

Mental Illness Stigma

What is it?

What are its Effects?

How can it be Reduced?

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Mental Illness Stigma

The purpose of this packet is to describe stigma associated with mental illness. The effect of stigma on help-seeking behavior will be detailed and a precursory explanation of stigma reduction strategies will be provided as well. For further information about stigma reduction and access to free stigma-reduction services, go to www.scattergoodfoundation.org/stigma

What is Stigma?

Stigma is often identified as a damaging force, but the term is steeped in ambiguity and the definition can vary from person to person. Within the peer-reviewed literature on stigma, there is a general consensus that stigma is comprised of three major componentsⁱ:

- Stereotypes
- Prejudice
- Discrimination

There are several prevalent stereotypesⁱⁱ:

People with mental illnesses...

- Are dangerous, irrational, and unpredictable.
- Are incompetent.
- Deserve blame for their conditions.
- Have little hope for recovery.

Endorsement of any or all of these stereotypes leads to prejudice. The main prejudicial reactions can be categorized as follows:ⁱⁱ

- Fear and exclusion: people with mental illnesses should be feared and kept out of most communities.
- Authoritarianism: people with mental illnesses are irresponsible and their decisions should be made by others.
- Benevolence: People with mental illnesses are childlike and must be cared for.

Prejudicial beliefs can lead to discriminatory practices. The prominent discriminatory behaviors are:ⁱⁱ

- Withholding help
- Social avoidance
- Coercive treatment
- Segregated institutions

The stigma described thus far is known as *public stigma*.ⁱ When an individual with a behavioral health condition internalizes these stereotypes and applies them to herself it is called *self-stigma*.ⁱ

What are the Effects of Stigma?

Stigma is an issue of inequity and reducing it is a matter of social justice. However, stigma has another impact on the lives of those with mental illness that may be even more detrimental. It is estimated that Worldwide, up to 70% of people with diagnosable behavioral health conditions do not seek treatment.ⁱⁱⁱ Stigma is not the only reason for this discouraging statistic, but it is a leading factor.ⁱⁱⁱ Research indicates that both public stigma and self-stigma greatly interfere with help-seeking and treatment adherence.^{iv} Public stigma impedes treatment-seeking through the following processes:

- Label avoidance
- Fear of prejudice

- Expectations of discrimination

Self-stigma interferes with help-seeking through these processes:

- Label avoidance
- Diminished self-esteem
- Lowered self-efficacy

Controlled social laboratory studies have also demonstrated an inverse relationship between stigmatizing attitudes and seeking care.^{iv} There is also an inverse relationship between stigmatizing attitudes and treatment adherence.^{iv} In other words, people who harbor prejudice towards individuals with mental illness are less likely to seek mental health services themselves if they have a diagnosable condition and are less likely to comply with treatment if they do receive care.

Individuals who avoid treatment can expect not only poorer mental health outcomes, but they may also encounter other negative health consequences. The evidence is clear that mental illness leads to poorer general health outcomes including significantly reduced life expectancies.^v A diagnosis of a mental health condition makes it more likely that an individual will develop certain medical conditions, such as coronary artery disease, and more likely that he will die or be disabled when diagnosed with a general health condition.^{vi vii viii ix x xi} Additionally, a patient with a general health condition and a comorbid mental health condition uses more medical resources and incurs significantly greater costs than a patient without a mental illness.^{xixiii} It stands to reason that increasing mental health service utilization would mitigate the effects of mental illness and improve general health outcomes as well, although more research is needed to demonstrate a causal link.

Stigma may also play a role in illness diagnosis and treatment regimens in general health settings. Patients with identified mental health conditions receive less care and services for physical conditions than patients without comorbid psychiatric diagnoses. This phenomenon is known as diagnostic and treatment overshadowing and may be a contributing factor to the lower life expectancies of people with mental illness.^v For instance, one study found that people with mental illness and ischaemic heart disease requiring hospitalization were less likely to have a revascularization procedure than those without a comorbid behavioral health condition^{xiv}. This held true even after controlling for potentially confounding variables.

There may be considerable financial benefits to increasing the percentage of people with behavioral health conditions who seek treatment. Mental illnesses are extremely costly for those affected and for employers, however, research indicates that proper treatment can reduce work impairment and increase productivity by reducing absenteeism and presenteeism.^{xv xvi xvii xviii xix xx xxi xxii xxiii}

Stigma Reduction

Research literature has identified three distinct methods of reducing stigma.^{xxiv} These strategies are:

1. Protest/Advocacy
2. Education
3. Contact

Protest/Advocacy methods traditionally have been referred to as protest strategies, but have evolved to include advocacy as well. Advocacy can be thought of as the carrot, and protest represents the stick. Protest involves voicing complaints against social institutions that discriminate against individuals with behavioral health conditions or reprimanding media outlets that promote negative stereotypes of people with mental illness. The advocacy component consists of building coalitions with like-minded organizations, legal advocacy, and acknowledging positive media portrayals, among other reinforcing activities. Advocacy and protest strategies have little to no effect on attitudes and beliefs, but they can change behaviors and arrest discriminatory practices. For example, the Mind Charity in the United

Kingdom employed a social media protest strategy in response to the stigmatizing “Psycho Ward” Halloween costumes sold by major retailers Asda and Tesco. Within 24 hours the costumes had been removed from store shelves and both companies offered public apologies, with Asda contributing a donation to Mind Charity along with the apology.

Education strategies can come in the form of pamphlets, flyers, videos, public service announcements, social media campaigns, structured teaching programs and can be effective at changing attitudes in the short-term. Education strategies seek to dispel inaccurate information—such as stereotypes—and replace it with factual content. Education strategies do have a modest, positive effect on attitudes and beliefs. Unfortunately, the magnitude and duration of these attitudinal effects are limited. Research regarding stereotypes indicates that people may process information in a way that gives greater weight to information that confirms their stereotypes than to information that disconfirms them; a confirmation bias of sorts. However, individuals with the motivation to refrain from stigmatizing those with behavioral health conditions may rely on stereotypes for initial judgment, but can consciously override these stereotypes if they have been educated with accurate information about individuals with mental illness. An education program or campaign does have the benefit of potentially reaching a wide audience at a relatively low cost.

Contact is the most effective of these methods for reducing stigma. It involves interpersonal contact between members of the public and individuals with mental illnesses who mildly disconfirm stigmatized ideals. It is important that individuals from the stigmatized group are not extraordinary—a Nobel Prize winner, for instance—because this may allow people to consider them exceptions to a rule that is still considered valid. Contact strategies have a greater and longer-lasting effect on attitudes than protest or education.^{xxv} Research has found that attitudinal improvements that occur in contact settings are associated with positive changes in behavior.^{xxiv} Research indicates that there are five characteristics that should be in place for participants during an in-person contact intervention^{xxv}:

1. Meet as equals in status
2. Have an opportunity to get to know each other
3. Share information that challenges negative stereotypes
4. Actively cooperate
5. Pursue a mutual goal

The evidence-base regarding the effectiveness of in-person contact strategies is strong and consistent.^{xxvi} Unfortunately, because these strategies can only reach a relatively small audience each time they are employed, they are somewhat neglected and underutilized. However, recent research has indicated that video contact strategies involving a personal story in a video medium can reduce stigma, but not as much as in-person contact.^{xxvi} This finding offers hope that elements of a contact strategy can be adapted for a larger audience.

Targeted Messaging

An important feature that can increase the effectiveness of any anti-stigma program or campaign is that the message targets a specific group and the corresponding attitudes and behaviors for which change is desired.^{xxvii} For instance, a program could target landlords about their reluctance to rent housing units to individuals with behavioral health conditions. Once the targeted group and attitudes or behaviors are identified, the appropriate strategy or strategies among protest, education, and contact can be chosen. Messages that are not targeted at a specific group and do not identify a desired attitude or behavior for change may increase awareness, but likely will fail to reduce stigma.^{xxvii} If the campaign is intended for the public at large, and not a specific group, a slight variation can be made by selecting a particular stigmatized subgroup and the stigmatizing attitudes and behaviors that impact the members of that group. For example, a campaign could focus on individuals affected by Schizophrenia and seek to alter the broad, public stigma attached to them. However, anti-stigma programs and campaigns should narrow the focus of their messages as much as possible to achieve optimal impact.

Has Stigma Decreased in Recent Years?

Despite concerted efforts to reduce stigma during the last fifteen years, there have been no discernible improvements in public stigma.^{xxviii} In 1999, the Surgeon General's Report on Mental Health delineated a stigma-reduction strategy that called for increased efforts to describe mental illness and the causes of mental illness in neurobiological terms (brain disease, illness of the mind, a disease like any other, etc.) Unfortunately, this blueprint has not reduced stigma and research indicates that people who accept neurobiological attributions of mental illness may be more likely to hold stigmatized attitudes.^{xxviii} Research has found that interventions that frame mental illness as a brain disease reduce stigmatized beliefs in regards to blame and responsibility, but increase stigmatized beliefs in terms of disease prognosis; intervention participants are less likely to blame those with mental illnesses for their conditions, but they are also less likely to believe that recovery is possible^{xxix}. This information is somewhat disheartening but it elucidates two critical observations: one, there is much work to do; and two, it is important to use methods that are proven effective and avoid methods that are proven not to work.

If you are interested in reducing stigma, the Scattergood Foundation offers consultation and evaluation services for creating stigma-reduction programs and measuring outcomes. If you are interested in these services or would like additional resources, please contact the Scattergood Fellow on Stigma Reduction, Timothy Clement, MPH: tclement@scattergoodfoundation.org.

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