Editorial

Don’t call me nuts: an international perspective on the stigma of mental illness

Mental illness strikes with a two-edged sword. On one side is the psychological distress and psychiatric disabilities that prevent people from accomplishing and enjoying life goals. On the other, is the public’s reaction to mental illness; a plethora of prejudicial beliefs, emotions, and behaviors that cause the public to discriminate against those labeled mentally ill. Unfortunately, public prejudice and self-stigma may provide equally large barriers to achieving and relishing life opportunities. Psychiatry and the other mental health professions have spent the past century successfully understanding how symptoms and disabilities interfere with personal wellbeing. In the process, they have developed a smorgasbord of evidence-based services to help people deal with the problems of mental illness. The professions, however, have lagged in both their understanding of stigma and in the development of approaches to erase it. We have lagged behind the development of clinical interventions that deal with the disease. Even more telling, we have lagged behind consumers of mental health services, who have eloquently complained about the broad and insidious effects of stigma on most aspects of their lives.

Almost 100 years ago, Clifford Beers (1) authored *A Mind that Found Itself* which, among its many purposes, highlighted the omnipresent and harmful aspects of stigma. Just about 30 years ago, Judy Chamberlin’s (2) *On Our Own* argued that stigma and discrimination can only be overcome when those struggling with mental illness, and society’s injustices against them, regain control over their lives. Nothing about us without us was the mantra that was popular among disenfranchised and disgruntled consumers of mental health services.

Consumers, family members, and other advocacy groups have been tackling stigma for a long time. What do mental health researchers now bring to the effort? Their efforts could serve two important goals: (i) a more rigorous understanding of stigma and its various ways of harming people with mental illness and (ii) an objective evaluation of approaches meant to erase its impact. Although research grappling with these goals has exploded during the past decade, the established research programs of two distinguished social scientists are especially noteworthy. More than 10 years before Chamberlin published *On Our Own*, Amerigo Farina conducted experimentally controlled studies on the impact of stigma (3). Among other findings, Farina showed that stigma can lead to discriminatory practices for people with mental illness in work settings (4), general medical doctor’s offices (5), and the psychiatric hospital (6). Bruce Link applied the more ecological concerns of sociology to research on mental illness stigma in the 1980s. He showed that stigma was entwined with public fear of dangerousness (7) and that internalizing stigma can diminish a person’s self esteem (8).

Their work has been augmented by large population studies like those conducted by Pescosolido et al. in the States (9), and (10) in Germany. Other recent research has sought to apply social psychological models to understanding the impact of stigma and discrimination (11). Common to all of these efforts has been an attempt to understand what is stigma and how does it impact people with mental illness. Much of the research thus far has been completed on Western samples; as such, it is biased by Western perceptions of psychology and society. Gaining a more complete understanding of the effects of stigma requires broadening stigma research into the international arena. The paper by Angermeyer et al. in this issue of *Acta* is an excellent example of the kind of work that needs to be done (12). They applied models developed in earlier research on Western Europeans to samples of subjects from Novosibirsk Russia and Ulaanbaatar Mongolia. Among the many illustrative elements of this paper is their effort to transpose the survey into the language and culture of participants. Specific findings can be learned by reading the article; but perhaps most important is their conclusion that labeling effects are culture-related.

I have just begun a 5-year project that is teaching me similar lessons. Funded by the National Institutes of Health in the USA, our group is examining...
the attitudes of employers in Hong Kong, Beijing, and Chicago towards people with mental illness, alcoholism, and acquired immunodeficiency syndrome. A significant hurdle at the onset has been translating the guide for a set of qualitative interviews into Mandarin and Cantonese. This task is more than a linguistic translation and back-translation into two languages. It must be equally sensitive to Chinese cultural processes that are largely absent from America. Guanxi, for example, refers to the Chinese concept of social relatedness that would likely influence employer decisions. Employers in China are likely to moderate their attitudes about a person’s disabilities based on who in one’s clan or neighborhood recommends the person. As Western researchers, we rely heavily on our Chinese partners to identify cultural processes that help us to better understand the actions of employers.

Understanding stigma is only half of the battle; of equal importance is testing strategies that are meant to erase its impact. Based on a review of basic behavior research on social change related to prejudice and discrimination, Corrigan and Penn (13) identified three broad processes used in anti-stigma programs: protest, education, and contact. Groups protest inaccurate and hostile representations of mental illness as a way to challenge the stigmas they represent. These efforts send two messages. To the media: STOP reporting inaccurate representations of mental illness. To the public: STOP believing negative views about mental illness. Largely anecdotal evidence suggests that protest campaigns have been effective in getting stigmatizing images of mental illness withdrawn (14). Education provides information so that the public can make more informed decisions about mental illness. Research has suggested that participation in education programs on mental illness led to improved attitudes about persons with these problems (15, 16). Stigma is further diminished when members of the general public have contact with people with mental illness who are able to hold down jobs or live as good neighbors in the community. Research has shown an inverse relationship between having contact with a person with mental illness and endorsing psychiatric stigma (17–19). Hence, opportunities for the public to meet persons with severe mental illness may discount stigma.

Like explanations of stigma, culture is expected to interact with stigma change approaches. For example, the educational message or nature of contact will likely vary across individualist vs. collectivist cultures. It is up to researchers to develop both theoretical models and methodological approaches that facilitate the testing of anti-stigma strategies in the International arena.

*Acta Psychiatrica Scandinavica*

Patrick W. Corrigan

Invited Guest Editor

---

**References**

1. BEERS C. A mind that found itself. 1908.
7. LINK BG, CULLEN FT. Contact with the mentally ill and perceptions of how dangerous they are. J Health Soc Behav 1986;27:289–302.