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Erase the Stigma: Make Rehabilitation Better Fit People with Disabilities

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Individuals with disabilities such as mental illness face stigma and discrimination from the public in many situations: employment, housing, and health care. In this article, the impact of public mental illness stigma is reviewed. Drawing from sociological and social psychological literatures on stigma, the paper discusses individual-cognitive and institutional/structural models that seek to explain the development and maintenance of mental illness stigma. These models are then framed as strategies which rehabilitation counselors might use to diminish stigma at the public and institutional/structural levels. These strategies include education, protest, consequences, contact, and affirmative action.

Papers in this special issue of Rehabilitation Education focus on the impact of stigma on various groups with disabilities. This paper specifically targets the stigma of mental illness and roles which rehabilitation counselors might provide in order to erase it. This paper reviews the impact of mental illness stigma and strategies that attempt to erase its impact. We seek to achieve this goal in three parts: (a) describe the various ways in which stigma harms people with mental illness, (b) summarize models that explain the development and maintenance of stigmatizing effects, and (c) review strategies that have been shown to decrease the impact of stigma. These strategies produce an armamentarium of approaches with which rehabilitation counselors may join people with disabilities to erase the stigma. Concerns about stigma are a political agenda embraced by many advocacy groups. Much recent research also has begun to focus on stigma and mental illness. Our goal in this paper is to balance the concerns expressed by advocates with those data that provide support for and against specific assertions.

The Impact of Mental Illness Stigma

The stigma of mental illness can rob people labeled mentally ill of important opportunities that are essential for achieving life goals. The impact of stigma in the lives of people with mental illness is evinced in such areas as obtaining personal goals, becoming enmeshed in the criminal justice system, and receiving treatment from the health care system. Two personal goals, in particular, are central to the concerns of most people, including those with psychiatric disabilities: (a) obtaining competitive employment, and (b) living independently in a safe and comfortable home. Clearly, problems in housing and work occur because of the disabilities that result from serious mental illness (Corrigan, 2001). Moreover, economic and other social factors can interfere with a group of people achieving employment and housing goals. 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 (Brockington, Hall, Levings, & Murphy,
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 differential service rate by race (Ayanian, Udvarhelyi, Gatsonis, Pashos, & Epstein, 1993; Wenneker & Epstein, 1989) and gender (Ayanian & Epstein, 1991; Krumholz, Douglas, Lauer, & Pasternak, 1992) bias. For this reason, Druss and colleagues (Druss, Bradford, Rosenheck, Radford, & 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 labeled with comorbid psychiatric disorder were significantly less likely to undergo percutaneous transluminal coronary angioplasty.

Models that Explain Mental Illness Stigma

Most of the current models that explain the phenomenon of mental illness stigma have emerged from basic behavioral science. Explanatory models can be fundamentally divided into two groups: those that explain stigma in terms of the naturally occurring results of the human cognitive apparatus and sociological models that ground some of the experiences of stigma and discrimination in social institutions and structures. Each of these is reviewed more fully in turn.

Individual Cognitive Models

Psychologists argue that the way humans come to know the world is bound by the limits of their cognitive forms and processes. For example, social cognitive models describe how stigma-related processes are formed and maintained at the psychological level. Three components make up this model: stereotypes, prejudice, and discrimination. Social psychologists view stereotypes as knowledge structures that are learned by most members of a social group (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 of groups of persons. They are "efficient" because people can quickly generate impressions and expectations of individuals who belong to a stereotyped group (Hamilton & Sherman, 1994). Common stereotypes about mental illness include dangerousness, incompetence, and character weakness.

Just because most people have knowledge of a set of stereotypes does not imply that they agree with them (Jussim, Nelson, Manis, & Soffin, 1995). People who are prejudiced endorse these negative stereotypes ("That’s right; all persons with mental illness are violent!") and generate negative emotional reactions as a result ("They all scare me!") (Devine, 1989; Hilton & Von Hippel, 1996; Krueger, 1996). Prejudice is also viewed as a general attitude toward a group. In contrast to stereotypes, prejudicial attitudes involve an evaluative (generally negative) component (Allport, 1954; Eagly & Chaiken, 1993).

Prejudice, which is fundamentally a cognitive and affective response, leads to discrimination, the behavioral reaction (Crocker, Major, & Steele, 1998). Prejudice that yields anger can lead to hostile behavior (e.g., physically harming a minority group) (Weiner, 1995). In terms of mental illness, angry prejudice may lead to withholding help or replacing health care with services provided by the criminal justice system (Corrigan, 2000). Fear leads to avoidance; e.g., employers do not want persons with mental illness nearby so they do not hire them (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003).

Institutional and Structural Models

Focusing on the individual and psychological level of explanation provides a limited snapshot of the problem caused by 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. In better understanding racism in America, civil rights activists (Carmichael & Hamilton, 1967; US Commission on Civil Rights, 1981) and sociologists (Friedman, 1975; Merton, 1948; Pincus, 1999b) made the distinction between 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.

The effects of institutional discrimination per se are 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 seek to diminish the opportunities of racial or ethnic groups by passing laws or regulations (Hill, 1988; Pincus, 1999b; Mayhew, 1968). 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 (Hill, 1988; Feagin, 1978).

For example, many universities and colleges use the SAT or ACT tests to restrict admission offers to students who have earned the highest scores. Given that African-American and Hispanic students typically score low on these tests, universities that rely on them 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.

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).

According to Link and Phelan (2001), there is evidence of institutional discrimination of people with mental illness in both public and private sectors. A good example from the public sectors is legislatures that enact laws that restrict the rights and opportunities of people with mental illness. Results of two comprehensive reviews of laws by state showed that approximately one third of the states restrict the rights of an individual labeled with
mental illness to hold elective office, participate in juries, and vote (Burton, 1990; Corrigan, Watson, Heyrman, Warpiniski, & Gracia, 2005; Hemmens, Miller, Burton, & Milner, 2002). Even greater limitations were evident in the family domain. More than 40 percent of states limit the right of people with mental illness to remain married. Depending on the year of the survey, from 40 percent to 50 percent of states limited the child custody rights of parents who are labeled with mental illness.

According to a structural view, group-neutral goals are frequently not accomplished because they seem to clash with dominant ideologies which unintentionally maintain the unequal status quo (Hill, 1988; Jackman & Muha, 1984). Two of these are a democratic belief in meritocracy and a capitalist value in cost-effectiveness (Pincus, 1999b). Note that although they are not malicious in intent, both ideologies yield unintended negative consequences. Societal concerns about cost-effectiveness, and decisions representing good business, also seem to yield structural discrimination and may be especially relevant to mental illness as well as race. Link and Phelan (Link & Phelan, 2001) extended 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.

Alternatively, 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 difficulties, and phase of life problems so providers opt for those kinds of jobs. Hence, the quality of services for people with mental disorders is inferior to many other conditions.

Problems with mental health insurance parity are an especially prominent example of structural stigma related to mental illness. Strong opposition was heard from the business community citing the kind of cost concerns that are frequently used to justify other examples 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 consequent impact of parity reflects key elements of the definition 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 actual 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).

► Third, 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 bad business.

The seemingly contradictory tension between wanting to support treatment equity, and not wanting to make a bad business move, is evident in public attitude. One review found that participants of national surveys on parity, on the one hand, highly endorsed the idea of equal resources for mental health and medical diagnoses but, on the other, did not support paying higher premiums or redistributing funds from medical/surgical services to mental health services to accomplish this goal (Hanson, 1998).

**Changing Stigma**

Given that stigma varies by level of explanation, it seems reasonable to conclude that stigma change will vary by conceptual level as well. We have summarized the stigma change literature in terms of its impact on public stigma at the psychological level OR institutions and structures that maintain stigma. Thus, we address stigma change at these levels as well. Rehabilitation providers can avail themselves of these strategies as they
seek to erase the stigma.

**Erase the Stigma at the Psychological Level**

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 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 persons with mental illness as dangerous and unpredictable. StigmaBusters efforts not only targeted the show’s producers and several management levels of ABC, they also encouraged communication with commercial sponsors including the CEOs of Mitsubishi, Sears, and the Scott Company. 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 attitudes and prejudices about a group remain unchanged or actually become worse (Macrae, Bodenhauen, Milne, & Jetten, 1994). Hence, while protest may be a useful tool for changing behavior, it may have little or negative impact on public attitudes about people with mental illness.

A focus on protest poses interesting lessons for the rehabilitation educator. It suggests that rehabilitation professionals need to actively adopt the role of advocate for themselves but rather to be sensitive to the needs of advocates with disability. In this support role, rehabilitation professionals also need to be aware of the strengths and limitations of distinct approaches to stigma change; e.g., protest may have some beneficial effects at the behavioral level but may actually make stigmatizing attitudes worse.

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). Evidence from studies of such interventions indicate that education produces short-term improvements in attitudes (Corrigan et al., 2001; Corrigan et al., 2002; Holmes, Corrigan, Williams, Canar, & Kubik, 1999); however, the magnitude and duration of improvement in attitudes and behavior may be limited (Corrigan & McCracken, 1997; McCracken & Corrigan, in press). Like protest, rehabilitation students need to learn about the role of education in stigma change. Students and nascent practitioners should understand the format of educational approaches as well as the limits of their impact. America is a society that is particularly enamored to educational approaches to social problems so it is important to caution those who might adopt education regarding its limits vis-à-vis stigma change.

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). Sever-
al studies specifically focusing on contact’s effect on mental illness stigma have produced promising findings. Corrigan and colleagues found that contact with a person with mental illness produced greater improvements in attitudes than protest, education, and control conditions (Corrigan et al., 2001). In a subsequent study, contact again produced the greatest improvements in attitudes and participant willingness to donate money to NAMI (Corrigan et al., 2002). Improvements in attitudes seem to be most pronounced when contact is with a person that moderately disconfirms prevailing stereotypes (Reinke & Corrigan, 2002).

Contact suggests that much of the role of stigma change occurs from the grassroots; namely, people with disabilities. Rehabilitation education is an important process to promote this mechanism. Rehabilitation educators may consider affirmative action strategies that actively incorporate those with disabilities in the student sample. Educators might also partner with individuals with mental illness in order to promote contact effects.

**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. 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 (Corrigan & Watson, 2003). 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. Affirmative actions have special relevance in terms of offsetting meritocratic notions in America (Pincus 1999a). 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. Giving advantageous consideration for membership in a minority group is justified because meritocracies actually represent structural discrimination and the advantages of the majority. The Americans with Disabilities Act (ADA) 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. Namely, reasonable accommodation gives people with psychiatric disabilities (a group that has been traditionally discriminated against in job settings) 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.

**Summary**

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. The thesis of 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 and institutional/structural models that explain from whence comes
mental illness stigma. In particular, cognitive-level models explain stigma in terms of relevant knowledge and behavior structures including stereotypes, prejudice, and discrimination. Structural models frame the impact of stigma in terms of societal-level constructs.

These models led to strategies that may decrease stigma. Strategies include protest, education, and contact. Rehabilitation educators need to understand the breadth of this information as they train future professionals who may directly or indirectly be part of the advocate’s agenda.

References
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