COMMENTARIES

Strategies for reducing stigma toward persons with mental illness

David L. Penn,
Shannon M. Couture
Department of Psychology, University of North Carolina-Chapel Hill, Davie Hall, CB#3270, Chapel Hill, NC 27599-3270, USA

Corrigan and Watson have written an excellent overview on the impact of stigma on the lives of persons with severe mental illness (SMI). In this commentary, we would like to expand on one aspect of that article, namely strategies for reducing stigma toward persons with SMI.

Corrigan and Watson have identified three approaches for reducing stigma: protest, education, and contact. Although these approaches have promise, they are not without weaknesses. A potential disadvantage of using protest (i.e., telling the public to stop believing negative views about mental illness) is that it may actually increase, rather than decrease stigma. In fact, research has shown that instructing individuals to ignore or suppress negative thoughts and attitudes towards a particular group can have paradoxical rebound effects; stigma will be augmented rather than reduced (1). To examine this issue with respect to psychiatric stigma, we instructed participants to either suppress or not to suppress their stereotypes of persons with SMI and evaluated the effects on stigma-related attitudes and behaviors (2). The results showed that suppression instructions did reduce negative attitudes, but *did not* impact behavior toward persons with SMI, and that the paradoxical rebound effects did not occur. This suggests that stereotype suppression may have modest, although limited effects, on psychiatric stigma.

There is evidence that individuals who possess more information about mental illness are less stigmatizing than individuals who are misinformed about mental illness (3). This suggests that providing individuals with factual information about SMI, in particular regarding dangerousness and SMI, would reduce stigmatization. We have generally found support for this hypothesis. Information regarding the residential context of persons with SMI (i.e., that they may live in supervised housing) (4), and the relationship between dangerousness and SMI (5), were both associated with reduced stigmatization to persons with SMI in general and to a hypothetical individual with SMI. However, the positive effects of factual information on psychiatric stigma were attenuated when subjects had to rate their reactions to actual persons with SMI (6). Thus, factual information regarding SMI may be more effective in reducing stigma toward persons with SMI in general, than toward specific individuals.

Finally, there is convincing evidence that increased contact with persons with SMI is associated with lower stigma (7). However, there are a number of problems that plague work in this area. First, many studies have examined the effects of *previous* self-reported contact on stigma, rather than how contact changes stigma *prospectively* (7). In those studies in which direct contact was measured, the manipulation often took place in the context of contrived laboratory situations or as part of a course and/or training program. Scant attention has been placed on how direct interpersonal contact affects stigma during *ongoing naturalistic* relationships. Second, the mechanism(s) underlying stigma reduction, as a function of contact, are unknown. In other words, how does contact reduce stigma? Two theories have been proposed for this. According to the recategorization theory (8), contact with an out-group member results in changes in out-group member classification, from ‘them’ to 'us'. A related model of stigma change is rooted in attribution theory. Attributions are explanations that an individual makes about another individual's behavior. Although attributions can be made along various dimensions (e.g., internal-external), the controllability dimension is especially relevant to perceptions of persons with SMI. Mental/behavioral disorders are viewed as more controllable than medical disorders and hence, more stigmatizing (9). These attributions result in perceptions of the person with SMI as being responsible for her/his condition, which culminates in feelings of anger and distaste toward her/him (9). Sustained interpersonal contact with a person with SMI may debunk the myth that her/his condition is under her/his control (i.e., that she/he may have caused the disorder). This shift in attributions, from controllable to uncontrollable, should correspond to a change in feelings, from anger to sympathy, which should augment helping behavior. Unfortunately, these theories have not been adequately tested in the area of stigmatization toward persons with SMI.

The foregoing underscores some of the problems with work in this area. Although we have made much progress in reducing stigma, we are, in many ways, still in the nascent stage of research, particularly with respect to theory development. It is hoped that this Forum will serve as an impetus to scientists, practitioners, and persons with SMI to collaborate on efforts to tackle this persistent and pernicious problem presented by psychiatric stigma.

References

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