How Stigma Interferes With Mental Healthcare: An Expert Interview With Patrick W. Corrigan, PsyD

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Editor's Note:

The stigmatization of people with mental illness is widespread in our society. What is stigma? How does it negatively affect patient outcomes and how can it be reduced? Randall F. White, MD, contributing writer at Medscape, interviewed Patrick W. Corrigan, PsyD, about these issues. Dr. Corrigan is a Professor of Psychiatry and Psychology at Northwestern University and Executive Director of the Center for Psychiatric Rehabilitation at Evanston Northwestern Healthcare, both in Evanston, Illinois. He and his collaborators work at the forefront of understanding the stigmatization of people with mental illness in our society.

Medscape: What is stigma in mental illness and how does it operate in individuals and in the social context?

Dr. Corrigan: I've tended to look at stigma in a social-cognitive way; namely, as a series of attitudes we have about groups. Stereotypes are the attitudes about a group of people: "all Irishmen are drunks; all people with mental illness are dangerous." Prejudice is agreeing with the stereotypes. Discrimination is the behavior that results: "I don't want Irishmen around me, therefore I discriminate against them."

Public stigma is when the public knows the stereotypes. Most people know the stereotype that the mentally ill are dangerous. Agreeing with the stereotype is where prejudice comes in and results in discrimination.

Self-stigma is when people do it to themselves; that is, they grew up in society with the same stereotypes as everyone else, then find themselves in the stigmatized group and beat themselves up about it.

Self-prejudice is agreeing with the stereotype and turning it against yourself: "Yes, people with mental illness are incompetent, I'm mentally ill, therefore I must be incompetent." Self-discrimination is what I call the "why-try" effect: "Why should I even try getting a job? I'm mentally ill and not capable of doing it."

Stigma leads to label avoidance, which is what my latest paper[1] was about; namely, that people with mental illness know that if they come out of the closet, if they're seen with a doctor, the public will

discriminate against them. One of the best ways not to be seen with other mental patients is not to go where they are receiving care.

Medscape: Another term you have used in your writing is "structural stigma." Can you discuss that, and is it another way to say "discrimination"?

Dr. Corrigan: It leads to discrimination. Structural stigma is a way sociologists look at the problem. Because of economic and political reasons, certain institutions have been created in our society that either promote stigma or result in discrimination. An obvious structural stigma for mental illness is the laws in some of the 50 states that undermine a person's ability to have a family, to vote, and things like that.

Parity is a big item in the mental health agenda, which would make the quality of insurance the same for mental health as for other health conditions. I would argue that the actions to block parity are a form of structural stigma. So you'll find legislators who are against parity because they argue it tends to undermine the good quality of healthcare we already have. Economists will tell you that parity would not have that kind of effect, and that legislators are acting in a naive way.

Medscape: You mentioned in your article that people with mental illness are less likely to get certain cardiac procedures.

Dr. Corrigan: Druss' work shows that people with mental illness were significantly less likely to get cardiac care compared with another group that was not labeled that way.[2] I would argue that the general healthcare system is one of those bodies that tends to treat people with mental illness differently.

Medscape: Let's go back to something you said a moment ago. You used the words "label" and, of course, "stigma." Do those reside in the individual with mental illness?

Dr. Corrigan: You just hit a big issue. The advocacy world is not in favor of the term "stigma" because it suggests that the social wrong is in the person. I would not throw away the word "stigma." I would argue with caution that people who are stigmatized have some social cues that signal to the rest of the world. Sometimes they are fairly obvious social cues, such as skin color or other body characteristics. Other people don't have an obvious mark but are labeled once they come out, and they tend to have all the problems with stigma. An example is gay people. We can't tell if someone is gay by looking at them, only if someone points the person out. Religious background, level of education, and history of being in prison are all things you can't tell unless the person comes out.

People can come out by association. This is the biggest way that people with mental illness come out. If you see someone leaving a community mental health clinic, you might assume they're mentally ill and tag them with the stigma of it. So I would argue that stigmata are signals that can lead to prejudice and discrimination.

Medscape: Let's go on from there. How does stigmatization interfere with treatment of mental illness?

Dr. Corrigan: As I discuss in the paper, there are many people who decide never to get treatment even though they would benefit from it. So people who want to avoid labels, avoid treatment so their neighbors don't see them coming out. Or for that matter, they don't want to admit it to themselves, so they don't go see a psychiatrist.

The next issue is people adhering to treatment. Some people already in treatment have identified themselves as having mental illness but might have that "why-try" effect: "why should I try to get better, I'm not capable of doing it." Therefore, they might not adhere to services as well as they should. These 2 effects might lead to worse care and worse outcomes.

Medscape: What are effective ways to combat stigma?

Dr. Corrigan: Looking at public stigma, we've broken down change mechanisms into 3 -- education, contact, and protest. Protest is usually a "shame-on-you" kind of statement and an appeal to stop thinking that way. As an attitude changer, protest tends to give you a rebound effect. Research shows that attitudes get worse. Behavior, on the other hand, might see some benefit.

One example is a show on ABC called *Wonderland*. In the first episode, which aired on March 30, 2000, a person with mental illness shot 5 people and stabbed a pregnant woman in the abdomen. Lots of advocacy groups came out and said, "We're not going to put up with this grossly stigmatizing image." ABC thought this was great because it got them a lot of press, but then the advocacy groups went to the sponsors and ABC eventually pulled the show off the air.

Medscape: In your paper, you focus on contact.

Dr. Corrigan: Let's talk about education first, which is transposing the myths of mental illness with facts. Education is popular because it's exportable -- you can package it up and send it around, such as public service announcements on TV. Unfortunately, the effects of education are small and tend to wash out altogether in a week or two.

Contact is introducing people with mental illness to the rest of the population, and usually that leads to a decrease in stigma. We've done a couple of studies on it. In 2 studies, we compared contact with

education, and contact led to significant changes in attitudes and behavior that were maintained until a month later.

We did a study in which we randomly assigned college students to 1 of 3 groups in which they had contact with either a live or videotaped person with mental illness.[3] One we called high contact, which would be meeting a person who would greatly challenge the stereotypes of people with mental illness. An example would be a famous person coming out of the closet, such as Mike Wallace or Patty Duke. A second type would be low contact. This would be people who greatly mirror the stereotype of mental illness, such as a person who's homeless. The third group is in the middle, someone struggling with mental illness who, despite that, is living on their own with a full-time job.

We measured attitudes precontact, postcontact, and at follow-up, and found that low contact does not work very well -- meeting a homeless person on the street does not challenge a stereotype; if anything, it reinforces it. High contact -- knowing about famous people -- did not tend to have a big effect.

What tends to work most is the middle group, when you find out a coworker or person in your church or a neighbor is struggling with a mental illness. That tends to greatly challenge the stereotypes.

Medscape: In your paper, you wrote that combating structural stigma is a matter of social justice. What are the implications of this?

Dr. Corrigan: As I was finishing the paper, I was at a conference where people were saying that stigma is like any medical condition that can be just treated away. I appreciated their intent, but we need to remember that some problems in the health field are not best looked at as a health disorder. I think that it's an injustice to call this a problem of the person with mental illness, because in doing that, we suggest that it's up to that person to get over the problem. Instead, it's society's problem, and we need to look at changes in society that will help give people an equal chance.

One of the ways to do this is through advertising and social-marketing campaigns. A second way is through something like affirmative action. The best example is the idea of reasonable accommodation in the Americans With Disabilities Act (ADA). If you're a person with mental illness working in a job and you need an extra leg up, I'd be compelled to give it to you.

Reasonable accommodation for mental illness is a support structure to allow someone to stay on their job. So, for example, in our supportive services program here, this includes job coaches to help people get to work and make sure they get what they need to stay there. It's

conceivable that the ADA would give legal protection for a coach to come on the job every day.

Medscape: Can you discuss the role of self-disclosure in combating stigma and the risks and benefits for the individual?

Dr. Corrigan: Another public movement that will have great effect on the stigma of mental illness is "coming out." I think that people with mental illness can learn a lot from the gay community. In some ways, there are similarities between the groups. Both have a condition that the parents did not have, so they don't have the parents' wisdom to deal with it. Both are forced into it in adolescence and young adulthood, and both frequently rely on members of their group to be successful.

There's some thinking that the gay community, over the past 10 to 15 years in the United States, has benefited from coming out. Similarly, I think there are benefits to coming out if you're mentally ill. One of the benefits includes using the ADA. Second, a person with mental illness has the same experience as a gay person about being in the closet. There tends to be anger and some sort of doubt about themselves or their illness (I don't mean to say that gays are ill). Most people who come out tend to feel more satisfied after doing it. The third is that if you come out, you're more likely to find other people who are like you so you can draw near to each other.

Is there a risk? For sure -- I think that one of the risks is just in perception. People are constantly going to wonder whether or not peers are doing things to them because they're mentally ill. And the other one is that when you come out, it's hard to go back, so people have to understand that and be appropriately cautious about it.

Medscape: What draws you to this work?

Dr. Corrigan: I think 2 reasons. One, I am a rehabilitation-services provider, and I have had clients ready to go back to work or to live on their own, and once they met a landlord or an employer who found out they had a mental health history, all sorts of barriers were thrown up that kept them from progressing. To fix disability, we need not just to look at the person with the problem, but we need to look at the community and the environment the person lives in.

The other reason is that I call myself a 60s voyeur. I wasn't old enough to participate, but I was old enough to watch. That striving toward community justice applies in this case. There's a part of me that likes to rectify injustices.