Special Section on Stigma as a Barrier to Recovery: Introduction

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The Surgeon General's 1999 report on mental health (1) determined stigma to be "the most formidable obstacle to future progress in the arena of mental illness and health" and concluded, "For our nation to reduce the burden of mental illness . . . stigma must no longer be tolerated." In keeping with the spirit of that report, the aim of this special section is to elucidate the adverse effects of stigmatization on the recovery of people with mental illness.

In focusing on stigma as a barrier to recovery, we intend to highlight the potential role of stigma both in reducing the effectiveness of efforts at psychosocial rehabilitation—for example, psychopharmacology combined with social skills training—and in impeding the restoration of self-esteem, a sense of purpose, and a better quality of life for persons with mental illness (2–4). Although we cannot address the full range of ways in which stigma potentially limits the prospects of recovery for persons with mental illness, the papers in this section were chosen to represent central areas of concern for persons with mental illness: treatment-adherence behavior, self-esteem management, and social adjustment.

The first paper, by Dr. Sirey and her colleagues (5), examines the impact of perceptions of stigmatization on compliance with medication regimens among persons with major depression in the first three months of psychiatric outpatient treatment. These authors found that higher levels of perceived stigma at the start of treatment predicted poorer compliance with the prescribed antidepressant drug regimen over the next three months, after sociodemographic and clinical characteristics had been controlled for.

In the second paper, Dr. Link and his associates (6) describe how they tested alternative hypotheses to explain temporal associations between perceived stigma and self-esteem among members of a clubhouse that served people with severe and persistent mental illness. Controlling for baseline self-esteem and depression, these authors found that each of two indexes of stigma that were assessed at baseline—a sense of being discriminated against or devalued and social withdrawal because of stigma—was an independent and significant predictor of self-esteem at six and 24 months. By contrast, self-esteem predicted only one of the two stigma variables at the six-month follow-up only.

In the third paper, my colleagues and I (7) evaluate the effect of concerns about stigma on social adaptation among persons with bipolar disorder. We found that concerns about stigma reported during an acute phase of illness were associated with significantly poorer social adjustment seven months later, even after baseline social adaptation and clinical status had been controlled for. This effect was specific to social interaction with individuals outside the family.

In the fourth and final paper, Dr. Struening (8) and his associates demonstrate that concerns about the stigma faced by consumers and their families are pervasive among family members who provide care to persons with schizophrenia or bipolar disorder. These authors addressed these family members' concerns about various forms of devaluation directed toward the patient and toward the family members themselves. They found that the levels of devaluation attributed by caregivers to "most people" were comparable to or higher than the levels of devaluation reported in national surveys of stigmatization of persons with mental illness.

Together, these papers present compelling evidence that concerns about stigma adversely affect the recovery of persons with mental illness. These concerns affect self-esteem and adaptive social functioning outside the family, and they influence the willingness of outpatients to take the medications that their psychiatrists prescribe for them. The effects are enduring and are not limited to one diagnosis. Although studies that compare specific effects of concerns about stigma on patients with differing psychiatric diagnoses might demonstrate an effect of diagnosis, the results of the studies presented in this special section suggest that, broadly defined, concerns about stigma adversely affect the recovery and the lives of persons with major depression, bipolar disorder, or schizophrenia.

Furthermore, it is not only the persons who have these disorders whose lives are affected by concerns about stigma. Their family members also experience stigmatization as relatives of a person with mental illness. Finally, because the subjective distress and well-being of family members influence the outcome of persons with mental illness (9), the family's re-

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sponse to stigmatization can be expected also to have an impact on the person who has the illness.

It is important to note that although the papers cite evidence that supports the occurrence of stigmatization of persons with mental illness, the original data collected and presented in all four papers are based on individual judgments of the degree to which persons with mental disorders are devalued or discriminated against in a variety of social roles or contexts—for example, as a teacher of young children or as a prospective spouse. These data should be interpreted as measuring perceptions of or concerns about stigmatization of persons with mental illness rather than the degree to which stigmatization actually occurs in society.

On one hand, the fact that the studies measured perceptions rather than actual stigmatization might be viewed as a limitation of the findings. On the other hand, there is ample evidence from research on social cognition that the ways in which people understand or make sense of external reality are important determinants of both their subjective sense of well-being and their adaptive behavior (10,11). Thus perceptions of stigma may have even greater repercussions for the recovery of persons with mental illness than objective findings related to stigmatization in society, which may or may not apply to individual circumstances.

In presenting this series of papers, we hope to increase the focus of clinicians, researchers, health policy administrators, and the American public on the adverse impact of stigma on persons with mental illness and their families. The findings of the studies reported here suggest that clinicians need to be aware that concerns about stigma may reduce adherence to the medications they prescribe or may delay recovery of self-esteem and adaptive social functioning, even under conditions of optimal psychopharmacologic response.

However, recognition of the adverse impact of stigma is only a first step toward curing the problem. The next steps involve continuing efforts to educate the public to have a more accurate and less prejudiced view of mental illness and to work with persons with mental illness to develop strategies for coping with stigma that do not lead them to avoid social and treatment settings. Because the roots of stigma are deeply embedded in our culture (1), a major research and outreach effort will be required if these goals are to be achieved. ♦

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