Dispelling the Stigma of Schizophrenia

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Introduction by the column editors: The current political controversy over parity for insurance coverage of mental disorders is a consequence of the long-standing stigma against mental illness, its treatments, and the professionals who provide the treatments. Psychiatrists have traditionally been viewed by their colleagues in other fields of medicine as lacking the full credentials and abilities of other practicing physicians. Psychiatric disorders have been caught up in the "mind" segment of the "mind-body" dualism still subscribed to by most citizens, many physicians, and even many in the mental health field itself. Few policy makers and legislators, and even few mental health providers, are aware that the success rate of many modern biobehavioral treatments for major mental disorders surpasses that of treatments for heart disease, cancer, and diseases of the kidneys, liver, and lungs.

In this month's Rehab Rounds column, Samatha Kommana and her colleagues conceptualize stigma from a social-psychological perspective and describe several methods for attacking stigma that are based on principles of social psychology. One such method—the media campaign—has been shown in controlled multisite studies to be effective in reducing risk for cardiovascular disease, and it should also have impact on the stigma surrounding mental disorders.

The National Alliance for the Mentally Ill (NAMI) is currently sponsoring a campaign to educate the public about the brain disorders of schizophrenia, bipolar disorder, major depression, and obsessive-compulsive disorder. This effort harkens back to the successful campaigns of Dorothea Dix and Clifford Beers, who worked to increase public support for treatment of mental disorders in the 19th and early 20th centuries. Since 1991 the Rotary Club has sponsored a public education program called "Erasing the Stigma," which is similar to NAMI's campaign.

Other advocacy programs currently under way, along with current political and scientific developments, may also help turn the tide against stigmatization of persons with mental illness. NAMI and its local affiliates monitor the media and initiate protests whenever inappropriate and biased descriptions of mental illness appear in newspapers, television programs, or movies. Other protection and advocacy efforts bring pressure on institutions and agencies to improve the quality of treatment and civil liberties for persons with mental illness.

On the political front, operationalization and enforcement of the Americans With Disabilities Act promise to give persons with mental disabilities increased access to jobs, housing, and community services. Finally, advances in biomedical and neuroscience research continue to clarify processes of brain dysfunction in psychiatric disorders and reduce the legitimacy of mind-body dualism.

Public perception of persons with severe mental illness is not favorable, and the public often views these persons as unpredictable and dangerous (1,2). The widespread rejection of persons with severe mental illness adds to the burden they bear as a result of being labeled mentally ill (3,4). Such negative perceptions create barriers for mentally ill people who wish to reintegrate into the community through jobs, friendships, and mate selection.

To overcome the stigma associated with mental illness, many myths must be dispelled. Research in attitude change and social psychology provides a basis for pragmatic approaches to reducing stigmatization. For example, researchers have found increased acceptance and reduced fear of persons with severe mental illness in communities where the public had increased exposure to these individuals (5,6). Similarly, undergraduate students who had no previous contact with persons with mental illness rated an individual with schizophrenia described in a brief vignette as more dangerous than did students who reported knowing someone with a mental illness (7). These studies suggest that direct contact between members of the general community and persons with severe mental illness over time may eliminate certain stereotypes and misconceptions that the public has about severe mental illness.

Direct contact could be promoted by encouraging community members to visit persons recovering from mental illness who are living in a group home or an aftercare facility. Alternatively, recovered or stabilized individuals could visit schools or businesses. Such contacts could also lead to employment and educational opportunities for those recovering from mental illnesses.

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Clinicians, case managers, clinical directors of aftercare facilities, and persons in the state office of mental health may be among those who take the lead in encouraging contact between community members and persons with severe mental illness. Regardless of who makes the initial overture, the critical step will be contact between members of the public replete with misinformation about mental illness and persons with mental illness who desire acceptance and fairness from the community.

Promoting direct contact on a one-to-one basis may not always be cost-effective and time-efficient. Furthermore, the mechanisms underlying how contact reduces stigma are still unknown. Mere exposure to someone with a severe mental illness may not be enough to reduce stigma—other contextual factors such as whether the mentally ill person is perceived as a threat or whether the community member has children—may need to be considered (8).

Stigma may be reduced more efficiently through use of mass media. Written and visual media may be useful for disseminating more realistic information about mental illness. Although previous efforts to reduce stigma through public education have not always been successful (9,10), a recent study found that the effectiveness of education was augmented by directly targeting misinformation about dangerousness and mental illness (11).

Another method for reducing stigma is to provide people who are recovering from mental illness with the interpersonal skills necessary to blend in with the general public. The clinical observation that persons with schizophrenia have difficulties interacting with others is buttressed by the finding that at least 50 percent of those with schizophrenia show persistent deficits in social skills compared with control subjects, that is, relative to the least skilled person in the control group (12). Such deficits may underscore the public's perception that individuals with schizophrenia are "strange," thus resulting in greater expression of fear and derision toward recovering individuals. These reactions may in turn militate against the recovering person's forming a social network, making the person more vulnerable to stress, relapse, and other negative outcomes.

The idea that social skills shown by individuals with schizophrenia may have a potentially positive effect on stigma was indirectly supported in an earlier study (13). Two pairs of independent observers rated the physical attractiveness of subjects with schizophrenia, either before or after observing a three-minute role play in which the subject was involved in social interaction; a third pair of observers rated subjects' social skills at the conclusion of the role play. The findings revealed a strong relationship between ratings of subjects' social skills and their perceived attractiveness rated after the role play.

In other words, the social skills of persons with schizophrenia made an impact on raters' assessments of their perceived attractiveness, even after controlling for ratings of attractiveness made before the role play. Thus improved social skills could potentially reduce stigma by increasing the attractiveness and social desirability of persons with schizophrenia.

Changing public attitudes toward individuals with severe mental illness is an important step in the effort to eliminate stigma. Changes in behavior toward these persons can amplify the effects of changing attitudes. For example, various labels are used by mental health professionals to describe individuals with severe mental illness, including "schizophrenics," "consumers," "clients," and "persons with severe and persistent mental illness." The impact of these labels, even apparently positive ones such as "consumer," in maintaining negative stereotypes needs to be assessed. Recent findings indicate that there is no clear consensus among persons with mental illness about the terms they prefer to describe themselves (14).

It is heartening to know that practical approaches for dispelling the stigma of severe mental illness exist. These approaches include promoting personal contact between the public and persons with severe mental illness, providing empirically based information about the relationship between dangerousness and severe mental illnesses, and providing social skills training for persons recovering from these illnesses. Efforts to reduce stigmatization must be an integral part of treatment and rehabilitative programs. Without these efforts, people recovering from severe mental illness may not maintain the changes they have made in treatment once they are outside protected treatment settings.

Afterword by the column editors: Surveys have revealed that the public's perception of mental illness is gradually changing to a more rational approach, possibly in response to the public statements of celebrities such as Mike Wallace, William Styron, Patty Duke, and Rod Steiger who have "come out of the closet" about their battles with mental disorders and the prospects for recovery. In addition, new and better medications and psychosocial treatments for mental illnesses have increased public awareness of their treatability, thereby mitigating the hopelessness and help- lessness long associated with these disorders. The Americans With Disabilities Act and the increasing employment and mainstreaming of persons with mental illness have also had desirable impacts on stigma.

Mental health professionals also have a potentially potent role to play in the fight against stigma and discrimination. For example, we might ask why more mental health professionals do not appropriately disclose the successful treatment of their own mental disorders—to consumers as well as to the media. Until mental health professionals have given up their own shame about and stigma toward mental disorders, we cannot expect major changes in these attitudes among the general public.

Fortunately, the recent popular books by Kay Jamison, Fred Friese, and Carol North and the efforts of Daniel Fisher at the National Empowerment Center show that mental health professionals are beginning to come forward about their experiences with mental illness. Such efforts are particularly significant because they form a basis for therapeutic relationships with consumers that can serve as models for acceptance, insight, and collaboration in treatment.

However, one need not have suffered from mental illness to serve as an advocate for persons with mental illness. For too long the advocate role has been delegated by highly trained mental health professionals to lower-level staff and paraprofessionals. True leadership in the field of psychiatric rehabilitation and community mental health requires professionals to acquire and model the same competencies usually subsumed under the case manager function—including advocacy for the individual consumer as well as at the local, state, and national levels and activities aimed at destigmatization such as developing jobs and job coaching with community-based employers, educating the public through speaking engagements, and supporting consumer-operated organizations. Also required are the consultation-liaison skills needed to interact with the wide variety of social services agencies integral to the treatment process.

Just as in the times of Dorothea Dix and Clifford Beers, it is apparent today that if we as mental health care providers are to dispel the stigma of severe mental illness, we must first commit ourselves—with both words and deeds—to the long-term goal of recovery and enhanced quality of life for those with serious mental disorders. ♦

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