ABSTRACT
Life goals and the opportunities that define them are impaired by the stigma of mental illness. Three kinds of stigma may act as barriers to personal aspirations: public stigma, self-stigma, and label avoidance. Challenging mental illness stigma is essential in helping individuals accomplish recovery-related goals. Public stigma may be changed through protest, education, and contact. Self-stigma can be addressed by fostering group identity, changing the perceived legitimacy of stigma through cognitive rehabilitation, and making strategic decisions about disclosing one's mental health history. Stigma change for label avoidance is not as well understood but may include the education and contact approaches used for public stigma. Evidence-based approaches to stigma change need to be substantiated by rigorous investigations.

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Mental illness strikes with a double-edged sword. On one hand, the distress and lost opportunity that accompanies the illness may be a direct result of psychiatric symptoms, cognitive dysfunction, and social skills deficits. On the other hand, lost opportunity and personal demoralization occur because of the stigma of mental illness (Corrigan & Kleinlein, 2005). This article briefly reviews models of mental illness stigma and their effects on the course and outcome of mental illness. Strategies that diminish stigma are also discussed. The summary is based largely on empirical findings, because just as mental health advocates believe treatment should show a solid base of evidence, so too must anti-stigma strategies.

**STIGMA MODELS**

Stigma is a complex term and, in this article, represents the overall stereotypical and prejudicial process. Current models represent mental illness stigma as cognitive-behavioral constructs (Crocker, Major, & Steele, 1998); a model representing these constructs is illustrated in the Figure. As a broad theory, cognitive-behavioral models define the process of human behavior in three parts:

- **Situational cues** signal a specific setting for which behavioral responses may be indicated.
- **Cognition** makes sense out of these cues.
- **Behavior** results from these cognitions.

Current models of stigma correspond with cognitive-behavioral theory. Marks are the cues that signal stereotypes. Stereotypes, the cognitive products that emerge from the mark, are cognitive efficiencies that summarize characteristics of a social group. For example, people in blue uniforms with badges are police officers; this is the mark. The belief that police officers are vital in emergency situations is a stereotype about that group.

Stereotype is not synonymous with prejudice. People learn many stereotypes that describe outgroups by virtue of being reared in a specific culture. If one learns a stereotype, it does not necessarily mean he or she agrees with it. Prejudice is concurring with the stereotype (i.e., believing that all individuals with mental illness are dangerous) and applying it to members of the outgroup to yield a negative evaluation. Discrimination is the behavioral result of prejudice (i.e., deciding not to hire someone because he or she is from a certain stereotyped group that has been negatively prejudged). This cognitive model is used to describe the processes of public stigma, self-stigma, and label avoidance.

**Public Stigma**

Public stigma represents what the public does to people who are marked with a mental illness (Corrigan & Kleinlein, 2005). These marks can either be obvious or hidden. Obvious cues include psychotic behavior and a disheveled appearance that may distinguish a person as odd and, therefore, mentally ill. Mental illness may also be described in terms of hidden stigma. For example, if an individual has a history of serious mental illness and decides not to disclose his or her symptoms at work, coworkers are unaware of the condition. However, if the individual decides to be open about the illness, the label of mental illness can potentially signal stereotypes and prejudice (Link & Phelan, 2001).

Several discrete cognitions result from this kind of signal; three are prominent in the literature. Perhaps of greatest concern is the stereotype that individuals with mental illness are dangerous and unpredictable. Those who agree with this view tend to fear people with mental illness and avoid them as a result.

A second stereotype is blame (Weiner, 1995). Individuals with mental illness may have a weak moral backbone and feel responsible for their symptoms and disabilities as a result. Blame stereotypes may result in anger (i.e., “Why do people use ‘mental illness’ as an excuse to get everything handed to them on a silver platter?”), which may result in coercion. Examples of coercion include forcing people to comply with specific treatments or sending them away to institutions.

The third stereotype is known as benevolence, the belief that individuals with mental illness are like children and need a parental figure to make decisions for them. This kind of stereotype leads to other people making authoritarian and unilateral decisions for the individual because he or she is believed to be incapable of acting independently.

**Self-Stigma**

Some individuals internalize public stigma, harming themselves both cognitively and behaviorally as a result (Link, 1987). In this case, the link between marks and corresponding stereotypes is the construct of interest at the beginning of the self-stigma model. Four factors comprise perception of the mark and subsequent stereotype (Corrigan, Larson, & Kuwabara, 2007):

- Are individuals aware of the link between the marks of mental illness and corresponding stereotypes?
- If they are aware of the stereotype, do they agree with it? Thus far, stereotypes have not been internalized and hence yield no self-stigma effect.
- Do individuals apply the recognized and agreed-on ste-
reotypes to themselves? Consider the person who agrees that individuals with mental illness are to blame for their disorder, applies the stereotype to himself or herself, and concludes, “I have a mental illness, so I must be to blame for my illness.”

- Does applying the stereotype to one’s self diminish self-esteem and self-efficacy? This is a form of discrimination and differentiates people who “beat themselves up” about stigma versus those who use coping skills to ignore its effect.

In addition to decrements in self-esteem and self-efficacy, the discrimination of self-stigma may have a direct effect on the pursuit and accomplishment of life goals, such as getting a job, living independently, and developing meaningful relationships. Called the “why try” effect, absence of self-efficacy undermines one’s confidence (i.e., “Why should I try to get work? Someone like me is not able to handle a job!”) (Corrigan et al., 2007). The why try effect also occurs because of diminished self-esteem (i.e., “Why should I try to live on my own? Someone like me is not worthy of such goals!”).

Label Avoidance

Stigma can also harm a third group: individuals who have not been diagnosed with a mental illness but avoid mental health care so as to not be marked with the label. Research suggests as much as one half to two thirds of individuals who might benefit from psychiatric services opt not to pursue them (Corrigan, 2004). Several factors may explain this phenomenon, including a dearth of mental health resources in a particular community or government policies that dissuade participation in care. In addition, stigma is thought to block treatment seeking.

This process is different than the kinds of experiences found in public stigma or self-stigma. Public stigma is what the population does to a group by endorsing and implementing the stereotypes, prejudice, and discrimination that comprise mental illness stigma. Self-stigma is what people within a group do to themselves. Label avoidance is dodging a group altogether to escape the negative effects of public stigma and self-stigma. Those who avoid the label are aware of the stereotype and may even agree with it. However, they are strongly inclined not to apply the stigma to themselves and avoid any group that will lead to this mark. One way to obtain group identity is by associating with the group, but people who are known to receive mental health care may be labeled as crazy or weak. Hence, people who do not pursue treatment escape mental illness prejudice and discrimination (Link & Phelan, 2001).

STRATEGIES FOR CHANGING PUBLIC STIGMA

Research has identified three general categories of strategies for changing public stigma: protest, education, and contact (Corrigan & Penn, 1999).

Protest

In protest, advocates appeal to a moral authority after reviewing the disrespectful ways mental illness is perceived. As a result, people who hold these perceptions are asked to stop these beliefs. Unfortunately, protest may lead to rebound effects; people who are asked to suppress disrespectful endorsements may actually demonstrate worse attitudes (MacRae, Bodenhausen, Milne, & Jetten, 1994; Wenzlaff & Wegner, 2000). Keeping something out of mind is an active
effort, and active suppression of ideas can keep the idea in the forefront of current thoughts. The rebound effect might also represent cognitive stubbornness, a result of the “don’t tell me what to think” phenomenon.

If an advocate’s goal is to change employers’ minds about hiring people with mental illness, protesting against the employers’ current beliefs will make attitudes worse. Although troublesome for attitude change, protest is likely to influence behavior, especially when the target of this change is the media. Consider the effects of organized protest on an ABC Television Network program called Wonderland. Aired in the spring of 2000, the first episode portrayed a person with mental illness shooting at several police officers and stabbing a pregnant psychiatrist in the belly with a hypodermic needle. Advocacy groups came together to let ABC sponsors know they would boycott the network if the tone of the show was not amended (Corrigan & Gelb, 2006). ABC, realizing individuals with mental illness and their families had a huge economic influence on the network, pulled Wonderland from the lineup, rather than risking a boycott. Anecdotes like this suggest the behavioral effects of protest, yet more careful research needs to be conducted to support such stories with corresponding evidence.

Education

In education, myths about mental illness are contrasted with facts. Consider the myth of incompetence, or the belief that individuals with mental illness are incapable of living independently or working a real job. The myth is diminished when contrasted with information from long-term follow-up research (Harrison et al., 2001) which, contrary to expectations, showed that most individuals with mental illness are able to live on their own and hold a job. Research suggests that education yields small effects on attitudes; unfortunately, this kind of attitude change is not maintained over time (Corrigan et al., 2001).

Nevertheless, education is widely endorsed for influencing prejudice and discrimination. One reason is because education processes are believed to be fundamental to human behavior. If people had the correct knowledge of their anti-stigma public service announcements need to collect data to show the effects of such action. At this point, research is mostly limited to process and outcome findings. What does this suggest about public service announcements (PSAs), which embody education in its many forms? PSAs produced for television and radio have the potential for influencing entire population segments (Kotler, Roberto, & Lee, 2002); however, this kind of broad-scale approach may have limited effect (Corrigan & Gelb, 2006). One major effect of PSAs is to alert people of the same mind-
KEY POINTS

1. Individuals with mental illness who internalize stigma experience self-stigma. One way to address self-stigma is to identify with a group of individuals with mental illness.

2. Many of the problems of mental illness are related to public stigma against these illnesses. Strategies that help erase such stigma include being in contact with people with mental illness.

3. Label avoidance is dodging a group altogether to escape the negative effects of public stigma and self-stigma. Strategies for addressing label avoidance are not well known.

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methods. Research of this kind needs to assess penetration (How much of a specific population recalls seeing the PSA and can remember its message?) and outcome (Do these recalled PSAs lead to effects in prejudice and discrimination?).

Contact

Contact can yield the most robust and positive findings toward public stigma change (Pettygrew & Tropp, 2000). Namely, public stigma is challenged when people from the stigmatized group interact with the targeted populations. Interaction may be formal in nature, such as a speaker's bureau at which individuals talk about their mental illness. Alternatively, it may be casual, such as when a person learns that a coworker has depression. This kind of real-world connection has perhaps the greatest effects on changing stigma. Contact effects are enhanced when the person providing contact and the public group are perceived to be on the same social level (Cook, 1985; Gaertner, Dovidio, & Bachman, 1996). The person with mental illness should not be viewed pitifully, nor should he or she be seen as aloof from the situation.

Contact can also be augmented by integrating empathy (Batsell et al., 1997). For example, contact program participants who are instructed to "walk in the others' shoes" and to imagine themselves as a person with mental illness show greater benefits than do those in which participants are encouraged to remain aloof and approach the situation scientifically.

Although changing public stigma in the whole population is a worthy goal, stigma change is more successful when limited in scope. Challenging public stigma is most effective when it targets people who frequently interact with individuals with mental illness: landlords, employers, police officers, health care providers, and legislators. These targets outline relevant behaviors by social role: landlords decide whether the person lives independently, employers hire the person, police officers help the person in an emergency, health care providers yield a breadth of services, and legislators determine available resources for mental health. Anti-stigma programs are more effective when applied within regularly existing meetings (Fiske, 1993; Link & Phelan, 2001; Pincus, 1999), such as Rotary International meetings for employers and perhaps landlords, morning roll call for police officers, grand rounds for health care providers, and constituent meetings for legislators.

STRATEGIES FOR CHANGING SELF-STIGMA

The loss in self-esteem and self-efficacy caused by self-stigma is viewed as the anchor of one end of a continuum, with personal empowerment anchoring the other end. People who believe they have control of their lives and their treatment are less likely to experience self-stigma. Several factors influence personal empowerment, with group identification being the most pronounced. People who purposefully affiliate with groups and publicly admit this relationship are less overwhelmed by stigma and are more in control.

Consumer-operated services, programs developed by people with serious mental illness for people with serious mental illness (Clay, 2005), are one way to promote group identity. Specific examples of consumer-operated services include mutual help programs, advocacy training, and drop-in centers. Common beliefs across consumer services include personal empowerment and accountability, choice and self-determination, recovery orientation, and spirituality.

Many people who experience self-stigma believe the stereotypes of mental illness are legitimate and that they are the results of mutual stereotypes they apply to themselves. As such, stereotypes may be viewed as the irrational self-statements, which are the focus of many cognitive-behavioral therapies (CBT) (Kingdon & Turkington, 1994). Self-applied stereotypes (e.g., "I think that people like me are unable to accomplish most of their life goals.") are viewed as personally hurtful and
false beliefs that CBT may help diminish. One way such stereotypes are challenged in CBT is to collect evidence that disputes its core. This is an iterative process that tests such beliefs by asking life mentors (e.g., an older relative, a church pastor) to provide contrary evidence. As individuals become stronger in disputing the stereotype, they develop counteractions that can be used in the future to challenge it (Garety, Fowler, & Kuipers, 2000) (e.g., “Although I have some struggles, I am still able to achieve most of my life goals just like other adults who face similar barriers.”).

Mental illness is largely hidden; thus, so is the stigma. People can be battling significant psychosocial problems, depression, or distress while others around them are unaware of this turmoil. Individuals with self-stigma must decide whether they want to come out of hiding and attack the stigma's roots, which means they must recognize mental illness and admit they are challenged by it. This can occur privately; however, people may also benefit from “coming out” publicly (Cass, 1979; Cross, 1971). Several benefits can result. First, coming out is frequently experienced as relief that individuals need not be ashamed of or hide an important part of who they are. Second, coming out facilitates identification with other people with similar experiences in a social setting (e.g., work, church, neighborhood potluck) and with whom mental illness and stigma experiences might be shared. Third, the more people come out, the more public stigma is challenged. The public will see that mental illness actually affects a larger group of people than might be expected.

However, coming out also encompasses several negative aspects (Chin & Kroes, 1999). Downsides to coming out include experiencing worse discrimination. Coming out is not a categorical decision; individuals are either out or they are not. Instead, disclosing mental illness can be understood on a four-point continuum (Herman, 1993):

- **Secrecy.** Individuals attempt to achieve life goals by not letting anyone know about their mental health history.
- **Selective disclosure.** Individuals decide to let only some people know about their mental illness. For example, an individual with a mental illness can ask his or her officemate whether he or she saw the episode of ER in which Sally Fields played a person with bipolar disorder. If the coworker responds with vitriol, saying he or she is tired of such politically correct messages, then the officemate is not a good person with whom to share one's mental illness history. However, if the officemate says the episode caused him or her to think, then selective disclosure may be successful.
- **Indiscriminate disclosure.** Individuals do not care who knows about their mental illness. They are comfortable with their mental illness and public disclosure thereof.
- **Broadcasting.** Individuals realize the only way in which stigma is going to change on a grand scale is to come out in a big way, using most of their social situations as an opportunity to share their psychiatric history.

Choosing how to handle stigma is a personal decision. Individuals need to weigh the pros and cons of coming out and consider how disclosure will affect their lives.

**LABEL AVOIDANCE**

Research on understanding and changing label avoidance is not as well developed as for the two other forms of stigma. At this point of knowledge development, anti-stigma strategies for the public are expected to have positive effects on individuals participating in treatment and therefore accepting the label. Therefore, contact

As individuals become stronger in disputing the stereotype, they develop counteractions that can be used in the future to challenge it.

**IMPLICATIONS**

Some research suggests that nurses and other mental health care providers actually endorse the stigma of mental illness (Mirabi, Weinman, Magnetti, & Keppler, 1985). One reason is because these professionals have been slow to relinquish out-of-date ideas that the prognosis for people with serious mental illness is always negative, thereby challenging notions of recovery. Innovators have recognized the problem and have targeted nursing and other professional education as
a venue to challenge stigma and replace it with hope, recovery, and empowerment.

CONCLUSION

Most individuals with serious mental illness aspire to a variety of life goals consistent with recovery. Pharmacological and psychosocial strategies that help people with mental illness accomplish such goals have emerged. However, evidence-based clinical strategies are not sufficient to address barriers to recovery. The stigma of mental illness may also impair achievement of personal aspirations; therefore, evidence-based practices need to be examined in terms of their effect on stigma.

Social psychologists have established a broad program of research on other stigmas that affect the human condition. Adaptation of these theories to mental illness stigma will broaden the understanding of ways to overcome these barriers. In addition, translation of the research methods derived from basic social psychological research will enhance the quality of corresponding research. The outcome of this research agenda will help advocates better understand ways to diminish the effects of stigma on personal goal accomplishment.

REFERENCES


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