

Stigma: many mechanisms require multifaceted responses

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Intense attention to the problem of stigma in mental illness is emerging around the world. The fruits of this burst of attention will be wide ranging and deep to the extent that our efforts are sustained and address fundamental stigma processes. In this commentary I set forth a definition of stigma that is derived from thinking about many different stigmatizing circumstances. Then in light of this definition I draw attention to several ways in which stigma-related discrimination can limit the life chances of people with mental illnesses. Attending to this definition and to the multifaceted ways in which discrimination affects life chances underscores the need for interventions that can address the fundamental causes of stigma processes.

A DEFINITION OF STIGMA

Frequently, investigators provide no explicit definition and seem to refer to something like the dictionary definition («a mark of disgrace») or to some related aspect like stereotyping or rejection (e.g. a social distance scale). When stigma is explicitly defined many commentators turn to Goffman quoting his definition of stigma as an «attribute that is deeply discrediting» and that reduces the bearer «from a whole and usual person to a tainted, discounted one» (Goffman, 1963, p. 3). But since Goffman both implicit and explicit definitions of stigma have varied. In response to this variety Link & Phelan (in press) returned to the issue of stigma to construct a definition that locates the meaning of the term in the convergence of interrelated components. In this conceptualization stigma exists when the following interrelated components converge.

In the first component, people distinguish and label human differences. Stigma cannot accompany the very

large number of human characteristics and attributes that people generally ignore (e.g. hairy ears). In the second component, dominant cultural beliefs link labeled persons to undesirable characteristics – to negative stereotypes. This component would be evident if, for example, a person who has been hospitalized for mental illness (a label) is then assumed to be dangerous as a consequence. In the third component, labeled persons are placed in distinct categories so as to accomplish some degree of separation of «us» from «them». In the extreme a person is thought to be a completely different kind of being – very different from «us». In the fourth, labeled persons experience status loss and discrimination that leads to unequal outcomes with regard to a broad array of life chances including jobs, housing, health care, quality of life, self-esteem and longevity. Stigmatization is entirely contingent on access to social, economic and political power that allows those who would stigmatize to put real teeth into their treatment of the stigmatized. Thus we apply the term stigma when elements of labeling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows them to unfold.

MECHANISMS OF STIGMA-RELATED DISCRIMINATION

A great deal of research in stigma has focused on the first two components of the definition just presented, that is on the construction of categories and the linking of those categories to undesirable characteristics. This is very important and useful work emerges from the social cognitive approach in psychology and provides guides for some of the ways we might address the stigma of mental illness (Crocker *et al.*, 1998). At the same time we need to go beyond these social cognitive approaches to understand how peoples attitudes and beliefs are translated into broad scale discriminatory outcomes that limit the life chances of the stigmatized. Toward this end I present three generic mechanisms through which labeling and stereotyping can have consequences for persons with mental illnesses.

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Direct discrimination

This standard way of conceptualizing the connection between labeling/stereotyping and discrimination is to posit direct discriminatory behavior on the part of the person who holds the stereotyped beliefs. In this approach, the importance of attitudes and beliefs are thought to lie in whether person A's labeling and stereotyping of person B leads person A to engage in some obvious forms of overt discrimination directed at person B like rejecting a job application, refusing to rent an apartment and so on. There are several studies that when taken together offer compelling evidence that this form of discrimination occurs with some regularity in the lives of people with mental illnesses. In an experiment Page (1977) demonstrated clear cut discrimination in landlords reports of apartment availability by varying whether a prospective tenant indicated that he/she was calling as a patient from a psychiatric hospital or from another setting. There is also evidence from non-experimental studies of real world circumstances in which people with mental illnesses receive less than adequate treatment following a myocardial infarction. Druss *et al.* (2000) demonstrate that like women and ethnic minorities people with schizophrenia are less likely to receive state-of-the-art procedures such as angioplasty or coronary artery bypass graft following myocardial infarction than are people who do not have schizophrenia but have similar physical conditions. Finally, Wahl (1999) asked a large sample of consumers of mental health services about experiences of rejection and found that sizeable minorities reported being denied educational opportunities, jobs, apartments and health insurance. Thus reports from investigator constructed experiments, from quasi-experiments conducted in real world settings and from surveys of consumers converge to indicate that direct discrimination occurs with unacceptable regularity in the lives of people with mental illnesses. But direct discrimination is not the only way in which discrimination can occur.

Structural discrimination

This form of discrimination sensitizes us to the fact many disadvantages can result outside of a model in which one person does something bad to another (direct discrimination). In the United States structural discrimination is clearly evident with regard to differences in life chances between African Americans and Whites (Hamilton & Carmichael, 1967). For example, employers (more often white) rely on the personal recommendations

of colleagues or acquaintances (more often white and more likely to know and recommend white job candidates) for hiring decisions. In instances like these there is no direct denial of a job to an individual African American person and the employer offering a job in such an instance need not hold racist beliefs. But does structural discrimination have an impact on, say, people with schizophrenia? Consider some possible examples.

Suppose that because it is a stigmatized illness, less funding is dedicated to research on schizophrenia than for other illnesses and less money is allocated to adequate care and management. As a consequence people with schizophrenia are less able to benefit from scientific discoveries than they would have been if the illness they happened to develop was not stigmatized. Further, the resources available to deliver state of the art treatments are not as well developed as they are for illnesses that are not as stigmatized as schizophrenia. Consider further that because of historical processes influenced by stigma, treatment facilities tend to be either isolated in settings away from other people (Rothman, 1971) or confined to some of the most disadvantaged neighborhoods in urban settings in communities that do not have enough clout to exclude this stigmatized group from their midst (Dear & Lewis, 1986). These disadvantaged communities tend to have higher rates of crime, more pollution, higher rates of infectious disease, and inadequate medical care. To the extent that the stigma of schizophrenia has created such a situation, a person who develops this disorder will be the recipient of structural discrimination whether or not anyone happens to treat him or her in a discriminatory way because of some stereotype about schizophrenia. He or she will receive less of the good things and more of the bad things as a simple consequence of having developed a stigmatized illness – stigma has affected the structure around the person, leading the person to be exposed to a host of untoward circumstances.

Social psychological processes operating through the stigmatized person

Once the cultural stereotype is in place, it can affect labeled persons in important ways that do not involve obvious forms of discriminatory behavior on the part of people in the immediate presence of the stigmatized person. For example, according to a modified labeling theory about the effects of stigma on people with mental illnesses (Link, 1982; Link *et al.*, 1989), people develop conceptions of mental illness early in life as part of socialization into our culture (Angermeyer & Mat-

schinger, 1996; Scheff, 1966; Wahl, 1995). Once in place, people's conceptions become a "lay theory" about what it means to have a mental illness (Angermeyer & Matschinger, 1994; Furnham & Bower, 1992). People form expectations as to whether most people will reject an individual with mental illness as a friend, employee, neighbor, or intimate partner and whether most people will devalue a person with mental illness as less trustworthy, intelligent, and competent. These beliefs have an especially poignant relevance for a person who develops a serious mental illness, because the possibility of devaluation and discrimination becomes personally relevant. If one believes that others will devalue and reject people with mental illnesses, one must now fear that this rejection applies personally. The person may wonder, «Will others think less of me, reject me, because I have been identified as having a mental illness?» Then to the extent that it becomes a part of a person's world view, that perception can have serious negative consequences. Expecting and fearing rejection, people who have been hospitalized for mental illnesses may act less confidently, more defensively, or they may simply avoid a threatening contact altogether. The result may be strained and uncomfortable social interactions with potential stigmatizers (Farina *et al.*, 1968), more constricted social networks (Link *et al.*, 1989), a compromised quality of life (Rosenfield, 1997), low self-esteem (Wright *et al.*, 2000), depressive symptoms (Link *et al.*, 1997), unemployment and income loss (Link 1982; 1987).

Again note that in the modified labeling theory no one in the immediate context of the person needs to have engaged in obvious forms of discrimination. Rather, the discrimination lies anterior to the immediate situation and rests instead in the formation and sustenance of stereotypes and "lay theories." Still the consequences are sometimes severe and undoubtedly contribute greatly to differences in the life chances of people with mental illnesses.

THE MECHANISMS OF DISCRIMINATION ARE INTERCHANGEABLE AND MUTUALLY REINFORCING

The forgoing discussion of mechanisms of discrimination brings to light the possibility that labeling and stereotyping can produce discriminatory outcomes in several different ways and not just through direct discrimination. But an observation that discrimination can occur through multiple mechanisms has other important implications as well. One reason this is so is brought to light by the sociological observation that mechanisms like

the ones we have described are both interchangeable and mutually reinforcing in achieving ends that discriminate against stigmatized groups (Lieberman, 1985). If potential stigmatizers are motivated to discriminate against an outgroup such as persons hospitalized for mental illness there are many ways in which such discrimination can be achieved. If stigmatized persons cannot be convinced to voluntarily accept their lower status and inferior rewards, direct discrimination can be used to accomplish the same outcome. If direct discrimination becomes ideologically difficult forms of structural discrimination – like locating people with schizophrenia in disadvantaged areas of the city – can achieve some of the same ends. The mechanisms are mutually reinforcing as well. To the extent a stigmatized group like persons with schizophrenia accept the dominant view of their lower status, they are less likely to challenge structural forms of discrimination that block opportunities they desire. Further, direct discrimination reinforces the belief among stigmatized persons that they will be treated in accordance with stereotypes and therefore reinforces processes like those explicated in the context of modified labeling theory. Stigma thereby becomes a persistent predicament in the following sense – as long stigmatizers sustain their view of the people they would stigmatize, decreasing the use of one mechanism through which disadvantage can be accomplished simultaneously creates the impetus to increase the use of another.

Changing Stigma. One approach is to become very focused on a particular behavior in a particular group. For example, one might target the hiring practices of employers with the aim of increasing the chances for employment for a stigmatized group like people with mental illnesses. One might then try to change employers beliefs about and attitudes towards hiring persons with such illnesses. This approach is very appealing in that it breaks down the morass of interconnecting stigma-facets into a more tractable problem. If one were to develop an intervention, one could target the intervention to the specific beliefs, attitudes and behaviors of employers thereby increasing the likelihood of an apparently successful outcome for the intervention research study. But what is appealing about this approach is also what makes it such an inadequate response to the broader problem of stigma. The intense focus on one specific behavior in one specific group leaves the broader context untouched and as a consequence even the very positive outcomes of an unusually successful program will erode with time. This will occur for reasons we have stated: there exists a flexible package of mutually reinforcing mechanisms linking the attitudes and beliefs of dominant groups

ps to an array of untoward outcomes for stigmatized persons.

Our conceptualization leads us to focus on two principles in considering how to really change stigma. The first is that any approach must be multifaceted and multilevel. It needs to be multifaceted to address the many mechanisms that can lead to disadvantaged outcomes, and it needs to be multilevel to address issues of both individual and structural discrimination. But second, and most important, an approach to change must ultimately address the fundamental cause of stigma—it must change the deeply held attitudes and beliefs that lead to labeling, stereotyping, setting apart, devaluing and discriminating. In the absence of fundamental changes, interventions targeted at only one mechanism at a time will ultimately fail, because their effectiveness will be undermined by contextual factors that are left untouched by such a narrowly conceived intervention. Thus in considering a multifaceted multilevel response to stigma, one should choose interventions that either produce fundamental changes in attitudes and beliefs or else directly limit the power of would be stigmatizers to act on their attitudes and beliefs. In light of these considerations the most propitious approach lies in implementing the kinds of multi-faceted multi-level interventions that represent our best hope for producing real change in stigma-related processes.

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