At Issue:
Stop the Stigma: Call Mental Illness a Brain Disease

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Abstract

Educating the public that mental illness is a brain disease is a popular strategy for combating mental illness stigma. Evidence suggests that while such an approach reduces blame for mental illness, it may unintentionally exacerbate other components of stigma, particularly the benevolence and dangerousness stigmas. Conversely, psychosocial explanations have proven promising, yet they ignore the growing evidence regarding genetic and biological factors. We propose a balanced approach that combats the various myths about mental illness with factual information.

Keywords: Stigma, brain disease, mental illness.


During the past decade, several groups have become concerned about the harmful effects of stigma on people with mental illness. In an effort to change public attitudes, some advocates have called for equating mental illness stigma with other medical disorders. Perhaps most prominent of the many public service campaigns and educational curricula that promote this view is NAMI's slogan that mental illness is a brain disease. Although this equation seems to have face validity, a review of the evidence that might support the slogan for education efforts that seek to diminish stigma is mixed.

Many studies have found that the public views people with mental illness as responsible for their disorders: because of poor character or lack of moral backbone, people with disorders like schizophrenia and major depression choose to have their mental illness and are to blame for the symptoms and the disabilities that result (Weiner et al. 1988; Corrigan et al. 1999, 2003; Watson et al., submitted). In his theory of human attribution, Weiner (1995) argued that blaming someone for a negative life condition such as mental illness leads to anger and social avoidance ("I don't want that weak-willed person around me!"). Hence, educating the public about the biological roots of mental illness—for example, comparing people with mental illness to those with other chronic disorders such as diabetes—should decrease blame for psychiatric illness. There is some limited research that supports this hypothesis; namely, people are less likely to endorse blame, anger, and social avoidance toward people with mental illness after they have been educated about how mental illness is a biological disorder that people do not choose (Corrigan et al. 2002).

There is, however, another facet to Weiner's attribution model that suggests that framing mental illness as a brain disorder may have its limitations. People make attributions about not only the onset of a disorder (Is schizophrenia caused by weak character or biology?) but also its offset (Will the person get better so he or she can live a normal life?). Framing mental illness as a brain disorder may resolve onset questions but exacerbate offset issues. There is some evidence that suggests that the public views mental illness as a disorder from which people do not recover—that they do not regain productive lives (Weiner et al. 1988; Corrigan et al. 1999). This kind of attitude may support what is called the benevolence stigma; namely, that people with mental illness are innocent children whose lives need to be controlled by a parental figure (Brockington et al. 1993). While well intentioned, this type of stigma can be disempowering, leading persons with mental illness (and others) to view themselves as dif-
fere different from other people, less competent, and less acceptable as friends. This suggests that the public also needs to be educated that people with mental illness recover. Whether recovery from mental illness is viewed as a naturally occurring phenomenon (Harding and Zahniser 1994), the result of competent treatment (Liberman and Kopelowicz, in press), or a psychological process (Ralph 2000), the public needs to be taught that mental illness is a chronic disease from which people can recover—a disease not unlike diabetes.

Biological explanations may also imply that people with mental illness are fundamentally different or less human. Research has shown, for example, that disease explanations for mental illness reduced blame but provoked harsher behavior toward an individual with mental illness (Mehta and Farina 1997). The studies suggest that this harsher behavior may have been the result of seeing the person with mental illness as physically distinct—almost as a different species. Phelan (2002) reminds us that in the not-so-distant past, biological and genetic explanations for stigmatized conditions were linked to a range of harsh policies, including marriage restrictions, sterilization, and even extermination.

The biological explanation may also exacerbate yet another key stereotype of mental illness, the belief that people with mental illness are dangerous. Many researchers believe that the stereotype that people with mental illness are violent ranks among the most prejudicial and discriminating of attitudes (Phelan et al. 2000). Unfortunately, there is evidence that biological arguments may actually strengthen dangerousness stereotypes, suggesting that people with mental illness have no control over their behavior and therefore are unpredictable and violent (Read and Law 1999).

In contrast to biological arguments, psychosocial explanations of mental illness have been found to effectively improve images of people with mental illness and reduce fear (Morrison et al. 1979; Morrison and Teta 1979, 1980; Morrison 1980; Read and Law 1999). Instead of arguing that mental illness is like any other medical illness, psychosocial explanations of mental illness focus on environmental stressors and trauma as causal factors. These may include childhood abuse, poverty, and job stress. The idea is to reframe psychiatric symptoms as understandable reactions to life events (Read and Law 1999).

Does this mean we should abandon the "brain disease" explanation of mental illness? As scientists compile more and more evidence of the genetic and biological components of many mental illnesses, it would be unethical to exclude this information from educational programs (Phelan 2002). In addition, reducing blame is an important goal of any antistigma campaign, particularly if we are interested in increasing the public's willingness to allocate resources for mental health treatment (Watson and Corrigan, in press). Hence, challenging the stigma of mental illness is going to require a multidimensional approach, providing the public with facts that challenge the variety of myths that maintain mental illness stigma. Such an approach would address the contributions of both biological and psychosocial factors, the effectiveness of mental health treatment, and accurate information about violence and mental illness. Combining education with contact with a person with mental illness can enhance the effect of an intervention (Corrigan et al. 2002), perhaps by diminishing the perception of "otherness." Challenging the stigma of mental illness is an essential item on the public health agenda. However, just as other public health concerns need to be informed by data, so efforts to build antistigma programs need to be evaluated empirically.

References


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