How Stigma Interferes With Mental Health Care

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Many people who would benefit from mental health services opt not to pursue them or fail to fully participate once they have begun. One of the reasons for this disconnect is stigma; namely, to avoid the label of mental illness and the harm it brings, people decide not to seek or fully participate in care. Stigma yields 2 kinds of harm that may impede treatment participation: It diminishes self-esteem and robs people of social opportunities. Given the existing literature in this area, recommendations are reviewed for ongoing research that will more comprehensively expand understanding of the stigma–care seeking link. Implications for the development of antistigma programs that might promote care seeking and participation are also reviewed.

Although the quality and effectiveness of mental health treatments and services have improved greatly over the past 50 years, many people who might benefit from these services choose not to obtain them or do not fully adhere to treatment regimens once they are begun. Stigma is one of several reasons why people make such choices; namely, social–cognitive processes motivate people to avoid the label of mental illness that results when people are associated with mental health care. A brief definition of stigma is provided, followed by a more complete description of two specific manifestations that dissuade people from treatment: the threats of diminished self-esteem and of public identification when labeled "mentally ill." The article ends by briefly reviewing implications of these two factors for research and antistigma programs that seek to increase consumer use of mental health services.

An important question throughout this article is whether the problem of stigma and adherence applies to the generic concept of mental illness or differs by diagnosis and/or level of disability. Research evidence on this issue is mixed. On one hand, research suggests there is a nonspecific label effect, implying that people labeled mentally ill, regardless of the specific psychiatric diagnosis or level of disability, are stigmatized more severely than those with other health conditions (Corrigan et al., 2000; Weiner, Magnusson, & Perry, 1988). On the other hand, studies suggest the public discriminates among psychiatric groups in terms of stigma; for example, people with psychotic disorders are judged more harshly than people with depression or anxiety disorders (Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). Moreover, treatment participation and adherence seem to be greater problems in indi-

viduals with psychotic disorders (Fenton, Blyler, & Heinssen, 1997). Given the equivocal nature of stigma and diagnosis, the relevance of specific diagnoses and disabilities is highlighted where appropriate in the remainder of this article.

Mental Health Problems and Care Seeking

Most clinical and services researchers recognize several interventions as having sufficient empirical evidence to commend them for treatment of specific disorders (American Psychiatric Association, 1997, 2000; Gibbs & Gambrill, 2002; Proctor, 2002; Torrey et al., 2001). Two task forces of the American Psychological Association (APA)—on Psychological Intervention Guidelines (1995) and on Promotion and Dissemination of Psychological Procedures (1995)—have developed standards for defining research evidence that describes empirically supported interventions. Division 12 members have summarized these proceedings and similar efforts into a continually evolving set of guidelines and recommendations (Chambless et al., 1996, 1998; Weisz, Hawley, Pilkonis, Woody, & Follette, 2000). Chambless and Hollon (1998, p. 7) posed three questions that perhaps best define evidence-based treatment:

(a) Has the treatment been shown to be beneficial in controlled research? (b) Is the treatment useful in applied clinical settings, and if so, with what patients and under what circumstances? (c) Is the treatment efficient in the sense of being cost-effective relative to other alternative interventions?

As a result of ongoing clinical and services research, providers and policymakers have developed evidence-based guidelines that suggest specific treatments will improve the lives of people with particular problems and disorders.

Despite the plethora of evidence-based interventions, services researchers are familiar with two disconcerting trends vis-à-vis effective treatment: (a) Many people with mental illness never pursue treatment, and (b) others begin treatment but fail to fully adhere to services as prescribed. Large-scale epidemiologic research has provided evidence that supports the first assertion. Research from the Epide-

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miologic Catchment Area (ECA) Study showed that less than 30% of people with psychiatric disorders seek treatment (Regier et al., 1993). A subsequent large-scale study, the National Comorbidity Survey, showed similar results (Kessler et al., 2001). Less than 40% of respondents with mental illness in the past year received stable treatment. Perhaps these small ratios represent those with relatively minor adjustment disorders who choose to withstand brief psychological discomfort rather than engage mental health providers.

Additional analyses of ECA data, however, do not support this assumption. Although somewhat better, there is still concern about the number of people with serious mental illness who do not receive care. About 40% of people with such serious disorders as schizophrenia failed to obtain treatment (Regier et al., 1993), and people with serious mental illness were no more likely to participate in treatment than those with relatively minor disorders (Narrow et al., 2000). A national survey conducted by the Substance Abuse and Mental Health Services Administration found similar sobering results (Willis, Willis, Male, Henderson, & Manderscheid, 1998); fewer than 10% of people with psychiatric disabilities receive such diagnostically indicated services as vocational rehabilitation, case management, or day treatment. Findings from a national survey conducted by the Schizophrenia Patient Outcome Research Team are also alarming (Lehman et al., 1998). Although more than 90% of individuals in the survey received maintenance neuroleptic treatment, participation in evidence-based psychosocial treatments was far lower. Less than half of survey participants reported participation in appropriate psychotherapies, less than a quarter were involved in family therapy, and only about 10% received intensive case management. This lag has multiple causes, including avoidance of the public labels that yield stigma.

These problems are further exacerbated by the number of people who obtain mental health services but fail to fully adhere to component prescriptions. A recent review of 34 studies of compliance with psychiatric medication found, on average, that more than 40% of persons receiving antipsychotic medication failed to fully comply with prescribed regimens (Cramer & Rosenbeck, 1998). Failure to adhere to antipsychotic regimens increased rehospitalization by three-fold, accounting for an $800 million increase in hospital costs world wide (Weiden & Olfson, 1995). In addition, many persons drop out of psychosocial interventions before finishing the complete regimen (Falloon, Lindley, McDonald, & Marks, 1977; Tarrier et al., 1998).

The Relevance of Stigma

The question of interest in this article is why people with mental health problems fail to engage in treatment. The stigma process is proffered as one relevant factor and is framed here as four social–cognitive processes: cues, stereotypes, prejudice, and discrimination. First, the general public seems to infer mental illness from four cues: psychiatric symptoms, social-skills deficits, physical appearance, and labels (Corrigan, 2000; Penn & Martin, 1998). Many of the symptoms of severe mental illnesses like psychoses—for example, inappropriate affect and bizarre behavior—are manifest indicators of psychiatric illness that produce stigmatizing reactions (Link, Cullen, Frank, & Wozniak, 1987; Penn et al., 1994; Socall & Holtgraves, 1992). Moreover, poor social skills (Bellack, Mueser, Morrison, Tierney, & Podell, 1990; Mueser, Bellack, Douglas, & Morrison, 1991) that result from some psychiatric illnesses also lead to stigmatizing responses from others. Similarly, research suggests that poor personal appearance may lead to stigmatizing attitudes; for example, "that unkempt person on the park bench must be a mental patient" (Eagly, Ashmore, Makhijani, & Longo, 1991; Penn, Mueser, & Doonan, 1997).

It is important to note, however, the potential for misattributing someone as mentally ill on the basis of these three cues. For example, eccentric behavior that is not characteristic of a psychiatric disorder could be misunderstood as mental illness. Just as these signs may yield false positives, so may their absence lead to false negatives. Many people are able to conceal their experiences with mental illness without peers being aware. Juxtaposing concerns about false positives with the idea that the stigma of mental illness may be hidden begs the following question: What else, then, is the mark that leads to stigmatizing responses? Several carefully constructed studies suggest labeling as an important candidate (Jones et al., 1984; Link, 1987; Scheff, 1974). Labels lead to stigma in two ways. People can obtain labels from others (a psychiatrist can inform someone that Ms. X is mentally ill) or labels can be obtained by association (a person observed coming out of a psychologist's office may be assumed to be mentally ill).

Second, stigmas are cues that elicit stereotypes, knowledge structures that the general public learns about a marked social group (Augoustinos, Ahrens, & Innes, 1994; Esses, Haddock, & Zanna, 1994; Hilton & von Hippel,

1996; Judd & Park, 1993; Krueger, 1996; Mullen, Rozell, & Johnson, 1996). Stereotypes are especially efficient means of categorizing information about social groups. Stereotypes are considered "social" because they represent collectively agreed on notions about groups of persons. They are "efficient" because people can quickly generate impressions and expectations of individuals who belong to a stereotyped group (Hamilton & Sherman, 1994). Commonly held stereotypes about people with mental illness include violence (people with mental illness are dangerous), incompetence (they are incapable of independent living or real work), and blame (because of weak character, they are responsible for the onset and continuation of their disorders; Brockington, Hall, Levings, & Murphy, 1993; Corrigan et al., 2000; Hamre, Dahl, & Malt, 1994; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999).

Just because most people have knowledge of a set of stereotypes does not mean that they agree with them (Devine, 1989; Jussim, Nelson, Manis, & Soffin, 1995). Third, people who are prejudiced endorse negative stereotypes ("That's right; all people with mental illness are violent and incompetent!") and generate negative emotional reactions as a result ("They all scare me!"; Devine, 1988, 1989, 1995; Hilton & von Hippel, 1996; Krueger, 1996). In contrast to stereotypes, which are beliefs, prejudicial attitudes involve an evaluative (generally negative) component (Allport, 1954; Eagley & Chaiken, 1993). Prejudice, which is fundamentally a cognitive and affective response, leads to discrimination, the behavioral reaction (Crocker, Major, & Steele, 1998).

Fourth, discriminatory behavior manifests itself as negative action against the out-group or exclusively positive action for the in-group. Most notably, out-group discrimination may appear as avoidance, not associating with people from the out-group. For example, employers avoid workers with mental illness by not hiring them. Landlords wanting to protect their tenants from people with mental illness do not rent to them.

I made an additional distinction about stigma that has been applied to more general work with all health conditions (Corrigan & Penn, 1999; Corrigan & Watson, 2002). I have distinguished *public stigma* (what a naive public does to the stigmatized group when they endorse the prejudice about that group) and *self-stigma* (what members of a stigmatized group may do to themselves if they internalize the public stigma). The ramification of this distinction for understanding the link between stigma and care seeking is outlined in Figure 1 and is reviewed more thoroughly in the next section. Please note that although public and self-stigma are presented separately in the figure, their impact is likely to interact with and augment each other.

Public Stigma: Harm to Social Opportunities

Stigma harms people who are publicly labeled as mentally ill in several ways. Stereotype, prejudice, and discrimination can rob people labeled mentally ill of important life opportunities that are essential for achieving life goals. People with mental illness are frequently unable to obtain good jobs or find suitable housing because of the prejudice of key members in their communities: employers and landlords. Several studies have shown that public stereotypes and prejudice about mental illness have a deleterious impact on obtaining and keeping good jobs (Bordieri & Drehmer, 1986; Farina & Felner, 1973; Farina, Felner, & Bourdreau, 1973; Link, 1982, 1987; Olshansky, Grab, & Ekdhal, 1960; Wahl, 1999; Webber & Orcutt, 1984) and leasing safe housing (Aviram & Segal, 1973; Farina, Thaw, Lovern, & Mangone, 1974; R. Hogan, 1985a, 1985b; Page, 1977, 1983, 1995; Segal, Baumohl, & Moyles, 1980; Wahl, 1999).
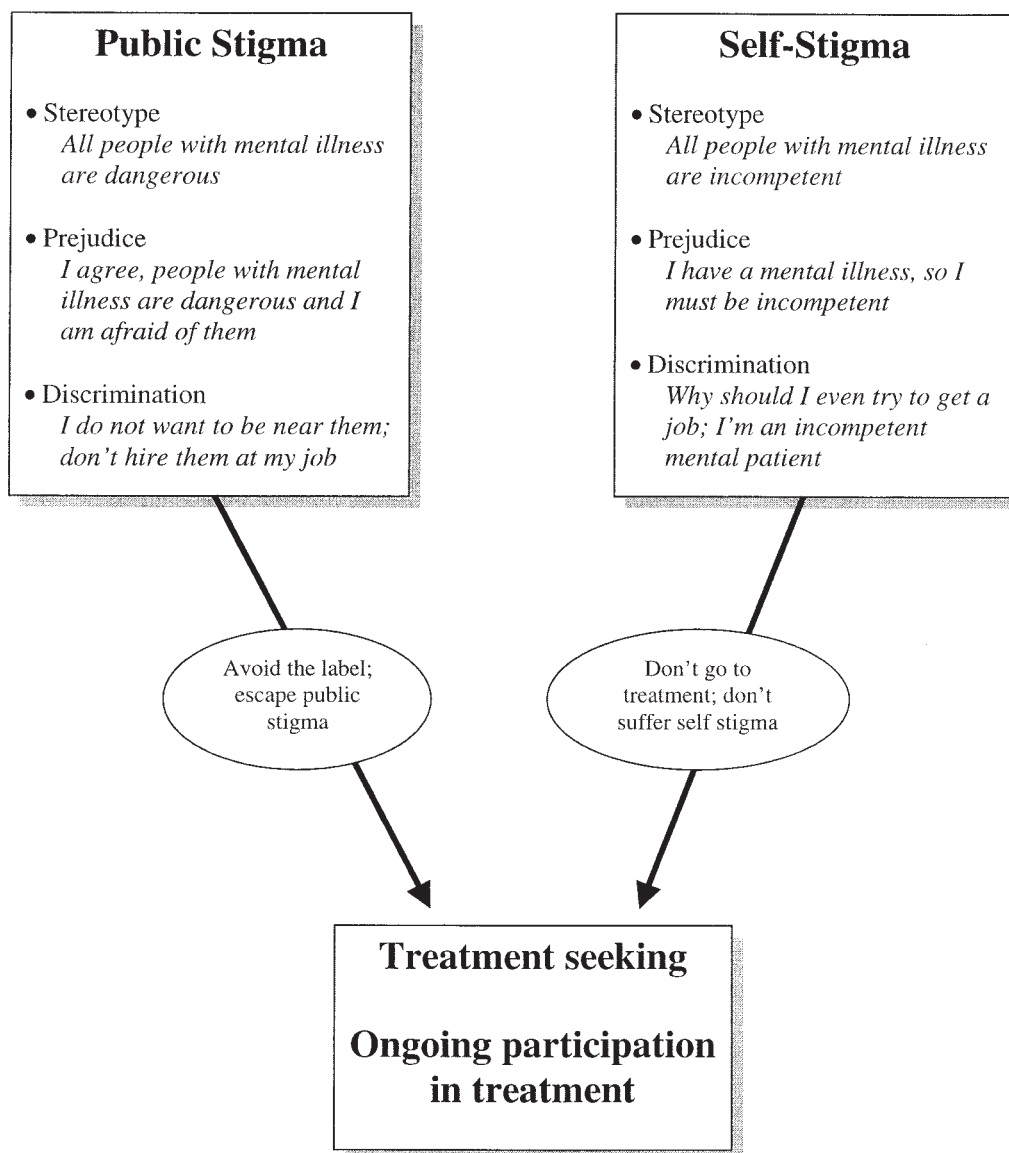
Stigma also influences the interface between mental illness and the criminal justice system. Criminalizing mental illness occurs when police, rather than the mental health system, respond to mental health crises, thereby contributing to the increasing prevalence of people with serious mental illness in jail (Watson, Ottati, Corrigan, & Heyrman, in press). Persons exhibiting symptoms and signs of serious mental illness are more likely than others to be arrested by the police (Teplin, 1984). Moreover, people with mental illness tend to spend more time incarcerated than those without mental illness (Steadman, McCarthy, & Morrissey, 1989). The growing intolerance of offenders in general has led to harsher laws and has hampered effective treatment planning for mentally ill offenders (Jemeka, Trupin, & Chiles, 1989; Lamb & Weinberger, 1998).

The negative impact of public stigma is also observed in the general health care system; 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. Druss and colleagues completed two studies on archival data that suggested people with mental illness receive fewer medical services than those not labeled in this manner (Desai, Rosenheck, Druss, & Perlin, 2002; Druss & Rosenheck, 1997). Moreover, studies by this group suggest that individuals with mental illness are less likely to receive the same range of insurance benefits as people without mental illness (Druss, Allen, & Bruce, 1998; Druss & Rosenheck, 1998). An additional study seems to implicate stigma more directly. Druss, Bradford, Rosenheck, Radford, and Krumholz (2000) examined the likelihood of a range of medical procedures after myocardial infarction in a sample of 113,653 individuals. Compared with the remainder of the sample, Druss et al. (2000) found that people identified with comorbid psychiatric disorder were significantly less likely to undergo percutaneous transluminal coronary angioplasty. Once again, mental illness is indicated as a barrier to receiving appropriate care.

Combined, this evidence suggests that public identification as "mentally ill" can yield significant harm. Research has suggested that people with concealable stigmas (people who are gay, of minority faith-based communities, or with mental illness) decide to avoid this harm by hiding their stigma and staying in the closet (Corrigan & Matthews, 2003). Alternatively, they may opt to avoid the stigma all together by denying their group status and by not seeking the institutions that mark them (i.e., mental health care). This kind of label avoidance is perhaps the most significant way in which stigma impedes care seeking.

Figure 1
Two Factors That May Influence Whether a Person Who Might Benefit From Mental Health Treatment Actually Seeks It

Public Stigma

- Stereotype
  All people with mental illness are dangerous

- Prejudice
  I agree, people with mental illness are dangerous and I am afraid of them

- Discrimination
  I do not want to be near them; don't hire them at my job

Avoid the label; escape public stigma

Self-Stigma

- Stereotype
  All people with mental illness are incompetent

- Prejudice
  I have a mental illness, so I must be incompetent

- Discrimination
  Why should I even try to get a job; I'm an incompetent mental patient

Don't go to treatment; don't suffer self stigma

Treatment seeking

Ongoing participation in treatment

Controlled social laboratory studies have demonstrated an inverse association between public stigma and care seeking. Results of one survey showed members of the general public who blamed individuals for their mental illness and withheld help to them were less likely to seek care for themselves (Cooper, Corrigan, & Watson, 2003). A second study showed an inverse relationship between stigmatizing attitudes and treatment adherence (Sirey, Bruce, Alexopoulos, Perlick, Raue, et al., 2001). In this study, stigma was measured using the Scale of Perceived Stigma (Link, Cullen, Struening, Shrout, & Dohrenwend,

1989). Scores on the Scale of Perceived Stigma were associated with whether 134 adults were compliant with their antidepressant medication regimen three months later. Findings on these small samples have been supported by additional population-based studies that frequently incorporated probability samples. One study on about 3,000 community residents is an example. Endorsing negative attitudes about mental illness inhibits personal service utilization in those at risk for psychiatric disorder (Leaf, Bruce, Tischler, & Holzer, 1987). Results from the National Comorbidity Survey identified several specific be-

liefs that might sway people from treatment (Kessler et al., 2001). These include concerns about what others might think and wanting to solve problems on one's own. These two studies were completed on adults. A third study using a national probability sample examined the influence of stigma on care seeking in adolescents (Penn et al., in press). The National Annenberg Risk Survey of Youth was conducted by telephone in the spring of 2002 with 900 respondents selected via random-digit dialing procedures. Results showed that adolescents who were more likely to endorse the stigma of mental illness were less likely to obtain care when needed. An additional interesting finding was that the connection between stigma and treatment seeking was mediated by perceptions about treatment success. Views about stigma were less relevant to care seeking when the adolescent believed treatment was likely to be successful. This result parallels another study done on adults with neurotic disorders; people in this group were less likely to seek treatment when they believed no one could help them (Meltzer et al., 2003).

Self-Stigma: Harm to Self-Esteem

People may also avoid the stigma of mental illness because of stigma's potential effects on one's sense of self. Living in a culture steeped in stigmatizing images, persons with mental illness may accept these notions and suffer diminished self-esteem, self-efficacy, and confidence in one's future (Corrigan, 1998; Holmes & River, 1998). Research shows that people with mental illness often internalize stigmatizing ideas that are widely endorsed within society and believe that they are less valued because of their psychiatric disorder (Link, 1987; Link & Phelan, 2001). Persons who agree with prejudice concur with the stereotype "That's right; I am weak and unable to care for myself!" Self-prejudice leads to negative emotional reactions; prominent among these is low self-esteem and low self-efficacy (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Markowitz, 1998). *Self-esteem* is typically operationalized as diminished views about personal worth (Corrigan, Faber, Rashid, & Leary, 1999; Rosenberg, 1965) and is often experienced as shame. Families frequently report an intense sense of shame secondarily as a result of a member's mental illness (Corrigan & Miller, 2004). *Self-efficacy* is defined as the expectation that one can successfully perform a behavior in a specific situation (Bandura, 1977, 1989). Low self-efficacy and demoralization has been shown to be associated with failing to pursue work or independent living opportunities at which people with mental illness might otherwise succeed (Link, 1982, 1987). Obviously, this kind of self-prejudice and self-discrimination significantly interferes with a person's life goals and quality of life.

Fundamental suppositions of social psychological research on prejudice suggest why self-stigma would dissuade people from being labeled and seeking treatment (Jost & Banaji, 1994). People in general are motivated to stigmatize others because of ego (Adorno, Frenkel-Brunswik, Levinson, & Sanford, 1950; Katz & Braly, 1935; Lippmann, 1922) or group enhancement (Tajfel, 1981).

Instead of thinking "I am not competent," individuals buffer their self- or group's image against interpersonal failings by viewing others as incompetent; in this case, people with mental illness (among the many possible stigmatized groups) are deficient. Hence, people avoid being labeled mentally ill, thereby escaping the negative statements that lessen self-esteem and self-efficacy.

Research has shown a significant relationship between shame and avoiding treatment. The measures used in the study by Sirey, Bruce, Alexopoulos, Perlick, Raue, et al. (2001)—the Scale of Perceived Stigma (Link et al., 1989)—included a proxy of shame. Research participants who expressed a sense of shame from personal experiences with mental illness were less likely to be involved in treatment. Family shame was also a significant predictor of treatment avoidance. Results of the Yale component of the ECA data (Leaf, Bruce, & Tischler, 1986) showed that respondents with psychiatric diagnoses were more likely to avoid services if they believed family members would have a negative reaction to these services, that is, if they learned from their family that being identified as mentally ill disgraced themselves and/or their family. Conversely, positive attitudes of family members were associated with greater service use in a sample of more than 1,000 drawn from a representative community sample and a group from a mental health clinic (Greenley, Mechanic, & Cleary, 1987). Hence, the potential of self-stigma can yield label avoidance and decreased treatment participation. A point made earlier in this article is reiterated here. What is presented as self-stigma here is clearly influenced by public stigma. Hence, the two constructs, and their impact on care seeking, are best understood in interaction.

Stigma and Diversity

Given concerns about diversity in the service system (e.g., some psychotherapies are not sensitive to differences in ethnicity), perhaps the impact of perceived stigma and service use is mediated by a third set of variables: demographics. A survey of 92 outpatients with depression tested this hypothesis by examining the effects of age on stigma perception and service use (Sirey, Bruce, Alexopoulos, Perlick, Friedman, & Meyers, 2001). Results showed that younger patients (under 65) were likely to perceive more stigmas about mental illness than a comparison group over 65. However, only the older group showed a significant association between perceived stigma and reluctance to participate in treatment. In another study, older adults with negative attitudes about mental health services were also shown to be less likely to talk to their primary care physician about psychiatric symptoms (Corrigan, Swantek, Watson, & Kleinlein, 2003).

Stigma and service utilization also seem to interact with the ethnic background of the potential consumer. Analyses of the ECA data, for example, suggest that European Americans with mental illness are more likely to use psychiatric services than African Americans or Hispanics (Narrow et al., 2000). It still needs to be clarified how much of this finding is due to public versus self-stigma in ethnic minorities. However, there is some evidence that

non-Caucasians are less likely to think that the medical system is a useful source of mental health treatment, perhaps reflecting basic prejudices in the health care system. This finding was supported in a recent qualitative study of African Americans in Chicago who reported that the church, rather than the mental health system, was often a better venue for mental health care (Matthews, Corrigan, Smith, & Rutherford, 2003). Moreover, persons with less education or income, a variable often conflated with ethnicity, express more concern about family reactions (Leaf et al., 1987).

Implications for Increasing Mental Health Care Seeking

This article argues that stigma represents a significant public health concern because it is a major barrier to care seeking or ongoing treatment participation. The evidence reviewed in this article vis-à-vis stigma and mental health care yields four sets of implications, which are explained in the subsequent sections.

Directions for Future Research

Existing bodies of research have extensively described why people might opt to avoid services because of stigma. Future research needs to build on this literature to develop a more cohesive paradigm for understanding the link between stigma and care avoidance. Six specific conundra need to be addressed in this research. First, determine how varying aspects of person-level stigma interfere with care seeking. Two elements of person stigma seem relevant from the literature review provided in this article. Some people might not seek treatment to avoid the public harm that results from labels. Alternatively, some people with mental illness may avoid the label to escape stigma's impact on their sense of self. Future research needs to determine the relative impact of these and other kinds of person-level stigma. Second, examine the impact of disease awareness. Many persons with psychotic disorders are unaware of the nature of their mental illness or its impact on the breadth of life functioning domains (Amador et al., 1994; Amador & Seckinger, 1997). As a result, some persons with mental illness may not realize they belong to a group of people who are stigmatized. Hence, they may be relatively immune to person-level stigma. Research examining the impact of stigma on care seeking should include awareness as a covariate.

Third, demonstrate causal relationships where existing studies have examined fundamentally correlational ones. Research reviewed in this article, for example, has shown that people who endorse some aspect of person-level stigma are less likely to admit to care seeking. Unclear from this research is whether this association represents a causal effect of stigma or some other relationship implied by correlation. Future research needs to include experimental or multipanel designs to test the causality of these relationships. Fourth, incorporate behavioral proxies for care seeking. For the most part, past research has used self-report to assess care seeking even though care seeking is fundamentally a behavior. Future research should incorporate measures of actual behavior, including direct observation, to find out whether stigma attitudes impede people from seeking care. Prospective designs, in particular, may be useful; over a period of time, determine how preexisting attitudes influence care seeking as the person needs mental health services.

Fifth, adopt broader models of care seeking. To focus the discussion of the article, I limited care seeking here in terms of the original decision to obtain treatment or maintain ongoing participation. Services researchers have framed this issue into the much broader construct of illness career, which includes problem recognition, care initiation, ongoing treatment adherence, and treatment exit framed within an undulating course (Pescosolido, Grauerholz, & Milkie, 1997; Pescosolido et al., 1999). Further research into the stigma–care seeking link needs to incorporate broader models of illness career. In a similar vein, researchers need to remember that the idea of care exceeds traditional mental health settings. Future research must also determine how care in other settings—primary health care, faith-based initiatives, or consumer operated programs (i.e., programs developed by people with mental illness for people with mental illness)—influences the stigma–care link. Faith-based communities, for example, provide a congregation of supportive peers rather than an identity of "mental patient" that corresponds with hospitalization.

Finally, use research methods that incorporate micro- and macrolevel variables. Integrating psychological and sociological constructs into a common model offers interesting methodological conundra (Corrigan, Markowitz, & Watson, in press). For example, units of analysis relevant to social cognition almost exclusively represent the individual and include proxies of cognitive content and processes, as well as emotions, related to stigmatizing attitudes plus the behavioral consequences of these attitudes. Structural discrimination involves processes that typically represent collective and macrolevel units rather than individuals; for example, how the insurance systems of national governments limit mental health benefits. The aggregate of individual properties serves as an index of macrolevel constructs.

The macro-to-micro link was an important research agenda of sociologists in the first half of the 20th century (Blau, 1960; Faris & Dunham, 1939). However, analyses of this form diminished in the 1970s after a series of critiques concluded that only a small amount of variance in individual-level variables is attributable to macrolevel variables (Alexander & Griffin, 1976; Hauser, 1977). Liska (1990) responded to this criticism by arguing that although macrovariables might account for relatively minor variance in microlevel individual variables (especially compared with other psychological predictors), the social scientist should not overlook the conceptual importance of macrolevel variables per se. Presence of a mental health parity law is still theoretically important to understanding the impact of insurance benefits. Hence, the interesting research question may not be whether macrovariables account for more variance than microvariables in a group's experience of stigma

and willingness to access services, but rather whether Macrovariable A accounts for significantly more variance than Macrovariable B and thereby seems to have a bigger role as a macrovariable in explaining the individual's experience of stigma. Future research efforts need to further struggle with the multiple levels of methodological possibilities.

Strategies That Diminish Stigma

Programs that decrease stigma will reduce the attitudes and behaviors that might be barriers to care seeking. Corrigan and Penn (1999) identified three approaches that may diminish aspects of the public stigma experienced by people with mental illness: protest, education, and contact. Groups protest inaccurate and hostile representations of mental illness as a way to challenge the stigmas they represent. These efforts send two messages: to the media, stop reporting inaccurate representations of mental illness; to the public, stop believing negative views about mental illness. Largely anecdotal evidence suggests that protest campaigns have been effective in getting stigmatizing images of mental illness withdrawn (Wahl, 1995). However, controlled studies on changing the stigmatizing attitudes of individuals suggest that protest may actually cause attitude rebound in the stigmatizing beliefs of the public (Corrigan, River, et al., 2001; Macrae, Bodenhausen, Milne, & Jetten, 1994). Instead of decreasing stigma, reactance seems to occur ("don't tell me what to think") and negative attitudes worsen.

Protest attempts to diminish negative attitudes about mental illness but fails to promote more positive attitudes that are supported by facts. Education provides information so that the public can make more informed decisions about mental illness. Research on education related to mental illness stigma has suggested that participation in these kinds of programs has led to improved attitudes about persons with these problems (Corrigan, River, et al., 2001; Holmes, Corrigan, Williams, Canar, & Kubiak, 1999; Keane, 1990; Morrison, Cocozza, & Vanderwyst, 1980; Penn et al., 1994). Given the research that suggests having confidence in treatment diminishes the negative impact of stigma on treatment seeking (Meltzer et al., 2003; Penn et al., in press), education programs should also reflect evidence about the success of treatment participation. Unfortunately, research also suggests that the effects of education may not endure over time (Corrigan et al., 2002).

Stigma is further diminished when members of the general public have contact with people with mental illness who are able to hold down jobs or live as good neighbors in the community (Corrigan, Edwards, Green, Diwan, & Penn, 2001; Corrigan et al., 2002; Pinfold et al., 2003; Schulze, Richter-Werling, Matschinger, & Angermeyer, 2003). Hence, opportunities for the public to meet persons with severe mental illness may discount stigma. The research question of particular interest here is how attitudes that may change as a result of these antistigma programs increase care seeking for persons in need.

Diminishing self-stigma. In this article, I also highlighted poor treatment adherence as another public health concern that might be exacerbated by stigma. Consumer advocates (Chamberlin, 1978; Deegan, 1990) have argued, and research (McCubbin & Cohen, 1996; Rappaport, 1987) seems to support the idea, that many psychosocial and medical treatments disempower people; as a result, people in need decide to not fully participate in services. People with mental illness who self-stigmatize tend to report little personal empowerment in terms of treatment and hence participation in treatment is diminished. As a result, interventions that challenge self-stigma and facilitate empowerment are likely to improve adherence (Corrigan & Calabrese, in press; Speer, Jackson, & Peterson, 2001). Professionals must be able to recognize what adherence means in this context; not blind compliance with whatever the therapist prescribes but active participation and engagement in all aspects of care. Consumer operated self-help services are among the best examples of practices that facilitate empowerment (Davidson et al., 1999).

Implications for advocacy. Many groups have called for antistigma programs to increase care seeking for people in need of mental health services; these include most of the professional mental health associations, the National Alliance for the Mentally Ill, the Mental Health Association, the Center to Address Discrimination and Stigma, and the Eliminate the Barriers Initiative (the last two represent Substance Abuse and Mental Health Services Administration-funded national projects with eliminating stigma as the primary goal). Explaining the relationship between stigma and care provides necessary information for antistigma programs. Given the APA's interest in the public health agenda, how might the association proceed given the position of these advocacy groups? It is important to note that advocacy groups do not speak with a single voice in terms of the stigma question and sometimes represent opposing views. For example, the Treatment Advocacy Center promotes the notion that untreated mental illness leads to great community violence. Advocacy groups like the National Stigma Clearinghouse believe this kind of message makes stigma worse. Hence, there is not a transparent agenda to which the APA might consider joining. Instead, advocacy efforts need more research to better understand stigma and ways to effectively reduce it. APA members should use its theoretical and methodological prowess to advance this goal.

Stigma as Social Cognition Is Only One of the Barriers

Stigma as a social–cognitive construct is only one of several stigma-related factors that undermine obtaining mental health care when in need. Services researchers have examined other interpersonal, economic, and policy factors that also mitigate service use. One manifestation of these factors is structural stigma; namely, economic and political pressures on the culture, rather than psychological influences on the individual, that yield discrimination and undermine care access (Corrigan et al., in press; Link & Phelan, 2001). Rather than stereotypes, prejudice, and discrimination, the products of these forces are social and institutional structures that rob people of opportunities.

Structural stigma develops during historical epochs that can be centuries long rather than the few years that might describe an individual's developmental period.

Although a thorough discussion of structural stigma is beyond the scope of this article, brief examples provide an illustration. Sociologists have identified legislative activities that are examples of intended structural stigma as applied to African Americans (Hill, 1988; Wilson, 1990). Jim Crow laws passed by many of the southern states after the Civil War restricted voting rights and other civil liberties of American Blacks. A store clerk who did not serve a Black customer may not have been acting out her own prejudice but instead complying with the law. Unfortunately, research suggests similar patterns still exist in terms of mental illness. Approximately one third of the 50 states restrict the rights of an individual with mental illness to hold elective office, participate on juries, and vote (Burton, 1990; Corrigan, Watson, Heyrman, et al., 2004; Hemmens, Miller, Burton, & Milner, 2002). Even greater limitations are evident in the family domain. About 50% of states restrict the child custody rights of parents with mental illness. It is important to note that these legal restrictions frequently do not reflect societal concerns about whether a person with psychiatric disabilities is incompetent to assume these social privileges. Instead, it is the label per se that leads to loss of these important opportunities.

Threats to confidentiality may also be an example of intended structural discrimination, especially relevant to care seeking. Many people may avoid mental health services because they fear that confidential information about their psychiatric history may become known to groups to whom they would opt to not disclose. For example, separated spouses in child custody battles may fear that confidentiality protections will not keep their mental health records out of court. Prospective employees who need security clearance as part of being hired may be concerned about private health information being disclosed to employers. Congress passed the Health Insurance Portability and Accountability Act in 1996 to offer further confidentiality protections. However, despite these kinds of protections, future research needs to determine public protections about confidentiality and the impact of these perceptions on care seeking.

Structural stigma may also result from unintended consequences. Pincus (1999) provided some useful examples. Many universities and colleges use the Scholastic Achievement Test (SAT) to limit admission to students who have earned high scores, believing this to be an unbiased way to select students. However, given that African American and Hispanic students typically score lower than Caucasians on these tests, universities that rely on the SAT and ACT admissions are likely to disproportionately favor admission of Caucasians over African American and Hispanic students. Alternatively, many large companies require job applicants to have a bachelor's degree, even though the kinds of skills this degree entails are sometimes not relevant to specific positions. Given that African Americans entering the job market have a much lower rate of college degrees, they are less likely to access these kinds of

jobs. Many insurance companies adjust claims and premiums on the basis of area crime rates. Given that crime rates are generally higher in Black communities, African Americans are likely to pay significantly more for the same level of coverage. It is important to note in each case that the goal was actually to be color blind, but the result was discrimination against people of color.

I have argued that the federal government's inability to move ahead on mental health parity (e.g., require private insurers to equate lifetime and annual limits on mental health benefits at a similar level as medical and surgical benefits) is one example of unintended structural stigma as applied to mental illness (Corrigan et al., in press). Opponents of the Mental Health Parity Act are not against it because they believe people with mental illness are to blame for their illness and, therefore, are not deserving of these kinds of protections. Rather, they cite financial concerns that are frequently at the root of structural discrimination. Lobbyists for the business sector argued that parity requirements could bankrupt small businesses by raising health care costs (Levinson & Druss, 2000). The inability to shake business concerns despite evidence to the contrary is an example of the ongoing influence of structural stigma.

An Issue of Social Justice

Framing stigma as a prominent public health concern has led to defining the problem vis-à-vis the medical model. Proponents of this model have argued that treatments that eliminate or otherwise control the disease will help to eradicate the accompanying stigma (Sartorius, Byrne, & Smith, 2003). They point to broad improvement in public attitudes toward diseases like leprosy, small pox, and tuberculosis with greatly diminished incidence and prevalence rates, as well as illnesses like AIDS and cancer with vastly improved treatments. Hence, stigma should diminish (and care seeking should improve) as specific mental illnesses are eliminated or controlled.

Although improving treatments may yield secondary effects including diminished prejudice and discrimination, framing mental illness stigma as a medical concern may also exacerbate the problem. Antistigma programs solely reflecting the medical perspective may have unintended consequences (Corrigan, Watson, Byrne, & Davis, 2004). The public may view mental illness as a genetic condition from which the person does not recover (Phelan, Cruz-Rojas, & Reiff, 2002). It might suggest the harm caused by stigma has greater impact on the mental health system rather than the person with mental illness. It might foster pity rather than parity. It places responsibility for the stigma on the person with mental illness rather than where it belongs—on the public.

When viewed in terms of the prejudice and discrimination experienced by other out-groups, such as ethnicity and gender, stigma is better understood as an issue of social injustice. On the basis of sociological research, a social injustice perspective argues that many of the lost opportunities experienced by people with mental illness result from the difference and defects suggested by stigma. Exaggerated notions of group difference result in less power for

people with mental illness. Most readers would protest any policy that suggested the best way to deal with the prejudice experienced by gays and lesbians would be to correct their sexual orientation. Framing stigma as social injustice expands understanding of the phenomena as well as broadens the approach to erasing stigma. Ultimately, it may be the integration of public health and social injustice models that leads to the greatest challenges to stigma. Psychologists and other social scientists need to partner with advocates to identify the best strategies to bring about these goals.

Summary

Research suggests that stigma may impede people from seeking or fully participating in mental health services. In particular, the threat of social disapproval or diminished self esteem that accompanies the label may account for underused services. Advocacy and government groups have strongly endorsed resolving the stigma of mental illness as a way to improve service use. The report of President Bush's New Freedom Commission highlighted antistigma programs as a primary goal to improve the mental health system (M. F. Hogan, 2003). A better understanding of the problem of stigma is needed to inform the development of these antistigma programs. Several areas for development of the research agenda were reviewed in this article. Psychologists who are able to embrace this research agenda will help advocates to better tackle the stigma problem and will significantly advance treatment use in turn.

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