CanJPsychiatry 2012;57(8):464–469

In Review

On the Self-Stigma of Mental Illness: Stages, Disclosure, and Strategies for Change

Patrick W Corrigan, PsyD[1]; Deepa Rao, PhD, MA[2]

[1] Distinguished Professor and Associate Dean for Research, College of Psychology, Illinois Institute of Technology, Chicago, Illinois. Correspondence: Illinois Institute of Technology, 3424 South State Street, Chicago, IL 60616; corrigan@iit.edu.

[2] Research Assistant Professor, Department of Global Health, University of Washington, Seattle, Washington.

Key Words: self-stigma, stigma reduction, mental illness, empowerment

Manuscript received and accepted January 2012.

People with mental illness have long experienced prejudice and discrimination. Researchers have been able to study this phenomenon as stigma and have begun to examine ways of reducing this stigma. Public stigma is the most prominent form observed and studied, as it represents the prejudice and discrimination directed at a group by the larger population. Self-stigma occurs when people internalize these public attitudes and suffer numerous negative consequences as a result. In our article, we more fully define the concept of self-stigma and describe the negative consequences of self-stigma for people with mental illness. We also examine the advantages and disadvantages of disclosure in reducing the impact of stigma. In addition, we argue that a key to challenging self-stigma is to promote personal empowerment. Lastly, we discuss individual- and societal-level methods for reducing self-stigma, programs led by peers as well as those led by social service providers.

Les personnes souffrant de maladie mentale font depuis longtemps l'objet de préjugés et de discrimination. Les chercheurs ont pu étudier ce phénomène comme étant celui des stigmates, et ont commencé à examiner des façons de réduire ces stigmates. Les stigmates du public sont la forme prédominante qui a été observée et étudiée, car elle représente les préjugés et la discrimination dirigés vers un groupe par l'ensemble de la population. L'auto-stigmatisation se produit lorsque les gens internalisent ces attitudes du public et par la suite, souffrent de nombreuses conséquences négatives. Dans notre article, nous définissons plus complètement le concept de l'auto-stigmatisation et décrivons les conséquences négatives que l'auto-stigmatisation provoque chez les personnes souffrant de maladie mentale. Nous examinons aussi les avantages et désavantages de la divulgation pour réduire l'effet des stigmates. En outre, nous alléguons qu'un moyen de défier l'auto-stigmatisation consiste à promouvoir l'habilitation personnelle. Enfin, nous présentons des méthodes au niveau individuel et sociétal de réduire l'auto-stigmatisation, des programmes menés par les pairs ainsi que ceux menés par des prestataires de services sociaux.

In making sense of the prejudice and discrimination experienced by people with mental illnesses, researchers have come to distinguish public stigma from self-stigma.[1] Public stigma is what commonly comes to mind when discussing the phenomenon, and represents the prejudice and discrimination directed at a group by the population. Public stigma refers to the negative attitudes held by members of the public about people with devalued characteristics. Self-stigma occurs when people internalize these public attitudes and suffer numerous negative consequences as a result.[2] In our article, we seek to more fully define self-stigma, doing so in terms of a stage model. We will argue that a key to challenging self-stigma is to promote personal empowerment. One way to do this is through disclosure, the strategic decision to let others know about one's struggle toward recovery. Then, we will discuss individual and societal level methods for reducing self-stigma.

Defining Self-Stigma

While acknowledging the role of societal and interpersonal processes involved in stigma creation, social psychologists study stigma as it relates to internal and subsequent behavioural processes that can lead to social isolation and ostracism.[3] Stereotypes are the way in which humans categorize information about groups of people. Negative stereotypes, such as notions of dangerousness or incompetence, often associated with mental illness, can be harmful to people living with mental illnesses. Most people

people have knowledge of particular stereotypes because they develop from, and are defined by, societal characterizations of people with certain conditions. Although broader society has defined these stereotypes, people may not necessarily agree with them. People who agree with the negative stereotypes develop negative feelings and emotional reactions; this is prejudice. For example, a person who believes that people with schizophrenia are dangerous may ultimately describe feeling fearful of those with serious mental illness (SMI). From this emotional reaction comes discrimination, or the behavioural response to having negative thoughts and feelings about a person in a stigmatized outgroup. A member of the general public may choose to remain distant from a person with mental illness because of their fear (prejudice) and belief (stereotype) that the person with mental illness is dangerous.

People who live with conditions such as schizophrenia are also vulnerable to endorsing stereotypes about themselves, which is self-stigma. It is comprised of endorsement of these stereotypes of the self (for example, "I am dangerous"), prejudice (for example, "I am afraid of myself"), and the resulting self-discrimination (for example, self-imposed isolation). Once a person internalizes negative stereotypes, they may have negative emotional reactions. Low self-esteem and poor self-efficacy are primary examples of these negative emotional reactions.[4] Self-discrimination, particularly in the form of self-isolation, has many pernicious effects leading to decreased health care service use, poor health outcomes, and poor quality of life.[5,6] Poor self-efficacy and low self-esteem have also been associated with not taking advantage of opportunities that promote employment and independent living.[7] Link et al[8] called this modified labelling theory; contrasting classic notions of the label (see Gove[9,10]), Link et al noted that people who internalize the stigma of mental illness worsen the course of their illness because of the harm of the internalized experience, per se. Self-stigmatization diminishes feelings of self-worth, such that the hope in achieving goals is undermined. Thus the harm of self-stigma manifests itself through an intrapersonal process, and ultimately, through poor health outcomes and quality of life.[2,4]

A Stage Model of Self-Stigma

Self-stigma has often been equated with perceived stigma; for example, a person's recognition that the public holds prejudice and will discriminate against them because of their mental illness label.[7] In particular, perceived devaluation and discrimination is thought to lead to diminished self-esteem and -efficacy. We believe this to actually be the first stage of a progressive model of self-stigma (Figure 1). As such, we see the process of internalizing public stigmas as occurring through a series of stages that successively follow one another.[2,4,10,11] In the general model, a person with an undesired condition is aware of public stigma about their condition (Awareness). This person may then agree that these negative public stereotypes are true about the group (Agreement). Subsequently, the person concurs that these stereotypes apply to him- or herself (Application). This may lead to harm and to significant decreases in self-esteem and -efficacy (Harm). Unlike other research on self-stigma,[12,13] the stage model shows that pernicious effects of stigma on the self do not occur until later stages. Not until the person applies the stigma, does harm to self-esteem or -efficacy occur.

Clinical Implications

- Self-stigma can significantly impact overall health outcomes.
- Techniques and interventions have been developed to help a person reduce self-stigma.

Limitations

- Although interventions have been developed to help a person reduce self-stigma, there are limited studies on the validation of these interventions and their adaptations for specific populations.
- Future research needs to continue to evaluate programs that promote empowerment to reduce self-stigma.

One of the challenges of a stage model of self-stigma is sorting out the effects of later stages from those of depression, which is frequently experienced among people with SMI.[14] Other staged models of behaviour suggest that any individual stage is most strongly influenced by the immediately preceding one.[15] Thus to fully understand stigma's contribution to poor health outcomes, research must crosswalk specific stages with common antecedents of poor outcomes, such as depressive symptoms. In this way, the effects of internalized stigma on self-esteem can be partialled out from other causes of depression.

The Why Try Effect

A related consequence of self-stigmatization is what has been called the why try effect, in which self-stigmatization interferes with life goal achievement.[11] Self-stigma functions as a barrier to achieving life goals. However, self-esteem and -efficacy can reduce the harmful results of self-stigma. Diminished self-esteem leads to a sense of being less worthy of opportunities, which undermines efforts at independence, such as obtaining a competitive job.

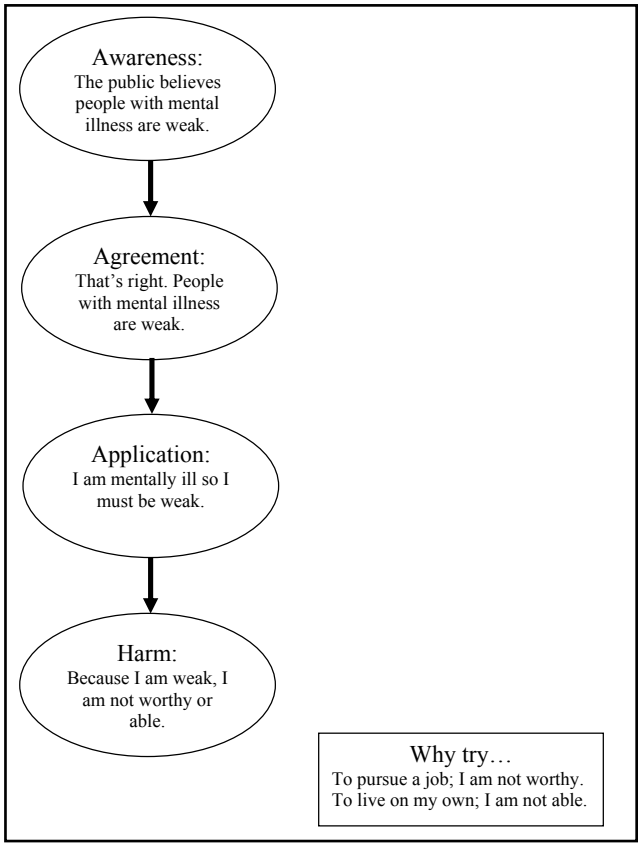
> Why should I seek a job as an accountant? I am not deserving of such an important position. My flaws should not allow me to take this kind of a job from someone who is more commendable.

Alternatively, decrements to self-efficacy can lead to a why try outcome based on a person's belief that he or she is incapable of achieving a life goal.

> Why should I attempt to live on my own? I am not able to be independent. I do not have the skills to manage my own home.

Why try is a variant of modified labelling theory,[8] in which the social rejection linked to stigmatization contributes to

Figure 1 The stage model of self-stigma



low self-esteem. Modified labelling theory also suggests avoidance as a behavioural consequence of devaluation. When people perceive devaluation, they may avoid situations where public disrespect is anticipated.

Challenging Self-Stigma

There is a paradox to self-stigma.[16] Some people with mental illness internalize it and suffer the harm to self-esteem, self-efficacy, and lost goals. However, many others seem oblivious to its effects and report no pain. Yet another group is especially interesting: people who seem to report righteous indignation at the injustice of stigma. It is this third group that may suggest an antidote to self-stigma: personal empowerment. Empowering people seems to be an effective way of reducing self-stigmatization, encourage people to believe they can achieve their life goals, and circumvent further negative consequences that result from self-stigmatizations. In a sense, empowerment is the flip side of stigma, involving power, control, activism, righteous indignation, and optimism. Investigations have shown empowerment to be associated with high self-esteem, better quality of life, increased social support, and increased satisfaction with mutual-help programs.[17–19] Thus empowerment is the broad manner by which we can reduce stigma. In the remainder of our article, we describe the specific mechanisms that are involved with empowering people as ways to decrease self-stigma.

Disclosure: The First Step

Many people deal with self-stigma by staying in the closet; they are able to shelter their shame by not letting other people know about their mental illness. One way for a person to promote antistigma and counter the shame is to come out, to let other people know about their psychiatric history. Research has interestingly shown that coming out of the closet with mental illness is associated with decreased negative effects of self-stigmatization on quality of life, thereby encouraging people to move toward achieving their life goals.[20] When people are open about their condition, worry and concern over secrecy is reduced; they may soon find peers or family members who will support them, even after knowing their condition, and they may find that their openness promotes a sense of power and control over their lives.[21] Still, being open about one's condition can have negative implications. Openness may bring about discrimination by members of the public, any relapses may be more widely known than preferred, and therefore more stressful, and in some cases, disclosure may be more isolating. For example, in India, documentation of mental illness is grounds for divorce, a situation that some would consider a form of institutionalized stigma.[22,23] A person with mental illness in India may feel doubly stressed by the threat of divorce and further public discrimination. Deciding to disclose is ultimately a very personal decision, closely tied to the cultural context, and requires thorough consideration of the potential benefits and consequences.

Coming out is not a black-and-white decision. There are strategies that vary in risk for handling disclosure, which are summarized in Figure 2.[24,25] At the most extreme, people may stay in the closet through social avoidance. This means keeping away from situations where people may find out about one's mental illness. Instead, they only associate with other people who have mental illness. It is protective (no one will find out the shame) but obviously also very restrictive. Others may choose not to avoid social situations but instead to keep their experiences a secret. An alternative version of this is selective disclosure. Selective disclosure means there is a group of people with whom private information is disclosed and a group from whom this information is kept secret. While there may be benefits of selective disclosure, such as an increase in supportive peers, there is still a secret that could represent a source of shame. People who choose indiscriminant disclosure abandon the secrecy. They make no active efforts to try to conceal their mental health history and experiences. Hence they opt to disregard any of the negative consequences of people finding out about their mental illness. Broadcasting one's experience means educating people about mental illness. The goal here is to seek out people to share past history and current experiences with mental illness. Broadcasting has additional benefits, compared with indiscriminant disclosure. Namely, it fosters

their sense of power over the experience of mental illness and stigma.

Methods of Reducing Stigma

There are other strategies that people living with mental illness can use to cope with the negative consequences of self-stigmatization. A caution needs to be sounded first. In trying to help people learn to overcome self-stigma, advocates need to make sure they do not suggest that the stigmatization is the person's fault, that having self-stigma is some kind of flaw like other psychiatric symptoms that the person needs to correct. Stigma is a social injustice and an error of society. Hence eradicating it is the responsibility, and should be the priority, of that society. In the meantime, people with mental illness may wish to learn ways to live with, or compartmentalize, that stigma. However, curing it lies with the community in which one lives. Hence erasing public stigma may be a broad-based fix of the stigma problem. What we broach here are more narrowly focused efforts to help people who are bothered by internalized stigma.

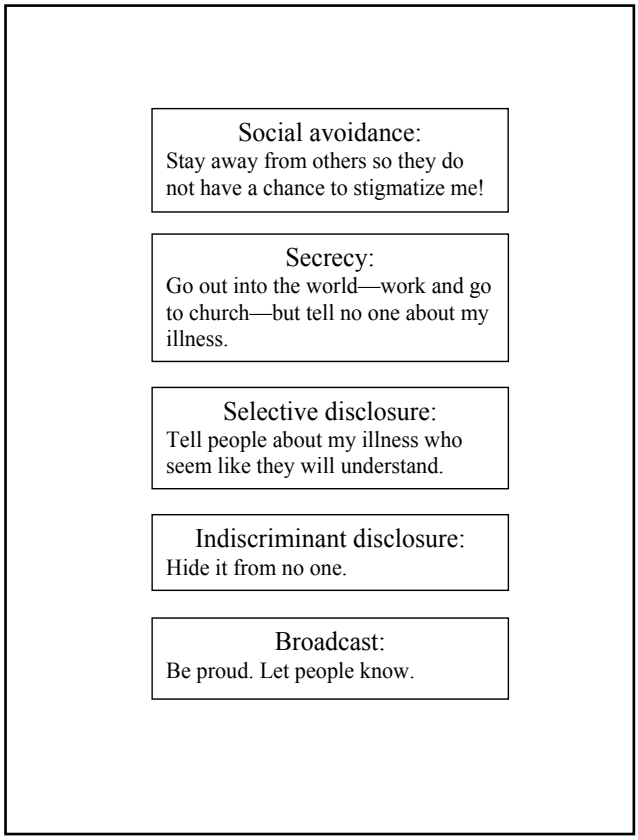
Manualized approaches to self-stigma reduction for people with mental illnesses are in development. One promising approach is the Ending Self-Stigma intervention,[26] which uses a group approach to reduce self-stigmatization. The intervention meets as a group for 9 sessions, with materials covering education about mental health, cognitive-behavioural strategies to impact the internalization of public stigmas, methods to strengthen family and community ties, and techniques for responding to public discrimination. The cognitive-behavioural strategies rest on insights from cognitive therapy[27] that frame self-stigma as irrational self-statements (for example, "I must be a stupid person because I get depressed") that the person seeks to challenge (for example, "Most other people do not think depressed people are stupid"). These kinds of challenges lead to counters—pithy statements people may use the next time they catch themselves self-stigmatizing.

> There I go again. Just because I got depressed last fall does not mean I am stupid and incapable of handling a job. I have struggles just like everyone else.

A pilot study of the intervention showed that internalized stigma was reduced and perceived social support increased after participation in the weekly intervention.[26]

A good example of a societal-level approach that may also benefit a person is the In Our Own Voice program, developed by the National Alliance on Mental Illness in the United States. This intervention involves a manualized group approach for targeted groups of the general population. Testimonials by people with mental illness are the key to stigma reduction in this program. Participants of the intervention can be, for example, health care professionals, church congregations, and students. Research has shown the program's effectiveness in reducing negative attitudes toward people with mental illness, in its long and short versions.[11] If programs such as these help to reduce public stigmas around mental illness, possible prejudices that a person with mental illness perceives and internalizes would be reduced, thus indirectly impacting self-stigma. In addition, the people providing testimonials as part of the intervention feel empowered by the activist role they play in advocating for themselves, thereby reducing self-stigma as the program is implemented.

Figure 2 A hierarchy of disclosure strategies



Peer Support

Consumer-operated programs offer another way for people with SMI to enhance their sense of empowerment.[28] Groups such as these provide a range of services, including support for people who are just coming out, recreation and shared experiences that foster a sense of community within a larger hostile culture, and advocacy and (or) political efforts to further promote group pride.[28] Several forces have converged during the past century to foster consumer-operated services for people with psychiatric disabilities. Some reflect dissatisfaction with mental health services that disempower people by providing services in restrictive settings. Others represent a natural tendency of people to seek support from others with similar problems. Recently, various consumer-operated service programs have developed, including: drop-in centres, housing programs, homeless services, case management, crisis response,

benefit acquisition, antistigma services, advocacy, research, technical assistance, and employment programs.[28,29] Results of a qualitative evaluation of consumer-operated programs showed that participants in these programs reported improvements in self-reliance and independence; coping skills and knowledge; and feelings of empowerment.[29] Future research needs to isolate the active ingredients of consumer-operated services that lead to positive change.

Conclusions

Stigma is a societal creation—what social psychologists have come to describe as prejudice and discrimination. Unfortunately, some people with SMI internalize the stigma and suffer significant blows to self-esteem and -efficacy. However, self-stigma is not an inevitable curse. People in a stigmatized group do not necessarily turn that stigma onto themselves. Consider research about racism affecting the African-American community. Classic psychological models believed African Americans to have lower self-esteem than White Americans because the former internalized the biases and prejudices about them that dominated in the culture of the latter.[30,31] Research consistently fails to show this, and, in fact, may suggest the obverse; African Americans may have higher self-esteem than White Americans.[32–37] How can this be? African Americans will report they are aware of White Americans prejudice but do not believe it actually applies to themselves. In fact, many African Americans report White Americans ignorance can be a personal rallying cry for their personal sense of empowerment and a wake-up call for their community.

The lesson seems to apply to self-stigma for mental illness, too. Internalizing prejudice and discrimination is not a necessary consequence of stigma. Many people recognize stigma as unjust and, rather than being swept away by it, take it on as a personal goal to change. Many others are unaware or unmotivated by the phenomenon altogether. However, there are people who seem to apply the prejudice to themselves and suffer lessened self-esteem and -efficacy. These people may benefit from structured programs to learn to challenge the irrational statements that plague their self-identity. They may benefit from joining groups of peers who have successfully tackled the stigma. They may benefit from a strategic program to come out about their stigma. Research needs to continue to identify and evaluate programs that promote empowerment at the expense of self-stigma.

Acknowledgements

This work was supported, in part, by US National Institutes of Mental Health grant 08598–01. Dr Rao is supported by a US National Institutes of Health career development award, K23 MH 084551.

The Canadian Psychiatric Association proudly supports the In Review series by providing an honorarium to the authors.

References

1. Corrigan PW. On the stigma of mental illness: practical strategies for research and social change. Washington (DC): American Psychological Association; 2005.
2. Corrigan PW, Watson A, Barr L. The self-stigma of mental illness: implications for self-esteem and self-efficacy. J Soc Clin Psychol. 2006;25(9):875–884.
3. Phelan JC, Link BG, Dovidio JF. Stigma and prejudice: one animal or two? Soc Sci Med. 2008;67(3):358–367.
4. Watson AC, Corrigan PW, Larson JE, et al. Self-stigma in people with mental illness. Schizophr Bull. 2007;33(6):1312–1318.
5. Sirey JA, Bruce ML, Alexopoulos GS, et al. Stigma as a barrier to recovery: perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence. Psychiatr Serv. 2001;52(12):1615–1620.
6. Sirey JA, Bruce ML, Alexopoulos GS, et al. Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. Am J Psychiatry. 2001;158(3):479–481.
7. Link B. Understanding labeling effects in the area of mental disorders: an assessment of the effects of expectations of rejection. Am Sociol Rev. 1987;52:96–112.
8. Link B, Cullen F, Struening E, et al. A modified labeling theory approach to mental disorders: an empirical assessment. Am Sociol Rev. 1989;54(3):400–423.
9. Gove WR. Labelling and mental illness: a critique. In: Gove WR, editor. The labeling of deviance: evaluating a perspective. 2nd ed. Beverly Hills (CA): Sage; 1980. p 53–99.
10. Gove WR. The current status of the labeling theory of mental illness. In: Gove WR, editor. Deviance and mental illness. Beverly Hills (CA): Sage; 1982.
11. Corrigan P, Larson J, Rusch N. Self-stigma and the "why try" effect: impact on life goals and evidence-based practices. World Psychiatry. 2009;8(2):75–81.
12. Corrigan PW, Watson AC. The paradox of self-stigma and mental illness. Clin Psychol Sci Pract. 2002;9:35–53.
13. Ritsher JB, Otilingam PG, Grajales M. Internalized stigma of mental illness: psychometric properties of a new measure. Psychiatry Res. 2003;121:31–49.
14. Ritsher JB, Phelan JC. Internalized stigma predicts erosion of morale among psychiatric outpatients. Psychiatry Res. 2004;129:257–265.
15. Butler A, Hokanson J, Flynn H. A comparison of self-esteem lability and low trait self-esteem as vulnerability factors for depression. J Pers Soc Psychol. 1994;66:166–177.
16. Perz C, DiClemente C, Carbonari J. Doing the right thing at the right time? The interaction of stages and processes of change in successful smoking cessation. Health Psychol. 1996;15(6):462–468.
17. Corrigan PW, Faber D, Rashid F, et al. The construct validity of empowerment among consumers of mental health services. Schizophr Res. 1999;38:77–84.
18. Rogers E, Chamberlin J, Ellison M. A consumer-constructed scale to measure empowerment among users of mental health services. Psychiatr Serv. 1997;48:1042–1047.
19. Rogers ES, Ralph RO, Salzer MS. Validating the empowerment scale with a multisite sample of consumers of mental health services. Psychiatr Serv. 2010;61:933–936.
20. Corrigan P, Morris S, Larson J, et al. Self-stigma and coming out about one's mental illness. J Community Psychol. 2010;38:259–272.
21. Corrigan P, Roe D, Tsang H. Challenging the stigma of mental illness. Hoboken (NJ): John Wiley and Sons, Ltd; 2011.
22. Thara R, Kamath S, Kumar S. Women with schizophrenia and broken marriages—doubly disadvantaged? Part I: patient perspective. Int J Soc Psychiatry. 2003:49(3):225–232.
23. Thara R, Kamath S, Kumar S. Women with schizophrenia and broken marriages—doubly disadvantaged? Part II: family perspective. Int J Soc Psychiatry. 2003;49(3):233–240.
24. Corrigan PW, Lundin RK. Don't call me nuts! Coping with the stigma of mental illness. Tinley Park (IL): Recovery Press; 2001.

25. Herman NJ. Return to sender: reintegrative stigma-management strategies of expsychiatric patients. J Contemp Ethnogr. 1993;22:295–330.
26. Lucksted A, Drapalski A, Calmes C, et al. Ending self-stigma: pilot evaluation of a new intervention to reduce internalized stigma among people with mental illnesses. Psychiatr Rehabil J. 2011;35(1):51–54.
27. Beck, AT. Cognitive therapy and the emotional disorders. New York (NY): International Universities Press Inc; 1975.
28. Clay S, Schell B, Corrigan PW. On our own, together: peer programs for people with mental illness. Nashville (TN): Vanderbilt University Press; 2005.
29. Van Tosh L, del Vecchio P. Consumer/survivor-operated self-help programs: a technical report. Rockville (MD): Department of Health and Human Services; 2000.
30. Allport GW. The nature of prejudice. Cambridge (MA): Addison-Wesley; 1954.
31. Allport GW. The nature of prejudice. Reading (MA): Addison-Wesley; 1979.
32. Hoelter JW. Factorial invariance and self-esteem: reassessing race and sex differences. Soc Forces. 1983;61:834–846.
33. Jensen GF, White CS, Gelleher JM. Ethnic status and adolescent self evaluations: an extension of research on minority self-esteem. Soc Probl. 1982;30:226–239.
34. Porter JR, Washington RE. Black identity and self-esteem: a review of studies of black self-concept, 1968–1978. Annu Rev Sociol. 1979;5:53–74.
35. Verkuyten M. Self-esteem among ethnic minority youth in western countries. Soc Indic Res. 1994;32:21–47.
36. Verkuyten M. Self-esteem, self-concept stability, and aspects of ethnic identity among minority and majority youth in the Netherlands. J Youth Adolesc. 1995;24:115–175.
37. Wylie R. The self-concept. Vol 2. Lincoln (NE): University of Nebraska Press; 1979.