental illness.

Intergroup relationships that entail frequent interactions define the optimal condition for change in prejudice. However, positive results were found for programs that entailed only one or two contacts.
(Batson et al., 1997). Moreover, research has shown that single episodes of contact in a structured program can lead to significant improvement in prejudicial attitudes (Corrigan et al., 2001) that are still evident several weeks later (Corrigan et al., 2002). Hence, a program such as IVOV should yield the kind of positive attitude change consistent with contact.

Two studies on IVOV examined its feasibility and effect on stigmatising attitudes. The first was a descriptive study that examined more than 2200 participants' responses to items reflecting amount and depth of information learned from the presentation (Wood, Wahl, & Adams, 2003). Results showed almost three quarters of participants said they got "lots of great information" from IVOV. Seventy per cent of participants said the presentation had excellent depth and scope.

Wood (2004) followed the general impressions of her descriptive study with an experimental test of IVOV. A total of 114 college students were randomised to IVOV or to a control condition in which they learned about psychology as a career. Research participants in both groups completed pre- and immediate post-test measures of knowledge, attitudes, and social distance. Results showed significant interactions for all three variables, suggesting that people participating in IVOV, compared to a control group, showed significantly greater decrements in stigmatising attitudes. This research was limited because it was done on college students, it did not include follow-up, and it lacked more direct measures of discriminatory behaviour. Nevertheless, research provides profound implications for stigma reduction in the general population and guidance for future research.

Conclusion

Of the three social approaches to changing public stigma (protest, education, and contact) there is strong evidence that contact between the general public and people with mental illness may be an effective approach to significant and lasting attitudinal changes. Contact has interesting implications for societal movements to erase the stigma of mental illness. It suggests that mental health professionals and researchers may not be best positioned to challenge the stigma and discrimination of mental illness. Instead, the stories and experiences of people who live with the challenges of psychiatric disorders and corresponding stigma may have the greatest impact.

At the societal level, perhaps the best way to promote contact among the general public and people with mental illness is widespread disclosure. This requires people who are hiding their psychiatric history to disclose it. While there are risks inherent in this decision, including possible public anger at admitting one's deviance from societal norms, there are benefits as well. Many people who have been forced to hide some stigmatised part of themselves find significant release at no longer having to keep the secret.

Influencing children in preschool and primary school provides the opportunity to reduce prejudice towards people with mental illness. Research among children also shows possible benefits of contact, with children reporting a friendship with a person from a stigmatised group (i.e., racial) being less likely to endorse stereotypes about that group. While most research in this area has been focused upon ethnic stigma, it provides a rich area for future research.

Emerging contact programs such as IVOV provide a structured format to reach out to the general public and provide a forum for stigma change. This interaction can disabuse the public of the myths surrounding people with mental illness and provide contact with members of the stigmatised group. With specific focus and results, it provides an opportunity to measure the effect of contact.

Overall, contact and disclosure reflect the empowerment principle now dominating rehabilitation approaches to services for people with serious mental illnesses. Namely, people with psychiatric disorders should have primary authority and responsibility for development and implementation of programs. As more people come out about their psychiatric history, and interact with the public at large, attitudes about those labelled mentally ill should improve.

References


