Research and the elimination of the stigma of mental illness†

Patrick W. Corrigan

Summary

Video-based and in vivo (face-to-face) contact have been shown to be effective ways to change stigmatising attitudes and behaviours. The two approaches reflect the strengths and weaknesses of sometimes conflicting priorities in anti-stigma programmes: broad audience v. grassroots control. Regardless of perspective, anti-stigma interventions have the greatest impact when contact is targeted, local, credible and continuous.

Declaration of interest

None.

Stigma strikes like the Lernaean hydra of myth, a multiheaded serpent capable of attack and injury from many directions. Stigma robs people with mental illness of rightful opportunities in work, education, housing and healthcare. It leads to institutionalisation and coercion where empowerment and recovery are required. It promotes internalised prejudice and why try reactions: ‘why should I try to live on my own; I am not competent’. It creates structural inequities, for example government systems that fail to provide appropriate supports for mental health services. For these reasons, stigma is a major target of advocates who embrace strategies meant to eliminate its pernicious influence on society. Governments in most Western countries have joined with these groups to institute broad-based anti-stigma programmes. Australia rolled out Beyond Blue more than a decade ago with the UK joining the fray a few years later with Time to Change. The USA, Canada, and most member nations of the European Union have similar active programmes. Like many public health priorities, the zeal to rectify the problem sometimes gets ahead of the research examining the strategic impact. Fortunately, researchers are partnering with advocates to examine the impact of anti-stigma strategies, in the process yielding a portfolio of studies that begins to shed light on effective anti-stigma programmes: broad audience v. grassroots control.

The inherent strength of broad audience approaches is that they can have an impact on a sizeable proportion of a population, something much harder to achieve when using in vivo approaches. Video-based approaches can be distributed across networks or internet platforms with a conceivable impact on vast audiences. Distribution, however, is not sufficient. Viewers need to attend to the message and subsequently recall it for it to have an impact. This can be a difficult achievement in a media universe where the population is bombarded with public service messages. Effects can be further muted by the passive and seemingly repetitive nature of some social marketing approaches. Social networking sites like Facebook may promote the kind of active interaction that can enhance anti-stigma effects: discussion boards or the viral spread of anti-stigma messages among one’s friends network may augment the anti-stigma message. Still, social marketing critics are concerned about the potential of ‘slackeracy’, a kind of slack advocacy that happens from mindlessly endorsing a position on a webpage (like a pink ribbon in solidarity with people with breast cancer) that does not lead to any meaningful action for the cause.

Clement et al juxtapose two important agendas in stigma-change programmes: broad audience v. grassroots control. Videotaped contact has the potential for a broad audience: disseminating the video via a variety of online platforms and television networks exponentially increases exposure of the anti-stigma effort compared with face-to-face approaches. Pursuit of a broad audience widens the domain of outcome assessment beyond a direct impact (how does the stigma-change programme diminish stigmatising attitudes and discriminatory behaviours?) to notions of market penetration (what percentage of a population is aware of and can recall an anti-stigma message?). The inherent strength of broad audience approaches is that they can have an impact on a sizeable proportion of a population, something much harder to achieve when using in vivo approaches. Video-based approaches can be distributed across networks or internet platforms with a conceivable impact on vast audiences. Distribution, however, is not sufficient. Viewers need to attend to the message and subsequently recall it for it to have an impact. This can be a difficult achievement in a media universe where the population is bombarded with public service messages. Effects can be further muted by the passive and seemingly repetitive nature of some social marketing approaches. Social networking sites like Facebook may promote the kind of active interaction that can enhance anti-stigma effects: discussion boards or the viral spread of anti-stigma messages among one’s friends network may augment the anti-stigma message. Still, social marketing critics are concerned about the potential of ‘slackeracy’, a kind of slack advocacy that happens from mindlessly endorsing a position on a webpage (like a pink ribbon in solidarity with people with breast cancer) that does not lead to any meaningful action for the cause.

The use of a broad audience focus has been criticised as undermining grassroots control, i.e. the kind of resources needed

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to produce social marketing campaigns are typically provided by
governments or large non-governmental organisations partnered
with advertising consortia. Government control centralises the
effort and distances it from the mass of people with mental illness
who are directly harmed by stigma, those likely to own the cause
after a specific campaign runs its course. These large campaigns
can be hijacked by government processes and agendas that lack
the kind of flexibility needed to bring real change at the local level.
Does this mean governments have no role in stigma change?
After all, governments have been known to be potent forces for
social justice. Opening Minds by the Canadian Mental Health
Commission may have got it right. They built their programme
on more than 75 user-based programmes distributed across the
country’s ten provinces and three territories.

Principles that promote a change in attitudes

Whether it be a broad audience or a grassroots focus, there are five
principles that promote strategic stigma change defined by the
acronym TLC3: targeted, local, credible, continuous contact.3

Contact with people with mental illness
is fundamental to public stigma change

Several factors enhance contact and are incorporated into the
remaining four strategic stigma-change principles.

Contact needs to be targeted

Rather than focusing on the population as a whole, contact is
more effective when targeting key groups, typically people in
positions of power like employers, landlords, healthcare providers,
legislators, and media outlets. Targeting stigma not only suggests
the ‘who’ of strategic contact but also the corresponding ‘what’;
what needs to be changed. These are affirming behaviours that
seek to increase employer hires and landlord leases and the
 provision of quality health services to people with mental illness.

Local contact programmes are more effective

‘Local’ has several meanings but may include geopolitical and
diversity factors. It seems reasonable, for example, to believe that
target-group interests are shared within geographical regions, such
as the UK or more narrowly within a country like Wales. Still
Wales is more homogeneous than other UK nations, and surely
more so than the diversity of the European Union where rural,
urban, and suburban considerations may vary greatly. Sociopolitical
factors within more narrowly defined areas are also important.
Large cities will include neighbourhoods of differing socio-
economic status that are likely to influence target-group interests;
for example, employers in impoverished parts of a city will require
different contact than peers located in wealthy suburbs. In
addition, rural and urban resources differ calling for distinct
contact programmes. Given research on health and healthcare
disparities, consideration of ethnicity and religious background
is additionally important for crafting local programmes.

Contacts must be credible

The contact person should be similar to the target. This could
mean employers, landlords, healthcare providers and police
officers with mental illness present to other employers, landlords,
healthcare providers and police officers. A message in addition to
‘people with mental illness recover!’ needs to be provided by a
member of the target group: ‘The person in recovery can be
successful’. For example, employers should tell peers that the
person will be a good worker. Contact ‘partnerships’ are a
good solution, combining consumers with representatives of the
target group; think of the compelling civic group meeting where
a person with mental illness talks about her recovery followed
by the boss who discusses the success resulting from having
hired her.

Contact must be continuous

One-time contact may have some positive effects but these are
likely to be fleeting. Contact must occur multiple times with the
quality of contact varying over time. This calls for different
consumer and target partners, messages, venues and opportunities.
It also reminds advocates that stigma change is not easily
accomplished and requires not only ongoing efforts, but continual
quality assessment of those efforts. Partnership with skilled
investigators like Clement et al helps achieve this goal. Continuous
and local priorities also call for participatory action research,
investigations that are equally directed by advocates and researchers.

As advocates continue to partner with social marketers in
order to erase the stigma of mental illness, they must continue
to discern what works, from what does not, from what might
actually result in unintended consequences. Many advocates wish
to ‘educate away’ our problems, a principle that is largely not
borne out by research. Face-to-face interchange with people with
lived experience is essential. As we seek to disseminate these
approaches to populations, we need to balance the benefits of
media-based approaches with the strengths of grassroots inter-
ventions. Careful and rigorous research like that conducted by
Clement and colleagues is a model for continued efforts in this
regard.

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