COMMENTARY

Mental Illness Stigma: Problem of Public Health or Social Justice?

Patrick W. Corrigan, Amy C. Watson, Peter Byrne, and Kristin E. Davis

The U.S. Surgeon General’s report on mental health (1999) and the report of President Bush’s New Freedom Commission on Mental Health (2003) highlighted the public health impact of mental illness stigma. Using a medical model, several education programs have sought to diminish stigma’s effect on public health by describing mental illness as a disease of the brain that can be treated successfully. This approach has been shown to be useful for reducing blame related to mental illness. Unfortunately, such public health messages may also exacerbate stigma by reinforcing notions of individual difference and defect. Alternatively, framing mental illness stigma as a social justice issue reminds us that people with mental illness are just that—people. The social justice perspective proposes that all people are fundamentally equal and share the right to respect and dignity. Applying this perspective to mental illness stigma allows us to increase our understanding of the problem and expands the means and targets of efforts to eliminate stigma. In this Commentary, we review the assertions of the public health perspective, highlighting some of the limitations that emerge from this approach. We then review stigma as social injustice and feature ways in which this paradigm advances understanding and changing stigma.

THE PUBLIC HEALTH MODEL OF STIGMA AND STIGMA CHANGE

Viewing stigma as a public health issue points to the ways in which stigma harms people with mental illness. Three are particularly notable: label avoidance, blocked life goals, and self stigma.

Label Avoidance

Epidemiological research suggests that more than half of the people who might benefit from mental health services opt not to pursue it (Narrow et al., 2000; Regier et al., 1993). One reason given is not wanting to suffer the stigma that accompanies being labeled “mentally ill” (Kessler et al., 2001).

Blocked Life Goals

People with mental illness frequently are unable to obtain good jobs or find suitable housing because of the prejudice of key members in their communities—employers and landlords (Farina, Thaw, Lovern, & Mangone, 1974; Link, 1987; Wahl, 1999).

Self Stigma

Some people with mental illness internalize stigma and experience significant decrements in self-esteem and self-efficacy as a result (Link & Phelan, 2001).

Public Health Approach

The public health approach to decreasing mental illness stigma largely relies on education programs dominated by the medical or disease model. Education is defined broadly in terms of any strategic format (that is, classrooms, public service announcements, magazine articles) that seeks to decrease stigma by informing the public about mental illness. One example is the National Alliance for the Mentally Ill’s (NAMI) “Mental Illness is a Brain Disease” campaign, in which the organization distributed posters, buttons, and literature that provided information about the biological basis of serious mental illness. On a global scale, the World Psychiatric Association (WPA) is sponsoring its Open the Doors Global Program against stigma and discrimination focusing on schizophrenia. Now in its eighth year, the WPA information program educates the public about mental disease and corresponding treatment.

There is some evidence that education may reduce the stigma of psychiatric illness. Several studies have shown participation in brief courses on mental illness and treatment lead to improved attitudes about
people with mental illness (Corrigan et al., 2002; Wolff, Pathare, Craig, & Leff et al., 1996). However, research has also found that framing mental illness in biological terms may increase other negative attitudes about mental illness. One study found that disease explanations for mental illness reduced blame, but also provoked harsher behavior toward an individual with mental illness (Mehta & Farina, 1997). Read and colleagues (1999, 2001) showed that members of the general public who endorsed biological causal beliefs about mental illness were more likely to agree with negative perceptions about people with psychiatric disorders. These negative perceptions include the view that people with mental illness are dangerous, antisocial, and unpredictable. A third study suggested that viewing mental illness as a genetic disorder leads to paradoxical effects (Phelan, Cruz-Rojas, & Reiff, 2002). On one hand, people who endorse genetic causality are less likely to blame individuals for their mental illness. However, this same group is also more pessimistic that people with mental illness will recover.

THE "CURE" FOR STIGMA

There is a corollary message that often accompanies teaching “mental illness as a brain disorder” (that is, curing mental illness will reduce the stigma (Liberman & Kopelowicz, in press). As a person’s disabilities vanish, prejudice against him or her based on mental illness also disappears. Some proponents of this approach note how the stigma of leprosy, for example, has been erased because the illness has been largely eradicated (personal communication, Sartorius, council member for Switzerland, World Psychiatric Association, Geneva, 2003). Researchers in third world countries, however, might disagree with the claim, differing with the suggestion that the stigma of the illness is minimal (Chatterjee et al., 1989).

Others who promote “treating the stigma away” argue that what is labeled stigma may be a “normal” response of fearful reactions to people who are psychotic (Torrey & Zdanowicz, 2001). This assertion rests on two related, and tenuous, assumptions: (1) There is a kernel of truth that underlies the stigma of mental illness (for example, some people with mental illness are more violent); treatment programs that can reverse this “truth” will help to erase the stigma. (2) Putting the symptoms, and hence the disease, undercover will decrease the stigma that signals prejudice and discrimination.

Kernel of Truth

Stereotypes function as rational categories that “grow up from a kernel of truth” (Allport, 1954, p. 22). Assessment of the kernel of truth hypothesis is a matter of assessing stereotype accuracy. Examples of stereotype accuracy are apparent in peoples’ perceptions of a variety of social groups. For example, professional basketball players are stereotyped as tall, and objective measures confirm that the average basketball professional is indeed taller than most people.

In terms of ethnic group prejudice, Vinacke (1949) uncovered evidence of stereotype accuracy in students’ perceptions of ethnically different peers. His research suggested, for example, that students accurately perceived Hawaiians as “musical” and “easy-going.” Perhaps the same is true when considering stereotypic perceptions of mental illness. That is, perhaps people with mental illness really do possess the traits commonly attributed to them—that is, they are dangerous and unable to care for themselves) (Nunnally, 1971).

Despite this kind of research, there are reasons to question the accuracy of stereotyped perceptions. History is replete with examples of inaccurate stereotyping that has served to justify pernicious forms of prejudice and discrimination. Armenian laborers in southern California, for example, were stereotyped as “dishonest,” “deceitful,” and “trouble makers.” However, more objective assessments of group characteristics failed to confirm the validity of these stereotypes. LaPiere (1936) found that Armenians in southern California appeared less often in legal cases and possessed credit ratings that rivaled those of other ethnic groups. It is clear that many stereotypes may possess a significant component of inaccuracy.

Psychiatry has provided several examples of inaccurate notions about mental illness. The discipline has generated an endless list of groundless theories to add to stigma—for example, influences of the womb (“hysteria”) and moon (“lunatic”). But what about the connection between violence and serious mental illness; might we not think this attitude rests on a grain of truth? Large scale analyses of epidemiologic databases showed that people with mental illness are generally more dangerous than the population as a whole (Swanson, Holzer, Ganju, & Jono, 1990). However, additional analyses of the data examining the size of these effects found that mental illness, compared with some demographics, is
actually a poor predictor of dangerousness (Corrigan & Watson, in press). In terms of group risk, men and young adults are three to six times more likely to be violent than people with mental illness. Hence, the accurate stereotype is that the size of the violence effect for mental illness is not large or meaningful.

No symptoms, No Stigma

Treating the stigma by hiding the symptoms has a counterpoint in the history of stigma and ethnicity; namely, racism can be fought by becoming color blind (Brown, Carnoy, Currie, Duster, & Oppenheimer, 2003). Some activists in the 1960s believed that Americans should be oblivious to outward signs that distinguish white from black and from other ethnic groups—that is, skin color. Instead we should identify and cherish a common set of supraracial values that serve as the benchmarks by which an individual's worth is judged. Unfortunately, the search for these supraracial values frequently led to Western European standards so that African Americans, for example, were still being judged by white American values. The notion of erasing mental illness implies that being "normal" is somehow better. Being color blind, or hiding the symptoms, may unintentionally add to the stigma. It may suggest that people who are not hiding their symptoms are somehow responsible for them.

Parity Not Pity

Research suggests that educational programs that focus on biological causes may increase pity, or sympathy, for people with mental illness (Corrigan et al., 2001; Corrigan et al., 2002; Watson, Otey, Corrigan, & Fenton, 2003). But pity yields both positive and negative results. Weiner (1995) argued that sympathetically viewing a person as victimized by a health condition is associated with willingness to provide help to that person. Research specific to mental illness has shown that members of the general public who pity individuals with mental illness are more willing to offer a helping hand to them (Corrigan et al., 2002).

However, pity from the public may also produce negative effects because, in trying to elicit sympathy, there is an overreliance on or dramatization of what people with mental illness cannot do. As a result, viewing people with mental illness as pitiable has been associated with the benevolence stigma (Brockington, Leving & Murphy, 1993; Madianos, Mandinou, Vlachonikolis, & Stefanis, 1987); because people with mental illness are viewed as unable to competently handle life's demands, they need a benevolent authority who can make decisions for them. Mental health advocates have argued that a major problem with the mental health system is disempowering practices that prevent people with psychiatric disabilities from pursuing life goals (Beers, 1908; Chamberlin 1978). Hence, antistigma advocates need to be very cautious about programs that make appeals to pity. Antistigma advocates need to cultivate empathy that leads to parity, not to condescension and exaggeration of difference.

MENTAL ILLNESS STIGMA AS SOCIAL INJUSTICE

The public health approach may have some value in reducing label avoidance and limited impact on aspects of blocked opportunities and self-stigma. However, in other ways it may exacerbate stigma-related problems. What might we learn from other perspectives on stigma that will diminish its impact? When not discussing health disorders, generic ideas of stigma are typically defined as social injustice; this general definition rests on the idea of discredited difference (Goffinian, 1963; Link & Phelan, 2001). Prejudice of any sort rests on human differences. Although the vast majority of human differences are irrelevant to prejudice—handedness, eye color, foot size—history shows some differences such as skin color and sexual orientation are salient and often paired with negative attributes.

Highlighting Institutions

Stigma is promulgated in part, through rules, practices, and processes of "liberal" institutions; for example, educational, medical, criminal justice, and social service agencies. A social justice perspective would target institutions that traditionally may not be considered worthy goals for change because they seek good ends (such as health care providers or police officers) but do so in ways that marginalize, exploit, or, in the worst case, victimize people with mental illness. A social justice perspective would scrutinize the means and the unintended effects of how institutions and larger political arrangements do not enable or empower people with mental illness.

Many institutional practices inhibit people with mental illness, for example, from cultivating basic
capabilities necessary to human achievement (educational institutions), from gaining access to resources that will improve their well-being (health care), from allowing people to define themselves on their own terms (places on media advisory boards), and from making decisions about their own care, and so forth. Hence, any institutional practice that marginalizes, exploits, or victimizes people with mental illness would be a viable topic of research and a just cause for advocacy.

Expanding Means and Targets
Looking at mental illness stigma from the perspective of social justice increases the means through which stigma is targeted to include more overtly political processes: for example, organizing around a political identity; that is, “mental illness and psychiatric disability”; changing decision-making processes within institutions, for example, health care; and getting “discreditable” people to do political work for the discredited (Stefan, 2001). Discreditable people are those who can hide their symptoms. The practice shifts change targets from prejudicial beliefs to institutional practices that are informed by and often perpetuate beliefs. Hence, although educational efforts to debunk myths would be part of a social justice solution, they would not be the sum total of attempts to challenge what would be seen as unfair treatment based on an inessential difference from other groups, and thus open to social solutions that have worked in the past to eliminate unfair treatment.

Consider a lesson from the women's movement, which targeted health care services that systematically denied their participation in decisions about their health through creating women-run services (for example, domestic violence centers and rape crisis lines). So too, may groups of consumers want to create a network of consumer run community services.

Improving Understanding
Last, and perhaps least obvious, a social justice perspective allows for a more complex understanding of stigma, because it may account for the intersecting stigmas of race and poverty that exacerbate the injustices faced by people with mental illness. By concentrating on the experience of and consequences for people with mental illness, a social justice perspective brings into relief the intersecting identifications and situations of people with mental illness so that the impact of potentially multiple stigmas can be explained. People with mental illness who face the most egregious injustices are most often those who are also stigmatized because of these additional stigmas. For example, the issue of who is able to keep his or her behavior and symptoms private—that is, who is not forced by circumstances to make their behavior public—is also a social justice issue. This is not to say that people with mental illness who have enough money and credibility to maintain privacy and confidentiality oppress those who do not, but that socioeconomic status affects how people with mental illness experience their mental illness.

Insofar as racial discrimination has led to a legacy of poverty, making it difficult to move out of disadvantaged neighborhoods, people of color are visible and unable to hide or pass. A social justice perspective on mental illness stigma would include poverty and homelessness as problems to be addressed in eliminating the injustices with which people with mental illness live.

AN INTEGRATED PERSPECTIVE
By no means are we implying that viewing stigma as a public health problem is categorically distinct from social injustice; an integrated perspective offers the most potent approach to understanding, and ultimately erasing, the phenomenon. We believe that it was important to highlight the limitations of framing mental illness stigma as solely a health problem because of the dominance of medical and public health models in addressing the harm associated with mental illness. These models have clearly enhanced our understanding of mental illnesses and ways to treat it. Moreover, we accept that stigma is a public health problem: It keeps many people from pursuing psychiatric services who might otherwise benefit from it and blocks the life opportunities of those labeled “mentally ill.”

Unfortunately, trying to erase the stigma by solely adopting the medical model might unintentionally worsen the prejudice and discrimination. Concerns about social injustice frame the stigma of mental illness as another example of in-group—out group biases. It explains stigma as a power issue and incorporates the various social and economic processes that are frequently the foundation of these issues. As a result, it opens the antistigma process to the same political processes that have
been used to address the injustices found across ethnic and gender lines.

What implications might this have for stigma change? It suggests that traditional focus on education-based interventions may not be sufficient. Contact between a sometimes prejudicial public and people with mental illness is an antistigma approach that seems to effectively augment education (Corrigan et al., 2001; Corrigan et al., 2002). Moreover, stigma change agents might want to consider the protest and boycott strategies that have proven effective in diminishing discrimination in other arenas. The ultimate proof of the antistigma pudding will be when people with mental illness report fewer hurdles to life opportunities and more willingness to seek help.

REFERENCES


Patrick W. Corrigan, PsyD, is professor of psychology, Joint Center for Psychiatric Rehabilitation, Illinois Institute of Technology, 3424 South State Street, Chicago, IL 60616; e-mail: corrigan@iit.edu. Amy Watson, PhD, is assistant professor, Department of Psychiatry, Northwestern University, Evanston, IL; Peter Byrne, MD, is senior lecturer, Department of Mental, University College, London, England; and Kristin Davis, PhD, is assistant research director, Thresholds Psychosocial Rehabilitation Center, Chicago. Please address all correspondence to Patrick W. Corrigan.

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