

The Stigma of Mental Illness

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Glossary

Affirmative actions Behaviors resulting from positive expectations and beliefs that purposefully and proactively increase opportunities for people with mental illness.

Affirming attitudes Positive expectations that people with mental illnesses are able to recover and make independent life choices.

Label avoidance When people are publicly labeled through association with a mental health program.

Public stigma The process in which individuals in the general population first endorse the stereotypes of mental illness and then act in a discriminatory manner.

Self-stigma The process in which a person with mental illness internalizes prejudice and discrimination that results from public stigma.

Structural stigma (1) The policies of private and governmental institutions that intentionally restrict the opportunities of people with mental illness and (2) the policies of institutions that yield unintended consequences that limit options for people with mental illness.

The why try effect The behavioral result of self-stigma stemming from lower self-esteem and self-efficacy that causes people with mental illness to give up trying to achieve personal goals.

Introduction

Serious mental illness strikes with a two-edged sword. On one side are the symptoms, distress, and disability that hamper people pursuing personal goals. On the other is stigma: the social injustice many people labeled mentally ill experience that can be equally challenging for achieving one's aspirations. The stigma of mental illness has been explained in terms of the cognitive and behavioral constructs of stereotypes, prejudice, and discrimination. Stereotypes are defined as seemingly fact-based knowledge structures inherent to any given culture that typically contain negative evaluative components. Stereotypes become prejudices when people develop negative emotions and evaluations toward the object of the stereotype (Crocker *et al.*, 1998). Discrimination is the behavioral result of prejudice, typically takes a punitive form, and is expressed by restricting access to a rightful opportunity or reacting aversively to the stereotyped group. A variety of prejudices and discriminatory behaviors resulting from the stigma of mental illness have been identified in the research literature. The most common of these are listed in Table 1.

A commonly held stereotype is that people with a mental illness are responsible for their condition. Weiner (1995) explains this by distinguishing between two types of responsibility: onset and offset. Onset responsibility occurs when the person is blamed for contracting a disorder, that by way of some voluntary act, the person was exposed to mental illness and absorbed it as a result (Corrigan *et al.*, 2003). Offset responsibility reflects failure to resolve the health condition by not fully engaging in treatment.

Perhaps most damning is the stereotype that people with a mental illness are dangerous and unpredictable. The resulting fear leads to what are the most problematic discriminatory behaviors: avoidance and withdrawal. Members of the general public seek to avoid people with mental illness in order to escape their violence. Hence, individuals resist residential programs for people with mental illnesses in their backyard and often avoid interacting with people with mental illness in

the community (e.g., at church). Avoidance by employers and landlords is especially troubling given the rehabilitation goals of many people with a mental illness. Prejudiced employers might not hire the person with serious mental illness out of fear of harm to coworkers; prejudiced landlords might avoid leasing an apartment to the same person in order to protect their property.

Individuals with mental illness also experience discrimination in the general healthcare system. Research by Druss *et al.* (2011) indicates that people with mental illness are less likely to benefit than others from the depth and breadth of the American healthcare system. They examined mortality data collected over 17 years from a representative, population-based sample and found that people with a mental illness died an average of 8.2 years younger than others in the general population. Another study found that among elderly patients with heart failure, patients with a mental illness were less likely to be evaluated for left ventricular systolic function, and had

Table 1 Stereotypes/prejudices of mental illness and the resulting discrimination

Stereotypes/prejudices	Discrimination
Dangerousness <ul style="list-style-type: none">● Those with mental health problems are unpredictable● Persons with mental illness are violent	Avoidance and withdrawal <ul style="list-style-type: none">● Employers do not hire● Landlords do not lease● Doctors do not treat● Members of the community do not socially interact
Responsibility <ul style="list-style-type: none">● Blame and shame● Onset responsibility● Offset responsibility	Coercion <ul style="list-style-type: none">● Outpatient commitment● Forced medication
Incompetence <ul style="list-style-type: none">● People with mental illness cannot work or live independently	Segregation <ul style="list-style-type: none">● State hospitals● Mental health ghettos

higher 1-year readmission and higher mortality rates than patients with no mental illness (Rathore *et al.*, 2008). Segregation and coercion are two other types of discrimination. In the past, people with serious mental illnesses were committed to state mental health asylums. Segregation of this kind presupposed these individuals were incompetent and therefore could not live independently in the community. Since then, many state institutions have closed and those that continue to exist house fewer people. However, segregation of people with mental illness continues because states rely on nursing homes that provide custodial care rather than empower the person with mental illness to achieve personal goals. Additionally, limited housing options have resulted in segregation of individuals with mental illness to impoverished communities that essentially form mental health ghettos.

Concerns about dangerousness have led to frequent use of coercive interventions. One example is involuntary commitment to acute inpatient settings. Mental health court and outpatient commitment have followed service consumers into the community and might also be considered coercive in some settings. We do not mean to suggest these strategies are bad practices *per se*; mental health court, in particular, might help the individual with mental illness avoid jail. Still, some strategies can be misused leading to coercive interactions.

Types of Stigma

A typology for understanding stigma would encompass the following categories: public stigma, self-stigma, label avoidance, and structural stigma. The first three evolved out of a social psychology tradition while the fourth, structural stigma, largely reflects the sociologist's approach to the issue and so is only briefly reviewed here. Public stigma is the process by which individuals in the general population first endorse the stereotypes of mental illness and then act in a discriminatory manner. It represents what the public does to people known to have mental illness. Self-stigma occurs when people internalize the prejudice and discriminate against themselves as they were. Self-stigma has been divided into three progressive stages. First, individuals with mental illness must be aware of the stereotypes about people with mental illnesses; then they must agree with the stereotype; and finally the stereotype is applied to themselves (Corrigan *et al.*, 2011). Applying or internalizing stereotypes can lower self-esteem and damage self-efficacy because of fears of incompetence or inability to keep up with demands because of a mental illness. Behaviorally, these three stages can cause people with mental illness to give up trying. The 'why try' effect results (Corrigan *et al.*, 2009): Why try to get a job; someone like me is not worthy.

Label avoidance refers to a third type of stigma. People are publicly labeled through association with a mental health program. "Is that Karen coming out of the psychiatrist's office? She must be nuts!" To avoid labeling, a person with a mental illness might not seek services that would be helpful, or might discontinue services once initiated. Data collected as part of the National Comorbidity Survey Replication revealed that more than half of those who met criteria for a mental illness did not seek treatment (Mojtabai *et al.*, 2011). Most (97.4%) who recognized a need for treatment reported that attitudes,

such as stigma, were barriers to seeking help. In the same study, people with moderate or severe mental illness reported that in addition to attitudes, structural barriers also kept them away from treatment. Structural stigma includes two important factors: (1) policies of private and governmental institutions that intentionally restrict the opportunities of people with mental illnesses and (2) the policies of institutions that yield unintended consequences that limit options for people with mental illness (Corrigan *et al.*, 2004). An example of structural stigma in mental health is statutes that restrict a person's parental rights because of past history of mental illness. A fundamental error of these laws is the assumption that a person who was diagnosed with severe mental illness 2 years ago will continue to be symptomatic today.

Additional examples of structural stigma are public and private sector policies that restrict opportunities of minority groups in unintended ways; instances where discrimination seemingly results without the conscious prejudicial efforts of a powerful few. Link and Phelan (2001) provide an example by showing that less money is allocated to research and treatment for psychiatric illness than for other health disorders like cancer and heart disease. In addition, many psychiatrists and other mental health professionals opt out of the public system that serves people with the most serious psychiatric disorders in favor of the higher salaries, benefits and reduced demands found in private health systems.

Erasing the Stigma of Mental Illness

Changing stigmatizing attitudes and behaviors has proven a difficult challenge. Often, the strategies employed to reduce stigma fall short of their objective, or worse, they exacerbate the problem. Erasing the stigma of mental illness will only be accomplished through efforts that put to use the most effective means of stigma change. Several small and large-scale approaches to stigma change are discussed below, including personal and grassroots efforts as well as extensive public campaigns that are designed to reach a broad audience.

Affirming Attitudes and Behaviors

Reducing prejudice and discrimination toward individuals with mental illness should be counterbalanced with efforts to increase affirming attitudes. Affirming attitudes are positive expectations that people with mental illnesses are able to recover and make independent life choices. Because the public frequently believes that mental illness blocks a person from achieving life goals, an effective message for combating stigma is that people with mental illness recover and mental illness does not keep a person from achieving a full range of positive outcomes. Ciompi *et al.* (2010) reviewed 11 studies that followed thousands of people with schizophrenia over 20–30 years and found rates of recovery or significant improvement as high as 46–68%. Affirming attitudes also include empowerment and self-determination. A person with mental illness should be afforded the opportunity, either by advocacy or influence, to make autonomous decisions about their treatment and life goals (Corrigan *et al.*, 2012).

Behaviors resulting from positive expectations and beliefs are referred to as affirmative actions. Government-approved programs of affirmative action are meant to redress disparities that have arisen from historical trends in prejudice and discrimination. According to affirmative models, members of a stigmatized group are given access to limited opportunities based on individual skills and achievements. 'Affirmative action' in this context is different from social change policies that were enacted as part of the anti-discrimination strategies of the 1960s. Affirmative actions here are defined as behaviors that purposefully and proactively increase opportunities for people with mental illness. Some of these actions are embodied in the *Americans with Disabilities Act (ADA) (1990)* that directs employers to provide reasonable accommodations (e.g., quiet work place, support of a job coach) so that a person with psychiatric disabilities can be fully employed. Similarly, the *Fair Housing Act (1988)* requires landlords to provide reasonable accommodations so the person can live independently (e.g., on-site support of a housing coach). Affirmative actions include efforts of legislators and other government officials who seek increased funding for programs that promote empowerment and recovery. Affirmative action may include the efforts of primary care physicians who make a conscious effort not to dismiss physical complaints by a patient with mental illness as merely an example of hypochondria. Mental health professionals can promote affirmative action by replacing custodial services with programs that help people attain real-world life goals. In all these examples, emphasis is on actions, efforts that can be made by people in key power positions that enhance the life opportunities of people with mental illness.

Processes for Erasing Public Stigma

Given that stigma varies by level of explanation (e.g., psychological vs. structural types), stigma change varies by conceptual level as well. Space, however, only permits a careful examination of how to erase one type of stigma. The current focus will be on public stigma since it serves as the basis for self-stigma and label avoidance. Public stigma change is discussed in terms of processes and vehicles for change. By processes, we mean actual strategies that impact public stigma. By vehicles of change we distinguish whether processes occur in face-to-face exchanges or through social marketing approaches. Each of these is considered in turn.

Social psychological research on ethnic minority and other group stereotypes provides important insight on the effectiveness of differing strategies for reducing mental illness stigma of the public type. Based on this literature, we grouped the various approaches to changing public stigma into three processes: protest, education, and contact (Corrigan and Penn, 1999). Protest strategies highlight stigma's injustices, chastising offenders for negative attitudes and behaviors. Anecdotal evidence suggests that protest can change some behaviors significantly. 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, they 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.

Educational approaches to stigma change attempt to challenge inaccurate stereotypes with factual information. For example, education can take the form of disseminating literature at a lecture given by a mental health professional in a work setting or by engaging students in an interactive drama followed by classroom instruction about mental illness and recovery (Roberts et al., 2007). Evidence from a meta-analysis of 72 studies (Corrigan et al., 2012) revealed that education strategies are effective means for positive stigma change. Education tends to perform best in reducing stigmatizing attitudes among teens and adolescents. The same meta-analysis examined contact as an avenue for stigma change.

Contact has long been considered an effective means for reducing intergroup prejudice (Allport, 1954; Pettigrew and Tropp, 2000). Although both education and contact were found to be effective for eliciting change, contact brought about a greater reduction in stigma. Moreover, in contrast to video-based contact, face-to-face contact with a person with lived experience produced the most compelling impact on attitudes and behavior.

Vehicles for Stigma Change

In vivo approaches to changing public stigma: *In vivo* contact is the first of five strategic stigma change (SSC) model components described by the acronym TLC-3: targeted, local, credible, continuous contact (Corrigan, 2011).

- (1) Contact with people with mental illness is fundamental to public stigma change. People who tell their stories of recovery have significant impact on others.
- (2) Contact needs to be targeted. Good targets are people in positions of power such as employers, landlords, and healthcare providers, faith-based and other community leaders, legislators, schools, entitlement counselors, and media outlets. When contacting target groups, careful consideration should be given to venue and timing in order to increase opportunities for contacting large numbers of the targeted group. Civic group meetings like the Rotary International to contact large numbers of employers or weekly grand rounds might be excellent opportunities for contacting healthcare providers. Research offers evidence that the most effective contact messages include 'way down' (what were the person's symptoms and disabilities that impeded goals) and 'way up' (recovery was achieved and goals attained) narratives. These stories culminate in the stigma punchline, namely, that despite the way up, goals are still impeded by ongoing stigma. Targeted messages are most effective; employers, for example, might want assurances that employee recovery means successful work, and landlords that tenants with mental illness will respect property.

Specific SSC objectives are affirming behaviors that provide evidence of change. For example, employers would interview and hire more people with mental illness, offer reasonable accommodations, and provide appropriate supervision that could include job coach participation.

- (3) Local contact programs are more effective. Targeted group interests are influenced by locally defined considerations, which can include both geopolitical and diversity factors. It seems reasonable, for example, that target group interests are shared within geographical regions, such as the Northeast, or more narrowly within a state like Vermont. Sociopolitical factors within more narrowly defined areas are additionally important. Large cities will include neighborhoods of differing socioeconomic status that are likely to influence target group interests; for example, employers in low-income parts of a city will require different contact than peers located in wealthy suburbs.
- (4) Contacts must be credible. Three considerations guide credibility. First, the contact individual should share the demographic characteristics of the target audience (e.g., similar ethnicity, religion, and SES). Second, the contact individual should mirror the target. This could mean that employers, landlords, healthcare providers, and police officers with mental illness would present to other employers, landlords, healthcare providers and police officers. Although this is an appealing goal, it is not without problems. Prejudice and discrimination could lead to severe consequences for some people who publicly disclose that they have a mental illness. Contact partnerships that combine consumers with representatives from the target group might be a solution. The message to the target audience should convey that people with mental illness can recover and that people in recovery can be successful. For example, employers can tell peers that a person with mental illness is capable of being a valued employee.

The third consideration for establishing credibility is a bit more complex. Research suggests interactions are most effective with people with serious mental illnesses who exhibit the benchmarks of recovery; that is, positive outcomes such as work, living independently, and having intimate relationships. Some advocates and researchers prefer definitions of recovery as a process (representing a journey marked by hope and goal attainment regardless of symptoms) rather than outcome (being symptom free, for example). Anchoring the standard for an anti-stigma contact to outcome rather than process could unintentionally exacerbate public stigma by suggesting that there is something flawed about an individual who does not reach the standard.
- (5) Contact must be continuous. Stigma change is an ongoing process that is not easily accomplished. Although one time contact might have some positive effects, they are likely to be fleeting. Contact must occur on multiple occasions with varying content to have lasting effects. A successful program would incorporate a range of consumer and target partners in different venues that provide multiple opportunities for contact while continuously assessing the quality of the program.

In vivo contact requires that people with mental illness come out of the closet, as it were, in order to tell others about their experience with mental illness. The more people come out about their mental illness, the greater the impact on stigma change. The term 'coming out,' as borrowed from the gay, lesbian, bisexual, transgender, and questioning (GLBTQ) community, involves proudly sharing one's own experience of living within a stigmatized group (Corrigan *et al.*, 2009). A clear distinction should be made between the GLBTQ community and the community of people with mental illness, in light of the recent past discriminatory categorization of homosexuality as a psychiatric disorder. That said, the GLBTQ community has paved the way for others, like those with mental illness, to come out with dignity and pride in the face of overt stigma and prejudice.

Coming out about one's mental illness raises a serious dilemma. On one hand, disclosing psychiatric status can have negative implications. On the other hand, people who disclose oftentimes report lower levels of self-stigma, a greater sense of personal empowerment, higher self-esteem, and enhanced quality of life. These conflicting factors can arouse uncertainty concerning the nature and appropriateness of disclosure. The Coming Out Proud program (COPp) was developed to aid in resolving this uncertainty. In three two-hour sessions, COPp facilitators with lived experience guide participants in making a calculated, personal decision about if, when, and to whom they want to disclose. The COPp approach provides a strategic framework with step-by-step instructions for (1) weighing the pros and cons of disclosing, (2) considering the most beneficial way to disclose, and (3) constructing a narrative that is personally meaningful. All these occur with the understanding that disclosing or not disclosing is within one's control and that disclosure can take on a variety of forms (Corrigan and Lundin, 2012).

Media-based approaches to changing public stigma: Contact might be provided *in vivo* or via some medium such as public service announcements (PSAs), short audio and/or video spots that serve as the mechanism by which social marketing campaigns activate and orient viewers to campaign materials (e.g., paper or online resources) that provide interested viewers with more in-depth information. Social marketing is the omnibus program that uses education and contact strategies to introduce, move forward, and maintain an agenda of social justice and health promotion. Formal media campaigns aimed to reduce the stigma of mental illness were first developed in the US after the 1999 White House Conference on Mental Health when Tipper Gore and Alma Powell formed the National Mental Health Awareness Campaign. Among its materials were PSAs aired on teen-friendly media (e.g., MTV), that featured adolescents forthrightly discussing their experience with serious mental illness. Since then, major anti-stigma campaigns using PSAs have been developed in the UK, Australia, Canada, the United States, and other Western countries.

The public health field measures the effectiveness of a PSA using two criteria: penetration and impact. Penetration is the extent to which a targeted population is aware of and informed by a specific PSA and is simply measured by asking if individuals remember seeing or hearing its message. Impact, which is more difficult to assess, is a measure of the degree to which penetration leads to change in prejudice and

discrimination. One approach to measuring impact is by tracking visits to websites associated with PSAs. However, counting website visits may be a fuzzy indicator of impact. In evaluating impact of the Elimination of Barriers Initiative, Bell *et al.* (2005) found that less than 1% of the targeted audience made visits to the suggested website, and a majority of those that did exited the website in less than 1 minute. Furthermore, less than 30% of those that visited returned to the site in subsequent months.

Addressing the stigma of mental illness in some ways is more difficult than addressing other health concerns because the target outcome is less discrete than those sought, for example, in an antismoking campaign. Thus, a campaign with the nebulous goal of combating stigma might afford the illusion of advocacy by requesting visitors sign Internet petitions, or join a Facebook advocacy page, but they frequently do little to provide actual avenues for activism that will translate to substantial change.

Conclusion

The aim of this article was to familiarize readers with mental illness stigma in terms of types and constructs. Moving forward, research suggests that scientists, advocates, and providers adopt targeted, contact-based approaches to stigma change which strive not only to decrease stigmatizing attitudes in an effort to reduce discrimination toward individuals with mental illness, but also to increase affirming attitudes meant to promote opportunities for these individuals. Focusing on such socially just outcomes for individuals with lived experience is critical in reducing the global burden of all types of disability and disease.

See also: Health Beliefs and Patient Adherence to Treatment. Hope. Mental Health Services in Primary Care Settings. Optimism, Motivation, and Mental Health. Self-Disclosure. Shame and Guilt. Social Contagion. Stereotyping

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