

The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care

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Mental illness has wide-reaching effects on people's education, employment, physical health, and relationships. Although many effective mental health interventions are available, people often do not seek out the care they need. In fact, in 2011, only 59.6% of individuals with a mental illness — including such conditions as anxiety, depression, schizophrenia, and bipolar disorder — reported receiving treatment.

In the second issue of *Psychological Science in the Public Interest* ([Volume 15, Number 2](#)), Patrick W. Corrigan (Illinois Institute of Technology), Benjamin G. Druss (Emory University), and Deborah A. Perlick (Mount Sinai Hospital) discuss the role of stigma in limiting access to care and in discouraging people from pursuing mental health treatment.

Commentary: Creating and Changing Public Policy to Reduce

the Stigma of Mental Illness

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From a public standpoint, stereotypes depicting people with mental illness as being dangerous, unpredictable, responsible for their illness, or generally incompetent can lead to active discrimination, such as excluding people with these conditions from employment and social or educational opportunities. In medical settings, negative stereotypes can make providers less likely to focus on the patient rather than the disease, endorse recovery as an outcome of care, or refer patients to needed consultations and follow-up services.

These displays of discrimination can become internalized, leading to the development of self-stigma: People with mental illness may begin to believe the negative thoughts expressed by others and, in turn, think of themselves as unable to recover, undeserving of care, dangerous, or responsible for their illnesses. This can lead them to feel shame, low self-esteem, and inability to accomplish their goals. Self-stigma can also lead to the development of the “why try” effect, whereby people believe that they are unable to recover and live normally so “why try?” To avoid being discriminated against, some people may also try to avoid being labeled as “mentally ill” by denying or hiding their problems and refusing to seek out care.

Structural stigma (i.e., stigma that is part of social and institutional policies and practices) presents additional large-scale barriers to mental care by undermining opportunities for people to seek help. A lack of parity between coverage for mental health and other health care, lack of funding for mental health research, and use of mental health history in legal proceedings, such as custody cases, all present structural reasons that people might not seek treatment.

Studies have shown that knowledge, culture, and social networks can influence the relationship between stigma and access to care. For example, myths about mental illness and its treatment can lead to the development of stigma and discriminatory practices. Cultural factors can influence the types of behaviors that are thought to violate social norms and the degree to which discrimination against people who display nonconformative behavior is accepted. Social networks, including family members, friends, and coworkers, can also have a big impact on people’s decisions to pursue treatment, serving either to enhance feelings of stigma or to encourage care seeking.

Because of the impact of knowledge, culture, and networks on people’s decisions to access care, many public-health and policy initiatives meant to encourage care usage have focused on educating people about mental health to combat harmful stereotypes related to illness and treatment. Addressing cultural barriers to care and including supportive networks in treatment plans can also encourage treatment.

At the structural level, legislation such as the Americans with Disabilities Act of 1990, the Mental

Health Parity Act of 1996, the Medicare Improvements for Patients and Providers Act, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and, most recently, the Affordable Care Act of 2010, have served to protect people with mental illness from discriminatory practices.

In a [commentary](#) accompanying this report, former U. S. First Lady Rosalynn Carter, along with Rebecca Palpant Shimkets and Thomas H. Bornemann of the Carter Center Mental Health Program, describe the challenges faced in trying to reduce the stigma of mental illness and increase access to care. The many legislative efforts spearheaded by the Carter Center have helped create or change public law to protect the rights of people with mental illness and ensure parity for mental health services. Although these laws often serve to force structural changes, the hope is that legislative efforts will eventually lead to true changes in attitudes toward mental illness.

Despite the Carter Center's many successes, more work needs to be done. Integrative research that connects the mental health, public health, education, and primary care fields is necessary. The authors of this report and commentary believe that such integrative efforts can help build a strong network of systems and services that encourage access to care without the fear of discrimination or prejudice.

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