The stigma of mental illness: Explanatory models and methods for change

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Abstract

For people with mental illness, diminished quality of life and loss of personal goals does not result solely from the symptoms, distress, and disabilities caused by their psychiatric disorder. Quality of life and personal goals are also hindered by people who embrace the stigma that accompanies mental illness and mental health care. This paper reviews evidence of the impact of mental illness stigma and strategies for seeking to ease its impact. To achieve these goals, we (a) describe the ways in which stigma harm people with mental illness, (b) summarize models that explain the development and maintenance of these stigmatizing effects, and (c) review strategies that have been shown to decrease the impact of stigma. Concerns about stigma are on the political agendas of many mental health advocacy groups. It has recently also become the focus of extensive research. Our goal in this paper is to balance the practical concerns raised by mental health advocates against data that support or contradicts specific assertions.

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1. The impact of mental illness stigma

Goffman (1963) adopted the term stigma from the Greeks who used it to represent bodily signs indicating something bad about the moral character of the person marked with the stigma. This mark can be obvious (such as skin color) or subtle (as in gays or people with mental illness). This kind of moral imputation has egregious affects on at least two levels, what we have called public stigma and self-stigma (Corrigan & Watson, 2002). Public stigma is the phenomenon of large social groups endorsing stereotypes about and acting against a stigmatized group: in this case, people with mental illness. Self-stigma is the loss of self-esteem and self-efficacy that occurs when people internalize the public stigma. The distinction between public and self-stigma is important for understanding, explaining, and building strategies to change stigma.

1.1. Public stigma

Public stigma impacts many people beyond those directly stigmatized. Although our review is limited to the impact of stigma on people with mental illness, research suggests public stigma impacts other groups as well. Family members and friends suffer the impact of public stigma (Lefley, 1987; Phelan, Bromet, & Link, 1998; Thompson & Doll, 1982). Mental health provider groups involved in mental health services have reported being harmed by public stigma (Dichter, 1992; Dickstein & Hinz, 1992; Fink, 1986; Gabbard & Gabbard, 1992; Persaud, 2000).

The stigma of mental illness can rob people labeled “mentally ill” of important life opportunities that are essential for achieving life goals. Two goals, in particular, are central to the concerns of most people, including those with serious mental illness (Corrigan, in press): (a) obtaining competitive employment and (b) living independently in a safe and comfortable home. Clearly, housing and work problems can occur directly because of the disabilities that result from mental illness (Corrigan, 2001). People with some mental illnesses frequently lack the social and coping skills needed to meet the
demands of a competitive work force and independent living. Nevertheless, the problems of many people with psychiatric disability are further hampered by stigma. Several studies have documented the public's widespread endorsement of stigmatizing attitudes. In a survey administered to two towns, one served by community psychiatry and the other served by a traditional mental hospital, Brockington, Hall, and Levings (1993) found that three primary factors arose in attitudes toward people with mental illnesses: benevolence, authoritarianism, and fear. Between the two towns, people from the one served by the traditional mental hospital were slightly more tolerant than people from the town served by community psychiatry (1993). Other research has found similar stigmatizing results (Bhugra, 1989; Hamure, Dahl, & Malt, 1994; Link, 1987; Madianos, Madianou, Vlachonikolis, & Stefanis, 1987; Rabkin, 1974; Roman & Floyd, 1981). These attitudes have a deleterious impact on obtaining and keeping good jobs (Bordieri & Drehmer, 1986; Farina & Felner, 1973; Farina, Felner, & Boudreau, 1973; Link, 1982; Link, 1987; Olshansky, Groh, & Ekdahl, 1960; Wahl, 1999; Webber & Orcutt, 1984) and leasing safe housing (Aviram & Segal, 1973; Farina, Thaw, Love, & Mangone, 1974; Hogan, 1985a, 1985b; Page, 1977, 1983, 1995; Segal, Baumohl, & Moyles, 1980; Wahl, 1999). Classic research by Farina (Farina & Felner, 1973) provides an example of the employment problem. A male confederate, posing as an unemployed worker, sought jobs at 32 businesses. The same work history was reported at each of the job interviews except 50% of Confederates also included information about a past psychiatric hospitalization. Subsequent analyses found interviewers were less friendly and less supportive of hiring the confederate when he added his psychiatric hospitalization.

Apart from its role in the universal concerns of work and housing, stigma also impacts people with mental illness who interact with the criminal justice system. Criminalization of mental illness occurs when people with mental illness are dealt with by the police, courts and jails, instead of the mental health system. Inadequate funding for mental health services and "get tough" on crime policies have contributed to the increasing proportion of serious mental illness in jail (Watson, Corrigan, & Ottati, 2004). Public fear of people with mental illness has increased over the past 40 years (Martin, Pescosolido, & Tuch, 2000; Phelan, Link, Moore, & Stueve, 1997; Phelan, Link, Stueve, & Pescosolido, 2000), resulting in a higher degree of preferred social distance from people with mental illness. The growing intolerance of offenders in general has led to harsher laws and hampered effective treatment planning for mentally ill offenders (Jemelka, Trupin, & Chiles, 1989; Lamb & Weinberger, 1998). As Teplin (1984) points out, people exhibiting symptoms and signs of serious mental illness are more likely than others to be arrested by the police. The selective process continues if the person is taken to jail. Someone with a mental illness tends to spend more time incarcerated than people without mental illness (Steadman, McCarty, & Morrissey, 1989). Treating people with mental illness like criminals has implications not only for their life, liberty, and well being, but also for the larger community such as loss of potential contributions by viable citizens.

Finally, research seems to indicate that people with mental illness are less likely to benefit from the American health care system than people without these illnesses. Research by Druss and colleagues suggests that people with mental illness receive fewer medical services than those not labeled in this manner (Desai, Rosenheck, Druss, & Perlin, 2002; Druss & Rosenheck, 1997). Moreover, studies suggest people with mental illness are less likely to receive the same range of insurance benefits as people without mental illness (Druss, Allen, & Bruce, 1998; Druss & Rosenheck, 1998). Previous research has used rates of procedures for cardiovascular disorders as an index of bias by race (Ayanian, Udvarhelyi, Gatsonis, Pashos, & Epstein, 1993; Wenneker & Epstein, 1989) and gender (Ayanian & Epstein, 1991; Krumholz, Douglas, Lauer, & Pasternak, 1992). Druss, Bradford, Rosenheck, Radford, and Krumholz (2000) examined the likelihood of a range of medical procedures after myocardial infarction in a sample of 113,653. Compared to the remainder of the sample, Druss et al. found that people with comorbid psychiatric disorder were significantly less likely to undergo percutaneous transluminal coronary angioplasty (PTCA), also known as coronary artery balloon dilation. PTCA is a less expensive, less traumatic alternative to bypass surgery (American Heart Association, 2004).

1.2. Impact of stigma on the self

Prior to the onset of mental illness, most people are aware of culturally endorsed stereotypes about mental illness. Upon diagnosis, awareness of stigma may affect a person's sense of self in at least two ways. First, people may constrict their social networks in anticipation of rejection, which leads to isolation, unemployment and lowered income. These "failures" result in self-esteem and self-efficacy decrements (Link, 1987; Markowitz, 1998). Second, people with mental illness may consider such stigmatizing ideas self-relevant and believe that they themselves are less valuable because of their disorder in the same way they are described by others. The net effect of these processes we define as self-stigma (Corrigan & Watson, 2002; Crocker & Major, 1989). Research suggests that both perceived- and self-stigma result in losses of self-esteem and self-efficacy and limit prospects for recovery. Link and colleagues (1980) assessed self-esteem and perceived stigma in 70 people with serious mental illness at three time points: baseline and 6 and 24 months (2001). After controlling for baseline self-esteem, depressive symptoms, diagnosis, and demographic characteristics, results showed that those with high perceptions of perceived stigma (90th percentile) were more likely to have low self-esteem than those with low perceptions of perceived stigma (10th percentile). These findings along with other research in the field
suggest that stigma perceived by people with mental illness harms their self-esteem (Corrigan, 1998; Holmes & River, 1998; Link, 1987; Link, Cullen, Struening, & Shrout, 1989; Link, Mirotznik, & Cullen, 1991; Markowitz, 1998; Perlick et al., 2001; Rosenfield, 1997; Sirey et al., 2001).

Of course not everyone with a mental illness suffers a loss of self-esteem due to stigma (Crocker & Major, 1989). Research has found that people with mental illness while being aware of the negative stereotypes endorsed by the public do not experience a sharp decline in self-esteem (Hayward & Bright, 1997). Elsewhere, we detail a model of personal reactions to stigma in which people may: (1) self-stigmatize and suffer a loss of self-esteem, (2) remain relatively indifferent to stigma, or (3) become empowered by stigma and advocate on behalf of themselves and others with mental illness (Corrigan & Watson, 2002). Among various factors, research suggests people who strongly identify with a stigmatized group – i.e., opt to strongly relate with consumer and survivor groups – are less likely to fall victim to self-stigma.

2. Models of mental illness stigma

Most current models that explain the phenomenon of mental illness stigma have emerged from basic behavioral science. Explanatory models can be divided into three general groups: those that explain stigma in terms of naturally occurring cognitive structures; motivational models that explain why people stigmatize; sociological models that ground some of the experiences of stigma and discrimination in social institutions and structures. Each of these is described more fully in turn.

2.1. Individual cognitive models

Psychologists argue that the way humans come to know the world is bound by the limits of their cognitive structures and processes. For example, social cognitive models describe how stigma-related processes are formed and maintained at the psychological level. Three components that make up this model are outlined in Fig. 1: stereotypes, prejudice, and discrimination. Social psychologists view stereotypes as knowledge structures that are learned by most members of a social group (Augustinos, 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 categorizing information about social groups. Stereotypes are considered “social” because they represent collectively agreed upon notions about groups of people. They are “efficient” because people can quickly generate impressions and expectations of people who belong to a stereotyped group (Hamilton & Sherman, 1994). The categorization functions as a method for people to organize the vast amount of stimulus encountered in everyday life (Eagly & Chaiken, 1993). Common stereotypes about mental illness include dangerousness, incompetence, and character weakness.

Just because most people have knowledge of a set of stereotypes does not require that they agree with them (Jussim, Nelson, Manis, & Soffin, 1995). People who are prejudiced endorse these negative stereotypes (“that’s right; all people 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, prejudicial attitudes involve agreement with an evaluative (generally negative) component (Allport, 1954; Eagly & Chaiken, 1993). Prejudice, which is fundamentally a cognitive and affective response, may or may not lead to discrimination, the behavioral reaction (Crocker, Major, & Steele, 1998). Prejudice that yields anger can lead to hostile discriminatory behavior (e.g., physically harming a minority group) (Weiner, 1995). Angry prejudice may lead to withholding mental health care or replacing mental health care with services provided by the criminal justice system (Corrigan, 2000). Fear may also lead to discriminatory avoidance, e.g., employers do not want people with mental illness nearby so they do not hire them. As outlined in Fig. 1, stereotype, prejudice, and discrimination manifest differently depending on whether the public is considering stigma or the self.

2.1.1. Motivational models

Motivational theories seek to explain why people stigmatize, or the function that stigma serves for the stigmatizer. Three such motivations have emerged in the literature: ego-justification, group-justification, and system-justification (Jost & Banaji, 1994). Psychoanalysts were among the first to write about ego-justification, suggesting that the self is protected when internal conflicts are projected on to stigmatized groups (Bettelheim & Janowitz, 1964; Freud, 1946). In this way, stigma serves to shield self-esteem from the effects of personal failings. Social psychologists expanded the ego-justification idea beyond personal defense mechanisms to include any function that protects ideas, images, or behaviors that reflect the self by projecting these negative conceptualizations and actions on others (Katz & Braly, 1935). Little empirical evidence has been found to support ego-justification as an explanation of stigma. Research has, however, provided support for stigma and stereotypes serving a self-protective function that does not have psychodynamic origins. This research suggests that the function of stigma may be to avoid potential threat to one’s body or psychological self possibly through the motivation to avoid danger of a socially perceived threat or by rationalizing negative group-based attitudes and discrimination (Bierant & Dovidio, 2000; Stangor & Crandall, 2000).

Group-justification models purport that stigmatization of an out-group, such as those with mental illness, emerges to support the goals of the in-group. From an evolutionary perspective, stigmatizing out-groups who may threaten
2.2. Institutional and structural models

Focusing on the individual psychological level of explanation in terms of cognition and motivation gives an incomplete picture of the problem of stigma. Stigma and discrimination may also be understood at societal levels in terms of the historical, political, and economic forces that influence institutions and social groups. For example, in better understanding racism in America, civil rights activists (Carmichael & Hamilton, 1967; US Commission on Civil Rights, 1981) and sociologists (Friedman, 1975; Hill, 1988; Merton, 1948; Pincus, 1999, 1996; Wilson, 1990) realized that discrimination impacts people of color in ways not explained by the direct effects of other people’s bigoted behavior. Activists and sociologists made the distinction between these individual-levels of impact and both institutional and structural causes of prejudice and discrimination. Institutional discrimination manifests itself as rules, policies, and procedures of private and public entities in positions of power that intentionally restrict the rights and opportunities of people with color. Jim Crow Laws were examples of public institutional discrimination. Mississippi, for example, passed legislation that required separate schools for whites and “colored people.” Extending from the end of the nineteenth to the middle of the twentieth century, these laws largely enacted by Southern States explicitly undermined the rights of African Americans in such vital areas as employment, education, and public accommodation.
The effects of institutional discrimination are by definition intentional, perhaps not by the line-level person carrying out the policy, but by a small group of powerful people at the top of an institution who explicitly sought to diminish the opportunities of racial or ethnic groups by passing laws or regulations (Hill, 1988; Mayhew, 1968; Pincus, 1999). Hence, one might conclude that institutional discrimination is the direct result of the stigmatizing behaviors and attitudes of a few powerful people. There is a separate set of public and private sector policies—what is called structural discrimination—whose unintended consequences restrict the opportunities of members of minority groups (Feagin, 1978; Hill, 1988). For example, many universities and colleges use the SAT or ACT to restrict admission offers to students who have earned the highest scores (Pincus, 1999). Given that African American and Hispanic students typically score lower on these tests, universities that rely on test scores for admissions are likely to prevent an unequal number of Black and Hispanic students from being educated at these institutions. Note that in this example, people at the top of the organization did not intend to restrict the prospects available to people of color. College presidents are typically people who seek to better their community by advancing principles related to social justice. Nevertheless, the results of these kinds of policies limit the possibilities for people because of their ethnic group and the economic and historical forces that have forged that group’s place in society (Merton, 1948, 1957).

2.2.1. Institutional discrimination and mental illness
According to Link and Phelan (2001), there is evidence of institutional discrimination against people labeled with mental illness in both public and private sectors. A good example from the public sector is legislative activity that restricts the rights and opportunities of people with mental illness. Results of two comprehensive reviews of laws by state showed that approximately one-third restrict the rights of an individual with mental illness to hold elective office, participate in juries, and vote (Burton, 1990; Hemmens, Miller, Burton, & Milner, 2002). Even greater limitations were evident in the family domain. More than 40% of states limit the rights of people with mental illness to remain married. Depending on the year of the survey, from 40 to 50% of states limited the child custody rights of parents with mental illness (Hemmens et al., 2002).

2.2.2. Structural discrimination and mental illness
Institutional discrimination is marked by an explicit and conscious attempt to distinguish between groups and withhold from the stigmatized subset some rights and privileges. Structural discrimination is based more on effect than intent, and hence it is much more difficult to define (Pincus, 1996, 1999). Examples from the US Supreme Court highlight the distinctions between structural and institutional discrimination. In determining whether state or federal laws were unconstitutional because they promoted segregation, Justices frequently distinguished between the law’s intent and its effect. For example, the Court has refused to declare school segregation unlawful unless direct evidence of discriminatory intent on the part of the school district could be found, regardless of segregation’s effect on minority children (Graglia, 1980; Hill, 1988).

According to a structural view, group-neutral goals are frequently not accomplished because they seem to clash with dominant ideologies that unintentionally maintain the unequal status quo (Hill, 1988; Jackman & Muha, 1984). Two dominant viewpoints are a democratic belief in meritocracy and a capitalist value in cost-effectiveness (Pincus, 1999). Note that although they are not malicious in intent, both ideologies yield unintended negative consequences. Meritocracy, for example, is the value that drives standardized test scores; i.e., decisions about college admissions, and the opportunities that those decisions entail, should be based on the candidate’s intellectual merit (e.g., abilities and achievements). Societal concerns about cost-effectiveness, and decisions representing good business, also seem to yield structural discrimination and may be especially relevant to mental illness. Link and Phelan (2001) expound upon the business value in listing examples of structural discrimination related to mental illness. Less money is allocated to research and treatment on psychiatric illness than other health disorders because illnesses like cancer and heart disease have dominated the American public health agenda. Many psychiatrists and other mental health professionals opt out of the treatment system serving people with the most serious psychiatric and substance abuse disorders. Salaries and benefits are better in the private health sector that is more likely to treat relatively benign illnesses like adjustment disorders, relational problems, and phase of life problems so providers opt for those kinds of jobs. Hence, the quality of services for people with more serious mental disorders is inferior to many other less serious conditions.

Problems with mental health insurance parity (i.e., insurance benefits for mental health problems equaling those provided for general health) are an especially prominent example of structural stigma related to mental illness. Strong opposition to mental health parity legislation was heard from the business community, citing the kind of cost concerns frequently used to justify other forms of structural discriminations. Lobbyists for the business sector argued that parity requirements could bankrupt small businesses by raising health care costs (Levinson & Druss, 2000). The history and subsequent impact of parity reveals key elements of structural discrimination. First, the resulting act leads to fewer financial resources for psychiatric disorders, compared to medical illness, thereby yielding diminished opportunity for people with mental illness. Second, this disparity does not seem to reflect conscious prejudice on the part of Congress or the public. Most members of both houses, regardless of political affiliation, support equal care for mental health disorders, as does the American public (Hanson, 1998). Lack of support for many of the provisions of parity stems from financial concerns that are frequently at the root of other structural
discriminations: parity makes for bad business. The seemingly contradictory tension between wanting to support treatment equity but not wanting to make a bad business move is evident in public attitude. One review found that participants of national surveys on parity supported equal resources for mental health and medical diagnoses, on the one hand, but, on the other hand, did not support paying higher premiums or redistributing funds from medical/surgical services to mental health services to accomplish this goal (Hanson, 1998).

3. Changing stigma

Given that processes giving rise to and producing differential effects of stigma vary by level of analysis, it seems reasonable to suggest that stigma change methods vary by conceptual level. Hence, we summarize the stigma-change literature in terms of its impact on public stigma, self-stigma, or institutions and structures that maintain stigma.

3.1. Erasing public stigma

In recent years, advocacy groups have made reducing stigma a priority, implementing campaigns aimed at the public and the media. These efforts have targeted various components of mental stigma with a variety of strategies, few of which have been formally evaluated. However, social psychological research on ethnic minority and other group stereotypes provides important insight on the effectiveness of these strategies for reducing mental illness stigma (Corrigan & Penn, 1999). Based on this literature, we have grouped the various approaches to changing public stigma into three processes: protest, education, and contact (Corrigan & Penn, 1999).

Protest strategies highlight the injustices of various forms of stigma chastising the offenders for their attitudes and behaviors. Anecdotal evidence suggests that protest can change some behaviors significantly (Wahl, 1995). For example, in 2000 NAMI StigmaBusters played a prominent role in getting ABC to cancel the program “Wonderland,” which portrayed people with mental illness as dangerous and unpredictable. StigmaBusters’ efforts not only targeted the show’s producers and several management levels of ABC, they encouraged communication with commercial sponsors including the CEOs of Mitsubishi, Sears, and the Scott Company. Hence, research might show protest to be effective as a punishing consequence to discriminatory behavior decreasing the likelihood that people will repeat this behavior. The punishing consequences of protest are especially relevant for examining the effects of legal penalties prescribed by the Americans with Disabilities Act and the Fair Housing Act. In like manner, research might identify reinforcing consequences to affirmative actions that undermine stigma and encourage more public opportunities for people with mental illness, e.g., government tax credits for employers who hire and provide reasonable accommodations to people with psychiatric disabilities.

Although organized protest can be a useful tool for convincing television networks to stop running stigmatizing programs, protest may produce an unintended “rebound” effect in which prejudices about a group remain unchanged or actually become worse. Protest programs asking people to suppress their prejudice about a group can promote psychological reactance (do not tell me what to think) and worsen attitudes as a result (Corrigan et al., 2001; Macrae, Bodenhausen, Milne, & Jetten, 1994; Penn & Corrigan, 2002). Hence, while protest may be a useful tool for changing the behavior, it may have little or negative impact on public attitudes about people with mental illness.

Educational approaches to stigma change attempt to challenge inaccurate stereotypes about mental illness and replace these stereotypes with factual information. Evidence about educational strategies targeting race and other minority group stereotypes is mixed and suggests that effects of educational interventions may be limited (Devine, 1995; Pruegger & Rogers, 1994). Educational strategies aimed at reducing mental illness stigma have used public service announcements, books, flyers, movies, videos, and other audio visual aids to dispel myths about mental illness and replace them with facts (Bookbinder, 1978; National Mental Health Campaign, 2002; Pate, 1988; Smith, 1990). Some benefits of educational interventions include lower cost and broad reach. It is important to note, however, that though education produces short-term improvements in attitudes (Corrigan et al., 2001, 2002; Keane, 1991; Morrison & Teta, 1980; Penn, Guyanan, Daily, & Spaulding, 1994; Penn, Komman, Mansfield, & Link, 1999); In a study by Holmes, Corrigan, Williams, Canar, and Kubik (1999), for example, participants either took either a semester-long course on serious mental illness or a general psychology course. Subjects were administered a pre- and post-test on knowledge of mental illness and opinions of mental illness questionnaire. Results showed that the education group interacted with pre-education depending on the attitude about mental illness. Those with greater prejudice were less likely to benefit from an education group like the semester long, stigma course.

The third strategy for reducing stigma is interpersonal contact with members of the stigmatized group. Contact has long been considered an effective means for reducing intergroup prejudice (Allport, 1954; Pettigrew & Tropp, 2000). Several studies specifically focusing on contact’s effect on mental illness stigma have produced promising findings. Corrigan et al. (2001) found that contact with a person with mental illness produced greater improvements in attitudes than protest, education, and control conditions. In a subsequent study, contact again produced the greatest improvements in attitudes and participant willingness to donate money to a mental health advocacy group (Corrigan et al., 2002). Improvements in attitudes seem to be most pronounced when contact is with a person who moderately disconfirms prevailing stereotypes (Reinke, Corrigan, Leonhard, Lundin, & Kubik, 2004).
Table 1
Understanding targets of anti-stigma programs

<table>
<thead>
<tr>
<th>Targets</th>
<th>Discriminatory behavior</th>
<th>Corresponding attitudes</th>
<th>Social context</th>
<th>Change strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Landlords</td>
<td>Fail to lease</td>
<td>Dangerousness</td>
<td>Economy</td>
<td>ADA</td>
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<td></td>
<td>No reasonable accommodation</td>
<td></td>
<td>Hiring pool</td>
<td>Erasing the stigma</td>
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<tr>
<td>Employers</td>
<td>Fail to hire</td>
<td>Incompetence</td>
<td></td>
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<td></td>
<td>No reasonable accommodation</td>
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<td>Health care providers</td>
<td>Withhold some services</td>
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<td></td>
<td>Unnecessarily coercive treatment</td>
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<td>Criminal justice</td>
<td>Unnecessarily coercive</td>
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<td></td>
<td>Fail to use mental health services</td>
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<td>Policy makers</td>
<td>Insufficient resource allocation</td>
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<td></td>
<td>Unfriendly interpretation of regulations</td>
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<td>The media</td>
<td>Perpetuation and dissemination of stigmatizing images</td>
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</table>

3.1.1. Targeted stigma change

Anti-stigma programs are more successful when they target specific groups of people instead of the general public. “Target” has a double meaning here. It is first defined in terms of specific social groups who are powerful vis-à-vis people with mental illness. Examples of these groups are listed in the first column of Table 1. Power is based on functional relationships (Fiske, 1993); the groups in Table 1 are frequently in positions of control and authority relative to people with mental illness. In particular, they can exercise discriminatory behavioral options that curtail the life opportunities of people with mental illness. These are the second set of targets for anti-stigma programs, which are highlighted in Table 1 as specific discriminatory behaviors. Table 1 is meant to be an example of the elements in targeted stigma change. As an example, Table 1 illustrates parts of the table: targets, discriminatory behavior, corresponding attitudes, social context, and change strategies. The table is not to be a comprehensive treatment of targeted stigma. Let us more fully consider how certain power groups may specifically harm people with mental illness.

By virtue of their social position, landlords and employers are in the position to influence two important life goals for people with mental illness: living independently and obtaining good jobs (Corrigan et al., 2002). Landlords and employers who believe stereotypes about mental illness may respond in a discriminatory manner. Landlords may be afraid of people with mental illness and decide not to rent property to them (Farina et al., 1974; Hogan, 1985; Page, 1995; Segal et al., 1980; Wahl, 1999). Employers might believe people with mental illness are incapable of competent work, and therefore, not hire them (Bordieri & Drehmer, 1986; Farina & Felner, 1973; Farina et al., 1973; Link, 1982, 1987; Wahl, 1999). Hence, stigma programs need to generate change strategies that target the specific prejudicial attitudes and discriminatory behaviors of these two power groups to advance the empowerment and life opportunities of people with mental illness. (“behaviors” or attitudes? Discrimination cannot be an attitude can it? I inserted “prejudicial attitudes and” before discriminatory behavior).

This kind of convergence between discriminatory behavior and attitude change strategies echoes what is generally known about attitude change in basic behavioral research, namely, behaviors are more likely to change when strategies target attitudes that correspond with the behavior (Ajzen & Fishbein, 1977; Cacioppo, Petty, Feinstein, Jarvis, & Blair, 1996). Correspondence is a function of several elements including participating actors and the context in which a specific event is likely to occur. Hence, changing the prejudice and discrimination of mental illness is likely to be more successful when specific power groups are targeted in the settings in which they might discriminate.

Consider some of the other important targets for stigma change listed in Table 1. Health care providers and administrators may endorse stigma about mental illness. As a result, general medical providers may fail to provide necessary treatments that would otherwise be prescribed to people (Felker, Yazel, & Short, 1996). As discussed earlier, research has shown that people with mental illness are less likely to receive appropriate cardiovascular procedures after myocardial infarct compared to a demographically matched group that is not labeled mentally ill (Druss et al., 2000; Druss, Bradford, Rosenheck, Radford, & Krumholz, 2001). Alternatively, mental health providers may endorse coercive or other mandatory treatments (e.g., being committed to a psychiatric hospital) when the person’s current profile of needs fails to show these kinds of interventions are warranted. Several levels of the criminal justice system may also be impacted by stigma (Watson, Hanrahan, Luchins, & Lurigio, 2001). Police, overestimating the risk of violence, may respond with undue force to people labeled “mentally ill.” The judiciary, holding people with mental illness responsible for their symptoms, may fail to divert offenders to appropriate services in the mental health system.

Two sets of discriminatory behaviors seem to be relevant to legislators and policy makers. First, members of this group seem to be unwilling to allocate sufficient resources to mental health services. This is evidenced by 1990s levels of funding having dropped more than 8% from the preceding decade even though service needs did not change (Willis, Willis,
& Male, 1998). Also, legislators have been unwilling to pass a parity bill that equalizes insurance benefits for mental and physical health (Gitterman, Strum, Pacula, & Scefler, 2001). Second, policy makers and legislators seem unwilling to interpret existing legislation in a manner that is friendly to mental health. Note that it took more than 5 years for the Equal Employment Opportunity Commission to issue an interpretation of the Americans with Disabilities Act (ADA) that is sensitive to the needs of people with psychiatric disabilities.

Two additional elements in Table 1 influence the relationship between discriminatory behavior and change strategies: corresponding attitudes and social context. As an example, consider the relevance of these factors to the possible set of discriminatory behaviors of employers. According to a social cognitive perspective, stigmatizing attitudes precede discriminatory behaviors (Corrigan, 2000). Path analytic research has shown that believing people with mental illness are dangerous leads to socially avoidant behavior, such as unwillingness to work alongside of people labeled mentally ill (Corrigan et al., 2002). Perceived incompetence may be an additional attitude that will influence discriminatory behaviors. This is the belief that people with mental illness are not able to work effectively so employers may refuse to hire them or to provide reasonable accommodations when they do.

The context in which targets behave may also influence the form of discriminatory behaviors (Lisa, 1990; Newman, 2001). In particular, the social-economic context in which employers operate may affect the likelihood of hiring people with mental illness beyond the stereotypes of those doing the hiring. Some studies suggest that people discharged from psychiatric hospitals often find employment in less desirable parts of cities, sometimes called “socially disorganized” neighborhoods (Silver, 1999, 2000). The likelihood of employers hiring people with mental illness may depend on the economic context of the neighborhood in which the job site is located. Employers in more desirable parts of the city may conform to norms regarding the “appropriateness” of employees. However, employers in more economically disadvantaged and less desirable parts of the city may not be under community pressure to restrict their hiring practices, and therefore, less likely to be as greatly influenced by stigma.

3.2. Coping with self-stigma

While the responsibility for eliminating mental illness public stigma rightfully falls on the shoulders of society, change will be slow. In the meantime, there are several approaches to diminish self-stigma including cognitive reframe of stigmatizing self-statements and enhancing one’s sense of personal empowerment. Recent developments in the area of cognitive therapy suggest that self-stigma may be understood as resulting from maladaptive self-statements or cognitive schemata of mental illness developed largely as a result of socialization. Cognitive therapy has been shown to be an effective strategy for helping people change the cognitive schemata that lead to anxiety, depression, and the consequences of self-stigma (Chadwick & Lowe, 1990; Drudy, Birchwood, Cochrane, & MacMillan, 1996; Kuipers et al., 1997; Tarrier, Beckett, Harwood, & Baker, 1993). Kingdon and Turkington (1991) specifically used a cognitive behavioral approach to help people reframe stigma as a normal event. While this study was not a randomized-controlled trial, the interventions were well received by consumers and seemed to lead to greater illness acceptance. Subsequent studies have more carefully examined the impact of similar cognitive therapies on psychotic symptoms, self-statements, and service utilization (Beck & Rector, 2000; Gould, Mueser, Bolton, Mays, & Goff, 2001; Turkington & Kingdon, 2000).

Another approach to changing self-stigma is facilitating personal empowerment, which has been argued as the opposite of self-stigma. Being empowered means having control over one’s treatment and one’s life (Rappaport, 1987). People who have a strong sense of personal empowerment can be expected to have high self-efficacy and self-esteem. Communities and health service providers can foster personal empowerment among mental health consumers by giving consumers greater control over their own treatment and reintegration into the community. Empowering services involve the consumer as a partner in treatment planning and promote the self-determination of consumers in relation to employment opportunities, housing, and other areas of social life. Research findings indicate that programs that include the person with disabilities in all facets of intervention are conducive to the attainment of vocational and independent living goals (Corrigan, Faber, Rashid, & Leary, 1999; Corrigan & Garman, 1997; Rappaport, 1990; Rogers, Chamberlin, Ellison, & Crean, 1997).

Many consumers have empowered themselves and become staff members of traditional treatment programs (Mowbray et al., 1997), while others have developed consumer-operated alternatives to the traditional service system, such as lodges, clubhouses, and self-help/mutual assistance groups. The Fountain House clubhouse in New York is a paradigmatic example of consumer empowerment through mutual help (Corrigan & Calabrese, in press). It destigmatized the recovering person by focusing on his or her strengths rather than weaknesses, and by developing social competence through involvement in the very activities that constitute community integration (employment, housing, education, etc.). Services like these greatly increase the consumer’s sense of power, thereby challenging any self-stigma with which they might be struggling.

3.3. Changing structures and institutions

Social scientists who have developed ideas related to institutional and structural factors conclude that individual-level strategies for stigma change are probably not sufficient for remediating prejudice and discrimination that are largely caused by collective variables (Hill, 1988; Pincus, 1999). Education of key power groups might have some limited impact on the kinds of intentional biases represented by
institutional discrimination. For example, one way to diminish legislative actions that unjustly restrict the opportunities of people with mental illness is to educate House and Senate members about how their actions are impinging on an important part of their constituency. More difficult, however, is altering the course of structural discrimination. Because its impact is unintentional, educational and other individual-level strategies should have no effect on structural factors. Instead, various social change strategies that fall under the rubric of affirmative action may be relevant for stopping the harm caused by structural discrimination.

Affirmative actions are a collection of government-approved activities, which are meant to redress the disparities that have arisen from historical trends in prejudice and discrimination. According to affirmative models, membership in a stigmatized group is added to considerations of an individual's skills and achievements for access to specific limited opportunities. The American with Disabilities Act seems to be a Federal Policy that mirrors affirmative goals. ADA clauses that prohibit discrimination by employers because of a person's psychiatric disability are effective for barring individual and institutional levels of discrimination. It is the ADA clause on reasonable accommodation, however, that is an affirmative action, which decreases structural discrimination. Reasonable accommodations are changes to the workplace environment that assist the person in working. Reasonable accommodation gives people with psychiatric disabilities an edge towards keeping their job. The 1988 amendments to the Fair Housing Act provide similar guarantees to reasonable accommodations for people with psychiatric disabilities in the housing sector. Affirmative actions like these are needed to offset the injustices that continue because of structural discrimination against people with mental illness.

4. Final thoughts

Psychiatric disability is defined as an inability to achieve significant life goals — e.g., a vocation that yields a reasonable income and living in a home with one's family — that results from serious mental illness. Our thesis in this paper was that achievement of life opportunities like these is also hampered by public and personal reaction to mental illness: stigma. We summarized cognitive, motivational, and institutional/structural models that explain from whence comes mental illness stigma. We used these models to describe ways to diminish stigma at the public and self-levels. With this kind of information, researchers can join advocates in understanding and diminishing this major barrier to a quality life.

References


