The Public Stigma of Mental Illness and Drug Addiction
Findings from a Stratified Random Sample

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Abstract
• Summary: Previous research has shown that people labeled with drug addiction are viewed as more blameworthy and dangerous compared to individuals labeled with mental illness who, in turn, are viewed more harshly than those with physical disabilities. Endorsement of such stereotypes often lead to less helping behavior and more avoidance of people with drug addiction compared to those with mental illness. In this study, attribution and dangerousness models are tested on a stratified random sample of the US population. The sample was recruited from a national online research panel (N = 815). Research participants read a vignette about a person with one of the three health conditions (mental illness, drug addiction, or physically handicapped in a wheelchair) and were asked to complete items representing attribution and dangerousness judgments about the person.
• Findings: Results are consistent with our hypotheses. Addicted to drugs was seen as more blameworthy and dangerous compared to mental illness.
• Applications: These findings are important for framing the stigma and stereotypes of mental illness and drug addiction are discussed. In turn, these kinds of basic models will inform stigma change efforts of advocates.

Keywords dangerousness drug addiction mental illness stigma

Public stigma influences the opportunities and outcomes of people with psychiatric disorders (e.g. mental illness and drug addiction). People who are discredited because of a stigma are less able to enjoy such important life
1 intimate relationships of public stigma on contrast to self-stigma in they internalize the general purpose of this study public stigma, such as disorders. Conducted biannually, a sample to address order (Link et al., 1999; research participants read a vignette schizophrenia, major abelishan issues. Each characteristics as delineated in terms about the person angry or should be tendencies are viewed. In turn, are viewed more echo by several views of these investi nation-level studies, findings were mostly owed attitude differ ences, with substance.

able to identify two a population-based and Phelan, 2001) social psychological on the social psycho active are two models of behavior: stereotypes of First, Weiner (1995) subsequent behaviors, believing someone is disease suppresses sitting for, a neighbor. Disorders that are not Weiner (1995) distinction. Onset attribution ion; how the person lead to the cessation of the illness. Offset attributions overlap with such constructs as prognosis, disease stability, and treatment participation.

The second prominent set of stereotypes related to psychiatric disorder is dangerousness, the belief that people with psychiatric disorders cause bodily harm. Dangerousness results in fear which, in turn, influences social avoidance (Angermeyer and Matschinger, 1996; Martin et al., 2000). A member of the general public does not want to work alongside people with psychiatric illness, nor live near them, because of fear. Two studies have substantiated the path models represented by attributions and dangerousness (Corrigan et al., 2002, 2003). Absent from these studies however, are stratified control trials with reasonably good external validity.

Psychiatric disorder is construed broadly here consistent with diagnoses in the DSM-IV-TR. Unlike the General Social Survey, we limited the description of three vignettes to a generic label which is expected to more clearly represent a stereotype. We contrast the generic ‘mental illness’ label with the label ‘addicted to drugs’. Physical disorders are generally viewed less negatively than psychiatric disorders (Weiner et al., 1988); therefore we used ‘a person in a wheelchair’ as the comparison physical disorder. We hypothesized that drug addiction compared to mental illness and physical disability would be viewed more negatively across all elements of the attribution and dangerousness models. In turn, we hypothesized that mental illness would be viewed more negatively than physical disorder.

Methods

Data for this investigation come from the Mental Illness Stigma study collected by Timed-Experiments for the Social Sciences (TESS) (NSF Grant 0094964, Diana Mutz and Arthur Lupia, Investigators). TESS uses a national online research panel obtained from Knowledge Networks (KN). KN recruits its sample via list-assisted random digit dialing techniques on a sample frame consisting of the entire United States telephone population stratified to be representative of the American, English-speaking, adult population. Recruits are then provided free WEB-TV access in return for agreeing to complete surveys that are sent to them weekly via e-mail. Random samples from the KN population are gathered for the specific analyses of the article reviewed herein. For this study, KN randomly identified and solicited 1141 individuals from its overall panel for the survey administered from 6 to 13 April 2006; 71.4 percent completed the survey (N = 815). Post-survey stratification weights were used to adjust sample demographics to values consistent with the 2000 US Census. Variables used to determine stratification weights included gender, age, race/ethnicity, geographic region in the US, and level of education. Data reported in this article represent weight-corrected cases. Demographics describing the sample are provided in Table 1.
experiences as a satisfying career, meaningful home, and intimate relationships (Goffman, 1963). In this study, we examine the effects of public stigma on people labeled with mental illness or drug addiction. In contrast to self-stigma (i.e., what people with a disorder do to themselves when they internalize the stigma), public stigma refers to the impact that members of the general population have when they endorse negative stereotypes. The purpose of this study is to examine how various stereotypes that comprise public stigma, such as causal attribution and dangerousness, differ across disorders.

Results of the 1996 General Social Survey (GSS, conducted biannually in the United States) provided a nationally representative sample to address important questions regarding stigma and psychiatric disorder (Link et al., 1999; Martin et al., 2000; Swindle et al., 2000). In this survey, research participants were randomized to one of five conditions and were asked to read a vignette about a person with one of the following disorders: schizophrenia, major depression, alcohol dependency, drug dependency or subclinical issues. Each vignette was defined in terms of key syndrome characteristics as delineated in the DSM-IV. Respondents were then asked several questions about the person in the vignette including their beliefs that the person is dangerous or should be avoided. Results showed that people with substance dependencies are viewed more negatively than those with schizophrenia who, in turn, are viewed more negatively than those with depression. These findings were echoed by several other studies using stratified random samples. In a review of these investigations, Angermeyer and Dietrich (2006) examined 33 nation-level studies, mostly from European countries. Like the GSS, these findings were mostly descriptive. Frequent among these were studies that showed attitude differences across mental health and substance abuse conditions, with substance disorders viewed more negatively.

In their review, Angermeyer and Dietrich were only able to identify two theoretical models that have been empirically tested using a population-based method: a sociological concept of the stigma process (Link and Phelan, 2001) and a model by Corrigan and Watson (2002) presenting a social psychological perspective on public stigma. In this article, we will focus on the social psychological model of public stigma. Included within this perspective are two models of stereotypes and their relationship to discriminatory behavior: stereotypes of causal attributions and stereotypes of dangerousness. First, Weiner (1995) showed that causal attribution of health conditions affect subsequent behaviors. As applied to the stereotypes of psychiatric disorders, believing someone is responsible for his or her mental illness or drug related disease suppresses helping behavior; for example, providing a ride to, or babysitting for, a neighbor with mental illness (Corrigan et al., 2002). Conversely, disorders that are not attributed to the person encourage helping behavior. Weiner (1995) distinguished two forms of attribution: onset and offset attribution. Onset attribution represents the factors that explain the start of a condition; how the person contracts the disorder. Offset attribution describes factors that lead to the
Table 1  Summary of demographic characteristics of sample

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Category</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>M = 47.7 years</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>50.4%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>European American</td>
<td>72.3%</td>
</tr>
<tr>
<td></td>
<td>African American</td>
<td>8.8%</td>
</tr>
<tr>
<td></td>
<td>Hispanic</td>
<td>13.4%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>5.5%</td>
</tr>
<tr>
<td>Education</td>
<td>Less than high school</td>
<td>12.3%</td>
</tr>
<tr>
<td></td>
<td>High school graduates</td>
<td>30.1%</td>
</tr>
<tr>
<td></td>
<td>Some college</td>
<td>31.2%</td>
</tr>
<tr>
<td></td>
<td>Bachelor's degree or higher</td>
<td>26.5%</td>
</tr>
<tr>
<td>Geographic dispersion</td>
<td>Northeast</td>
<td>17.7%</td>
</tr>
<tr>
<td></td>
<td>Midwest</td>
<td>22.8%</td>
</tr>
<tr>
<td></td>
<td>South</td>
<td>30.7%</td>
</tr>
<tr>
<td></td>
<td>West</td>
<td>28.7%</td>
</tr>
</tbody>
</table>

**Vignette Conditions**

Respondents were randomly assigned to read a vignette that varied across three health conditions: mental illness, drug addiction, or physical disorder that requires a wheelchair. Physical disorder that requires a wheelchair was provided as the control condition.

Chris is a person with [health condition] who recently attended a community meeting. The community meeting was a discussion about [health condition] and the role it should play in the work force.

Research participants were then asked a series of questions that reflected the attribution and dangerousness models discussed in the Introduction. First, did the research participant view Chris as A) responsible for his health condition (onset) and B) able to overcome problems related to it (offset). As a result of these attitudes, should Chris then C) receive help from the community and D) be given assistance related to work. (Note: the lettered items correspond with the histograms discussed in the results section.) Second, did participants view Chris as E) dangerous, F) frightening, and G) someone to avoid. Individual items were answered with a nine-point agreement scale (9 = highly agree).

**Data Analyses**

In order to clarify our findings, nine point distributions for each of the stigmatizing attitudes were transformed into binary values cut at the median. This is also consistent with findings from the General Social Survey. Individual responses were sorted with counts representing responses above or below the median. Figures 1 and 2 present data in these formats.
Results

Four histograms are presented in Figure 1 representing responsibility and willingness to help. A significant association for viewing the person as originally responsible for their mental illness 

\[ \chi^2(2) = 285.4, \ p < .001 \]

We used a Bonferroni correction given the large number of associations \( p < .01 \). The results showed that drugs were viewed as significantly more responsible compared to people with mental illness or those in wheelchairs. A person with a physical disorder that requires a wheelchair was viewed as significantly more responsible compared to a person with mental illness. This shows a significant difference in ability to overcome probablility of responsibility \( \chi^2(2) = 65.3, \ p < .001 \). In this case, the person was more likely to be perceived as able to overcome their disability. In addition, people with physical disorders that require a wheelchair were less likely to be viewed as able to overcome their disability. People with mental illness and physical disorders requiring a wheelchair were viewed as less able to help than drug addiction.

The findings about health conditions related to danger include the results from Graphs E and F, which were seen as more dangerous and fear evoking than mental illness or in a wheelchair. Mental illness was also seen as more likely to avoid people labeled with drug addiction being labeled with mental illness or in a wheelchair. Once again, people viewed more negatively than physical disorder; people a person with mental illness than a person in a wheelchair.

Discussion

Findings from this study, using a stratified random sample of the US population, correspond with similar research samples (Corrigan et al., 2000; Weiner et al., 1988). The data across disorders (physical versus psychiatric) as well as (drug addiction versus generic mental illness). General psychiatric disabilities were viewed more negatively than disabilities (in a wheelchair). Compared to physical disabilities, the psychiatric group were viewed as more dangerous at
Findings for attributions were a bit more complex. As expected, people labeled with drug addiction were viewed as more responsible for the onset and offset of their health condition compared to the person described as having a physical disorder that requires a wheelchair. However, people labeled with
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**Figure 2** Histograms representing endorsement of dangerousness, fear, and avoidance. Letters for each graph correspond with constructs described in the Methods section.

mental illness were viewed as less responsible for the onset and offset of their condition compared to physical disability. Perhaps the differences of onset and offset between mental illness and physical disability suggest a view that people with mental illness have less overall control over their health condition. Helping
behavior also divided groups. People who are labeled drug addicts are less likely
to be given help than people with mental illness or those described as being in
a wheelchair.

A strength of the study was its completion on a stratified, national-wide
sample. This kind of method has good external validity compared to studies
typically done on convenience samples. Despite this, there are some limitations that
might be addressed in future research. Responses regarding help and social avoid-
ance are meant to approximate behaviors. Nonetheless, they are verbal assertions
on how research participants might react. Future research should more directly
assess behavior. For example, the effects of public stigma on landlords would show
less frequency in renting to people with psychiatric disabilities. Similarly, public
stigma effects on employers would show less hiring of people with psychiatric
disabilities. Note that hiring and renting behaviors are more coarse parameters
than multi-leveled attitude measures. Instrument scaling will be necessary to
provide suitably sensitive indices of the behaviors of interest here.

What implications do our findings have for addressing stigma experienced
by these groups? First, viewing physical disabilities more benignly than psychi-
atriic disorder suggests the latter suffers a stigma worth doing something about.
In other work, we have identified three anti-stigma approaches for the public
stigma of mental illness: protest, education, and contact (Corrigan and Penn,
1999). When using protest, people appeal to a moral authority to suppress
stereotypic thinking. Unfortunately, thought suppression leads to a rebound
effect, ‘Don’t tell me what to think!’ As a result, negative attitudes might
worsen. Education contrasts the myths and facts about psychiatric disabilities.
Generally, education can show modest improvement in stereotypes but these
effects do not maintain over time. Contact is defined as purposeful interactions
between people with the disorder and control groups. Contact has been shown to
improve and maintain positive effects over time. This research has not
examined whether anti-stigma strategies vary by type of stigma. For example,
is the stigma related to drug addiction differently influenced by education and
contact? Moreover, do effects vary in terms of attribution or dangerousness
stereotypes? Future research needs to address questions like these.

Findings from this study also showed that the sample discriminated among
psychiatric disorders; with substance addiction generally viewed worse. This
suggests that anti-stigma programs should be specific by disorder. One error to
avoid, however, is to improve mental illness stigma on the back of substance
abuse, ‘Mental illness is not as bad as drug addiction!’ Instead, challenging
stereotypes needs to be an affirmative activity, highlighting positive character-
istics about mental illness or, for that matter, about substance addiction.

References
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