

EDITORIAL

Beware the Pity Narrative

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Many are motivated by pity to help those who are sick. They are moved by painful symptoms and significant challenges that undermine a patient's hope, achievement, and well-being. Illnesses become cumbersome cloaks that seemingly overcome patients and define them as broken. Illness moves others to sympathy, especially for those who answer the call of health care vocations. Stigma adds to the harm of health challenges. And so, pity also motivates advocates who seek to tear down the stigma of health conditions. Not only do people have to cope with symptoms and disabilities, they must deal with unfair beliefs and discriminatory reactions against them evoking even greater sympathy.

Is pity a good motivator for antistigma interventions and research? [Bernard Weiner \(1995\)](#) viewed pity as an important mediator between attributions about a condition or event and subsequent help. People who perceive sick patients as *victims* of external agents (e.g., cancer is genetic and not by choice) are likely to be pitied, leading to help from others. Hence, public service campaigns focus on the need for more resources to help innocent patients get the treatment they need. Although perhaps good-intentioned, this reflects a dated notion of charity; namely, that those with resources (the healthy and the provider) should *bestow* on others (the sick) advantages held by the first. This exacerbates the power hierarchy between those with illness and their healthy family, friends, and health care providers.

Pope Francis may have unintentionally given voice to the charity-as-bestowing narrative in his inaugural mass of March 19, 2013 ([The Holy See \(2013\)](#)). Jorge Bergoglio chose the name Francis in honor of Francis of Assisi, the saint who reminds Catholics of their duty to the poor and the weak. In the March 19 mass, the pope challenged his flock to serve these poor and weak, “embrace with tender affection the whole of humanity, especially the poorest, the weakest, the least important.” Somehow Pope Francis deemed those in need—the sick—as less than everyone else, which is yet another form of that hierarchy, the one-up, one-down relationship that occurs between patients and those around them. With illness comes a loss of power, power over aspects of one's body, one's life, goals, loved ones. With stigma also comes loss of power ([Link & Phelan, 2001](#)). Pity exacerbates power loss. In the guise of concern and intention, pity flames notions that sick people are somehow less than everyone else. Peter Byrne from University College London once taught me what people who are the object of stigma seek: not pity but parity. They do not want a leg up. They want the opportunities that everyone deserves.

The pity narrative is seductive. In the media we know “if it bleeds, it leads.” Most progressives would likely object to using tawdry stories of violence (“Addict Kills Three in Drug Induced Frenzy”) and sex (“Stripper Gets HIV in

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Boys Town”) to promote health agendas. But pity is used in this light; pictures and stories of the untreated ill make for compelling front pages, especially examples of worst rather than typical outcomes. Advocates are likely to use stories of failed health in order to attract donors and foundations to their causes. Children in those stories are especially potent draws. Although we may win the pyrrhic challenge, the more insidious message remains: People with illness are less than us, different from us. And difference is the base on which stigma rests.

Although being wary of pity, I do not suggest we deny that people are victimized by illness and the stigma that creates it. Nor should we turn away from those misfortunes and injustices. But, we must also be alert to reifying this victimhood by making people victims, by teaching them that “wounded” is now part of their identity. This kind of equation has been shown to undermine the person’s search for individual dignity (Meredith, 2009). There are many fixes to this. I encourage readers to consider these three in their work:

1. Stay rooted to the recurring call for person-first language. Do not refer to them as “the schizophrenic” or “the cancer case in bed one.” People with health conditions are just that: people, not patients. Objectifying and distancing them as patients adds to the difference.
2. Nothing about them without them. The potent message that beats stigma rests with the people who are the victims of the stigma. It is much easier to evoke pity when speaking about “those people” rather than having individuals speak for themselves, who, by the way, are more likely to demand parity than ask for pity.
3. Promote a 50–50 personal story of recovery. Oftentimes, people with health conditions tell personal stories to challenge stigma. Sometimes these stories are dominated by on-the-way-down narrative; the symptoms were overwhelmingly causing numerous problems. To be sure, personal stories should not deny the challenges of health. But they need to be balanced, if not superseded, by on-the-way-up narratives that demonstrate that, despite the challenges of symptoms and disabilities, I have achievable goals that I pursue like everyone else. Illness is not the pitiable end of the story.

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