THE STIGMA OF MENTAL ILLNESS AND ITS DELETERIOUS EFFECTS ON PSYCHIATRIC TREATMENT AND RECOVERY

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In spite of the 1960s social justice movements, discrimination against the mentally ill remains a pervasive problem. The stigma that routinely accompanies the diagnosis of a mental disorder prevents victims suffering in silence from seeking treatment and inhibits the recovery of those patients who have already been diagnosed. This paper examines the nature of this prejudice and its tangible effects, and then proceeds to evaluate potential solutions.

Mental illness is a rare category of medical afflictions in which the social repercussions for having such a condition can be just as harmful as the disease itself (Corrigan & Penn 765). In this respect, the widely uncontested stigma that accompanies mental illness is a health hazard similar to the one that pollution poses to asthma patients. However, unlike asthma, mental illness is viewed more as a character flaw deserving of scorn than a biological affliction in need of treatment (Corrigan & Penn 766). To understand why this discrepancy occurs, a short study of stigma in general will be presented, and then applied to the specific circumstance of mental illness. This will be followed by an examination of the measurable detriment suffered by the patient and an analysis of some techniques for fighting the stigma attached to psychiatric disability.

Stigmas are "social categories about which others hold negative attitudes, stereotypes, and beliefs, or which, on average, receive disproportionately poor interpersonal or economic outcomes relative to members of the society at large because of discrimination against members of the social category" (Crocker & Major 609). Stigmas arise when an individual's social identity fails to meet the normative expectations of his or her society (Kurzban & Leary 187). The negative characteristics that qualify someone for stigmatization, as opposed to mere censure, are collectively agreed upon. This leads Kurzban & Leary to argue that many of these characteristics are a result of human evolution, and are designed to discourage social exchange with poor partners and decrease "the probability of parasitic infection" by avoiding contact with persons deemed to be likely carriers (189).

Whatever the causes for stigma may be, its effect on individuals with Severe Mental Illness (SMI) is devastating. Individuals with Severe Mental Illness are often excluded because they disrupt social interactions, regardless of the individual's ability to control his or her behavior (Kurzban & Leary 190). Further, Corrigan and Penn found that participants reacted to persons with

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mental illness with anger, believing the patient to be unworthy of treatment (766). This is not surprising considering the public sentiment that psychiatric illness is akin to moral transgressions such as prostitution, drug addiction and criminality (Corrigan & Penn 166).

These negative perceptions exacerbate the condition of low self-esteem patients (Blankertz 458). This could be particularly damaging to patients suffering from severe depression. In addition to suffering from a disorder that causes low self-image and mood disorders, their self-esteem is likely to be further lowered by negative reactions from others. In this example, stigma could directly worsen a mental illness.

The stigma of mental illness engenders a potent form of discrimination that is largely accepted within our society. Perhaps the most difficult discrimination to combat is institutional, which derives from what Corrigan calls the "structural stigma" of social intuitions that rob people of opportunities (620). The criminal justice system is particularly biased against individuals with SMI. First, persons with mental illness are more likely to be victims of false charges for violent crimes (Corrigan & Penn 767). Because of the prevailing stereotype that persons with mental illness should be feared and isolated (Corrigan & Penn 766), patients with SMI become easy scapegoats for an actual crime and ideal victims of witch hunts to find the perpetrators of fabricated crimes. Second, mental illness is criminalized when police, rather than health professionals, intercede in times of crisis. This, in turn, contributes to the increasing prevalence of incarcerated SMI sufferers. Furthering this injustice is the fact that SMI patients tend to spend more time in jail than persons without SMI (Corrigan 616).

It is also possible that the mentally ill are more likely to be sentenced in the first place. A study by Sibicky and Dovidio showed that judges detected a difference in behavior between who they thought to be psychiatric patients and a control group (152). In fact, the judges had created the differences, for all the testimony they heard was by mentally healthy collaborators. State governments also practice the disenfranchisement of the mentally ill, almost one-third of them restrict mentally ill patients' ability to hold elected office, participate on juries and vote; and almost half of the state governments interfere with the child custody rights of severely mentally ill individuals (Corrigan 621).

The discrimination continues on an individual level, as employers are less likely to hire persons who are labeled mentally ill and landlords are less likely to lease apartments to them (Corrigan & Penn 767). Furthermore, in blatant defiance of the Hippocratic oath, physicians discriminate against mentally ill patients in that "people labeled mentally ill are less likely to benefit from the depth and breadth of available physical health care services than people without these illnesses" (Corrigan 616). The prevalence of discrimination against the mentally ill, in light of the Fourteenth Amendment, and in the aftermath of the civil rights and women's movements, suggests that these jurisprudential and political achievements did not ban discrimination. They simply removed women and minorities from the social groups against whom it is acceptable

to discriminate. In this sense, American society has not progressed. People with mental illness, among other groups, have simply filled this void.

Furthermore, the stigmatization of a mentally ill person is a shared burden. In the wake of the deinstitutionalization movement of the Reagan Administration, families are left with increased responsibility to care for severely mentally ill relatives. Adding to the stress of caring for a mentally ill relative is the scorn the entire family endures from society. According to Corrigan and Penn (767), "families also report lowered self-esteem and strained relationships with other family members because of stigma and may be the victims of a 'courtesy stigma' (i.e., being stigmatized because of their association with someone with a SMI)." Further, although SMI is *medically* treated, the public erroneously views these disorders as induced by the behaviors of others (Lefley 556). Not surprisingly, the family is often viewed by society as responsible for their relative's disorder (Lefley 556). This blame, which can become internalized on the part of family members, can deteriorate the relationships within the family and the strength of the family as a unit. This is particularly dangerous for the patient, who is in need of a strong and calm family, capable of reinforcing and continuing the clinician's treatment plan outside the hospital in order to recover successfully.

The stigma endured both by mentally ill patients and their families has led to a myriad of responses by those suffering from mental illness who have not yet been labeled as "mentally ill." For example, Fontana and Rosenheck found that World War II veterans likely underreported the severity of their post-traumatic stress symptoms to avoid the stigma that comes with admitting a psychiatric malady (31). In addition to underreporting, many persons suffering from mental illness are reluctant to seek treatment. For example, Asian-American patients tend to underutilize mental health services, delay seeking treatment, or they may not seek treatment at all (Okazaki 58). This phenomenon is not limited to Asian-Americans; many people who would benefit from psychiatric treatment do not pursue it or do not faithfully follow the treatment because of perceived stigma (Corrigan 614). Even more shocking is the fact that around 40% of individuals with more severe disorders like schizophrenia do not seek treatment, and the severity of the mental condition has virtually no effect on whether or not an individual seeks treatment. Furthermore, of those individuals who do seek treatment and are prescribed antipsychotic medication, more than 40% fail to fully follow their clinician's instructions (Corrigan 615). As far as mental health is concerned, the stigma imposed upon the mentally ill is so pervasive and severe that many choose to suffer through the anguish of a mental illness rather than risk being labeled as "mentally ill."

Even those patients who choose to seek and follow treatment take extensive measures to avoid stigma. Because a possible effect of psychological or psychiatric treatment may be negative evaluations and rejections from others, many people who seek professional help forego mental healthcare benefits provided by their employer, paying with their own funds instead, for fear of

disclosing their treatment and/or condition to their colleagues (Sibicky & Dovidio 152). Given this pattern, it is possible that many workers also refrain from taking needed "mental health days" for fear of the office gossip and any other negative reactions they may encounter.

Aside from the hurdles it creates in terms of seeking treatment, the social stigma associated with mental illness is also detrimental to a patient struggling to recover. For example, because of the stigmas associated with mental illness, newly diagnosed patients often feel hopeless about their future (Frese & Davis 244). The expectation of failure also affects the level of care a clinician will provide; he or she will not invest as much effort into a patient for whom he or she deems failure inevitable. A similar effect occurs within the context of the care provided by the patient's family (Frese & Davis 244). This form of stigma is often well-intentioned, stemming from authoritarian perceptions that the mentally ill are incapable of making their own decisions and the benevolent/paternalistic belief that mentally ill patients are child-like and need constant care (Corrigan 765). These stereotypes lead to disempowering styles of care, which inhibit personal growth and the acquisition of life skills that are essential for independent living.

This manifestation of stigma is particularly damaging because it can engender a self-fulfilling prophecy, a psychological phenomenon in which individuals behave so as to match the expectations of others, which in turn may lead them to alter their self-conceptions as well (Crocker & Major 610). In the case of mental illness, patients may internalize the negative stereotypes associated with mental illness, such as dangerousness and incompetence (Corrigan & Penn 768) and reflect them in their interactions with future perceivers (Sibicky & Dovidio 153). Therefore, the acknowledgment by clinicians that some patients do recover is critical. Not surprisingly, a key element in the potential recovery of a patient is the presence of caretakers who offer hope and support (Frese & Davis 244). By relating stories of recovery, the clinician raises the expectations he or she has for his or her patients, lowering the possibility that the patient will fall victim to a self-fulfilling prophecy.

Unfortunately, the presence of such success stories in popular discourse is scarce. One possible reason for this could be that the public chooses to ignore information that contradicts its firmly established prejudices. Also, evidence has shown underreporting of success induced by shame. For fear of stigma, many individuals who triumphed over mental illness do not share their stories, preferring to hide their past from the judgment of others. By choosing to withhold their personal successes that contradict the stigma, survivors leave current mental illness sufferers subject to the same low expectations they themselves proved to be false (Frese & Davis 245).

The effects of the negative stereotypes and stigma endured by persons with SMI are irrefutably harmful to the patient. Accordingly, mental health advocates use a variety of techniques to redefine the public perception in hopes of lessening, or ideally, eliminating altogether, the stigma that accompanies a psychiatric diagnosis.

The most grandiose of these tactics is protest, which aims to stop negative attitudes about persons with mental illness by suppressing their expression (Corrigan & Penn 767). A notable example is the photo essay "Denied Citizens" released by the World Health Organization to commemorate International Human Rights Day on December 10, 2005 (World Health Organization). The core principle behind protest is to address the symptoms instead of the disease; in other words, protest addresses the manifestations of stigma as a means to combat the stigma itself. For example, groups may protest inaccurate and hostile representations of the mental illness in music or in movies in hopes of challenging the message of that depiction (Corrigan & Penn 767). Anecdotal evidence suggests that protest reduces the frequency of acceptable stereotypes, which lessens the volume of sanctioned instances of stigma each target has to encounter (Corrigan & Penn 768).

However, protest is largely ineffective as a means to convert people who endorse stereotypes. One reason may be the difficulty of thought suppression. Research shows that when participants are instructed to avoid thinking about a certain stereotype (stereotype suppression), it simply increases the instance of stereotypical thought (stereotype rebound) (Macrae, Bodenhausen, Milne, and Jetten). Therefore, members of the public who do heed the demands of protesters by attempting to suppress negative stereotypes about psychiatric disability may actually be priming them (Corrigan & Penn 772). Research studying interactions between stereotype suppression and stereotype rebound appears to be particularly damning of the protest technique, but most of it examines only immediate attitude change. Longitudinal studies need to be conducted to determine if stereotype rebound stops when instructions to suppress a stereotype are repeated over an extended period of time (Corrigan & Penn 769). In addition, research needs to be done concerning protest's effects on behavior as opposed to its effect on attitudes, because the protest emphasizes the modification of behavior over attitude changes (Corrigan & Penn 769).

Another way that protest has been shown to be ineffective in the short term is it fails to replace negative attitudes with positive ones that are supported by facts. Education is an effective tool in providing those facts so that the public can make more informed decisions about psychiatric illnesses (Corrigan & Penn 768). Research indicates that individuals who understand mental illness are less likely to endorse stigma and discrimination (Corrigan & Penn 769). Education is one way to provide that understanding. In a study conducted by Homes et al. (in press, as cited in Corrigan & Penn), participants showed improved attitudes toward the mentally ill after a semester-long education program (Corrigan & Penn 769). However, the effect was limited, and attitude change was compounded by the amount of education on mental illness each participant had before the study (Corrigan & Penn 769). Additionally, because these education programs are costly, and mostly limited to higher education, this technique may not be feasible for the activists aimed at changing the attitudes of large populations.

To counteract the difficulty in reaching large audiences with traditional education means, many activists have encouraged contact between those persons with mental illness and those unaffected by psychiatric disabilities to foster understanding (Corrigan & Penn 771). This is a particularly useful technique because many research psychologists have found that individuals exposed to persons of a target group are more inclined to abandon stereotypes about that group (Corrigan & Penn 771). Unlike protest and education, contact provides a forum for social exchange and emotional bonding. In this process, the individual from the dominant group may gain knowledge of how the stigma of mental illness hurts the one who suffers from it, and to this end make a concerted effort not to discriminate against the mentally ill.

However, other psychologists have shown that contact with a target that does not fit the stereotype does not cause the perceiver to redefine his or her notions of the target group. For example, in the context of race relations, many white Americans, when confronted with black Americans who do not fit their stereotypical expectations, simply categorize that individual by some other social role such as "athlete" or "businessman," which leaves their racial stereotype intact (Devine & Baker 48). This phenomenon is known as "stereotype subcategorizing" (Corrigan & Penn 772). Corrigan and Penn related this effect to mental illness with the following example: a citizen suppressing a dangerousness stereotype about a patient from a psychiatric hospital could be so focused on suppressing dangerousness that they fail to notice any actual evidence the patient presents that he or she is not dangerous, but outgoing and friendly (768).

To overcome this problem, advocates have compiled numerous guidelines for facilitating successful contact. Because contact is more successful when all participants are equal in status, persons with mental illness need to be simply one of the many participants in the program, and not the "token" mentally ill person (Corrigan & Penn 771). An activist organization can create this equal status in a myriad of ways. First, encouraging cooperation on a task helps to combat stigma by highlighting the competency of the person with mental illness. This allows the perceiver to experience attributes of the person with mental illness that fall outside the realm of what is stereotypical of mentally ill patients. Second, instead of keeping dialogue businesslike, facilitators should provide opportunities for personal intimate contact because stigma is diminished under these circumstances. Finally, approval from an institution or authority figure makes a contact program more successful (Corrigan & Penn 771). Although there is no way to eliminate stereotype subcategorizing altogether, using the techniques described above, advocates can still use contact as an effective tool in combating stigma against the mentally ill.

The presence of mental health advocates is the first step of many needed to lessen the stigma against mentally ill patients. In an age where diversity seminars and affirmative action are frequently used to combat and compensate for racial and gender discrimination, the absence of comparable

programs regarding mental illness is inexcusable. The stigma that affects the mentally ill is not simply a matter of hurt feelings; it is a matter of public health. Negative perceptions lower the quality of care that mentally ill patients receive (Corrigan 618), dissuade patients from fully participating in their treatment regimen (Corrigan 615), and can lead afflicted individuals to simply refuse to seek treatment altogether (Corrigan 615). Although the Americans with Disabilities Act requires that the mentally ill be accommodated, it is not a sufficiently strong mechanism to protect the mentally ill from the myriad of documented harmful effects of stigma and discrimination. Therefore, mental healthcare as a profession needs to work to educate its own practitioners, so that they do not give the patient a sense of hopelessness, and to educate the public, so that stigma is no longer a barrier to seeking treatment.

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