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Review

Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma

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Abstract

Persons with mental illness frequently encounter public stigma and may suffer from self-stigma. This review aims to clarify the concept of mental illness stigma and discuss consequences for individuals with mental illness. After a conceptual overview of stigma we discuss two leading concepts of mental illness stigma and consequences of stigma, focussing on self-stigma/empowerment and fear of stigma as a barrier to using health services. Finally, we discuss three main strategies to reduce stigma - protest, education, and contact – and give examples of current anti-stigma campaigns. Well-designed anti-stigma initiatives will help to diminish negative consequences of mental illness stigma.

Keywords: Stigma; Self-stigma; Stereotyping; Prejudice; Social distance; Health behavior; Health education

Persons with mental illness often have to struggle with a double problem. First, they have to cope with the symptoms of the disease itself; depending on the particular mental disorder they may have problems such as recurrent hallucinations, delusions, anxiety, or mood swings. These symptoms can make it difficult for someone with a mental illness to work, live independently or achieve a satisfactory quality of life. Second, the misunderstandings of society about the various mental disorders result in stigma. Some persons who manage their mental illness well enough to work still have tremendous difficulties finding a job because employers discriminate against them. Thus, mental illness results not only in the difficulties arising from the symptoms of the disease but also in disadvantages through society's reactions. As a further complication, some people with mental illness may accept the common prejudices about mental illness, turn them against themselves, and lose self-confidence. The latter is referred to as 'self-stigma' and will be discussed further below.

In this paper we want to give a conceptual background of public and self-stigma, discuss how stigma of mental illness interferes with empowerment of persons with mental illness and with service use, review strategies to reduce stigmatization of persons with mental illness and give examples of current initiatives. We believe that it is important to review conceptually relevant work in the field of mental illness stigma to provide a framework for a better interpretation of various empirical findings. Therefore, in this review we wish to summarize conceptually driven work and research on mental illness stigma from different countries. We focussed on two concepts that have been most relevant in research on mental illness stigma: Stigma as conceptualised by Link and Phelan [63] and the concept of Corrigan and coworkers [28]. In this paper, we will first conceptualise stigma using an integrative conceptualisation, combining the two mentioned concepts. We will then discuss differences between these two concepts and their consequences for research and interpretation of results.

This review may be of help to readers from different backgrounds: It may be useful for researchers as a framework to generate and test hypotheses; for clinicians who work with people with mental illness to recognise public stigma and self-stigma more easily and help people with mental illness to cope with the consequences; for mental health professionals to question their own possibly stigmatising attitudes towards people with mental illness; for teachers and students to estab-

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lish educational and other anti-stigma initiatives in their schools or universities; last not least for people with mental illness to better understand stigma and self-stigma and to actively fight stigma and its consequences in their environment.

1. What is stigma?

Stigmatizing attitudes contain some core assumptions. Media analyses of film and print have identified three common misconceptions about people with mental illness: they are homicidal maniacs who should be feared; they are rebellious, free spirits; or they have childlike perceptions of the world that should be marveled [40,50,103]. Independent factor analyses from Canada, England and Germany confirm these findings by identifying the following factors: First, fear and exclusion: persons with severe mental illness are to be feared and, therefore, kept out of communities; second, authoritarianism: persons with severe mental illness are irresponsible, so life decisions should be made by others; and third, benevolence: persons with severe mental illness are childlike and need to be cared for [7,11,101]. Although stigmatizing attitudes are not confined to mental illness, the general public seems to disapprove of persons with psychiatric disabilities more than of persons with physical illness [83,97,105]. Persons with mental illness are more likely to be seen as responsible for causing their illness [22,105]. This assumption of responsibility is less pronounced for schizophrenia than for substance addiction and eating disorders [4]. These attitudes lead to corresponding discriminatory behavior. Citizens are less likely to hire persons with mental illness [9], less likely to rent them apartments [79], and more likely to falsely press charges for violent crimes [98,99].

As an example of a person suffering from stigma, consider what happened to Anne. Anne is 25 years old and has been hospitalised several times with acute symptoms of schizophrenia. For two years, she had been symptom-free, living on her own, working in a local tourist information office and enjoying an active social life. Recently though, she had a relapse of her mental illness. She again was hospitalised and it took her two months to recover and to get ready to go back to work again. However, after recovery she realised that getting over the symptoms of her disease did not suffice: Her employer discharged her because he believed she could have a dangerous outburst in the office due to her mental illness. In addition, her family convinced her that it was too risky to live on her own and made her move back to her parents' home. Since her family lived in another town, that made her lose her friends. In summary, despite a good recovery from the symptoms of her mental illness, within a month after discharge from the mental hospital Anne had lost her job, appartment and friends. Imagine in comparison a person with a chronic somatic illness like diabetes. Similar to schizophrenia, diabetes can lead to severe relapses and hospitalisations. However, unlike a person with schizophrenia, a person with diabetes is unlikely to encounter comparably consequential public stigma related to her illness.

2. Public and self-stigma

2.1. A social cognitive model of public stigma

Public stigma comprises reactions of the general public towards a group based on stigma about that group. Although we are used to distinguishing between groups in society and to label these groups with different attributes, this is not a self-evident process. Most human differences are mainly ignored and socially irrelevant in Western societies of our time. For example, the color of one's car or the size of one's shoes do not matter for most people under most circumstances. However, other personal features like skin-color, sexual orientation or income are often relevant to one's social appearance. There is obviously a social selection of which human qualities matter socially and which do not.

It is often taken for granted to distinguish between different groups in society and to label human differences accordingly. However, every demarcation of groups requires an oversimplification. Even with obvious attributes like skin-color, there is no clear demarcation line between, for example, 'black' and 'white'. Even more so, there is no sharp line between mental health and mental illness [63].

That cultural attitudes to behavior and (mental) illness change substantially over time is another aspect of the social selection of human differences in creating groups [13]. Whether patterns of behavior, thinking and feeling are being noticed at all and if so, whether they are described in moral, psychosocial or medical terms is influenced by societal discourse and usually varies over time. Attention deficit hyperactivity disorder is an example of a label that was unknown a few decades ago and is likely to change again [95].

It is further important to note that labeling often implies a separation of 'us' from 'them'. This separation easily leads to the belief that 'they' are fundamentally different from 'us' and that 'they' even *are* the thing they are labelled. 'They' become fundamentally different from those who do not share a negative label, so that 'they' appear to be a completely different sort of people [63]. Our use of language is revealing regarding the use of labels to distinguish 'us' from 'them'. For example, it is common to call someone a 'schizophrenic' instead to call her or him a person with schizophrenia. For physical illness, things are often handled differently and people usually say, a person *has* cancer. The person afflicted with cancer remains one of 'us' and has an attribute, while the 'schizophrenic' becomes one of 'them' and *is* the label we affix to the person [63]. In this way, language can be a powerful source and sign of stigmatization.

Given this background of distinguishing between groups, labeling and separating 'us' from 'them', social psychology has identified different cognitive, emotional and behavioral aspects of public stigma: stereotypes, prejudice, and discrimi-