Behavior Therapy Empowers Persons With Severe Mental Illness

PATRICK W. CORRIGAN
University of Chicago Center for Psychiatric Rehabilitation

Several behavioral strategies, when combined with appropriate medication, have been shown to significantly diminish the symptoms of severe mental illnesses (e.g., schizophrenia, major affective disorders, and severe personality disorders) as well as improve the quality of life of persons with these disorders. Hence, clinicians can call on a well-investigated armamentarium of behavioral and pharmacological interventions to aggressively treat psychiatric disease. The effect of mental illness is not limited to the effects of the disease, however; societal discrimination also accounts for many of the problems that accompany mental illness. For example, many persons with severe mental illness are unable to obtain independent housing or competitive jobs, not because of deficits due to their disease, but rather, because

AUTHOR'S NOTE: This article was made possible, in part, by grants from the U.S. Department of Education (H263A50006) and the Illinois Department of Mental Health and Developmental Disabilities. I wish to acknowledge helpful reviews by Andrew Garman, Stanley McCracken, and David Penn. Address all correspondence to Patrick W. Corrigan at the University of Chicago Center for Psychiatric Rehabilitation, 7230 Arbor Drive, Tinley Park, IL 60477, or via E-mail to pcorriga@mcis.bsd.uchicago.edu.

BEHAVIOR MODIFICATION, Vol. 21 No. 1, January 1997 45-61
© 1997 Sage Publications, Inc.
of misconceptions about the disorder. Persons with severe mental illness need to be empowered to challenge these misconceptions and stigma so they can obtain the opportunities they deserve.

Ironically, aggressively carrying out behavioral and medication programs may actually exacerbate misconceptions about severe mental illness (e.g., these persons are incapable of caring for themselves) and lead to greater discrimination. As a result, some clinicians who implement behavioral programs may be perceived as diminishing the power of persons with severe mental illness and adding to their stigma. In fact, some people argue that behavior therapy is disempowering in nature (see Corrigan, 1995). I counter, in this article, that negative experiences like these are not the result of behavioral principles, but rather, misunderstanding or misuse of these principles. Behavior therapy actually empowers persons with severe mental illness; examples of empowerment are provided in this article. First, though, disease and discrimination models of severe mental illness are more thoroughly described.

**DISEASE AND DISCRIMINATION**

Disease models of severe mental illness have been relatively well described in the research literature. A linear presentation of this model is outlined in the left panel of Figure 1. Biological events including genetic heritage (Asherson, Mant, & McGuffin, 1995) and in utero insult (Susser & Lin, 1992; Torrey, Bowler, & Rawlings, 1992) create a disease vulnerability in some persons. Such vulnerabilities combine with the stress of significant life events to produce psychotic symptoms, mood symptoms, or the deficit syndrome (i.e., diminished social functioning) in late adolescence or young adulthood (Bebbington et al., 1993; Ventura, Nuechterlein, Hardisty, & Gitlin, 1992). Moreover, subtle cognitive and interpersonal deficits that occur in childhood and late adolescence prevent many persons with severe mental illness from learning social and instrumental skills that help them ward off life stressors as well as assist them with the needs of independent living (Liberman, Spaulding, & Corrigan, 1995). Persons who are plagued by psychiatric symptoms and who lack social skills soon find they are missing a supportive social network. Few people are willing
Figure 1. Disease and discrimination models outlining the relationship between primary cause of the disease and loss of social opportunity.

to befriend them or help them with their problems (Meeks & Murrell, 1994). As a result, many persons with severe mental illness do not attain age-appropriate social roles; for example, they do not finish school, enter a vocation, or get married. This chain of events leads to a loss of social opportunity. Persons with severe mental illness are less likely to be employed competitively, to live in dignified housing, or to have sufficient monies to meet daily needs.

A discrimination or empowerment model of severe mental illness yields a different picture of the relationship between biological cause and loss of social opportunity (see the right panel in Figure 1). Proponents of a discrimination model acknowledge that biological agents may cause various psychiatric symptoms; the combination of psychiatric symptoms and disease vulnerabilities may, in turn, lead to diminished social skills and support networks. However, societal misconceptions about these symptoms, and the “illness” they entail,
### TABLE 1
Misconceptions About Severe Mental Illness

<table>
<thead>
<tr>
<th>Misconception</th>
<th>Fact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with severe mental illness will progressively become worse.</td>
<td>Long-term follow-up studies suggest that the majority of persons with schizophrenia have a good outcome as indicated by global measures of symptomatology and social functioning (Bleuler, Huber, Gross, &amp; Schüttler, 1976; Harding, Brooks, Ashikaga, Strauss, &amp; Breier, 1987; Hawk, Carpenter, &amp; Strauss, 1975).</td>
</tr>
<tr>
<td>Persons with severe mental illness are dangerous</td>
<td>The rate of aggression seems to be higher in persons who are acutely agitated or psychotic (Taylor, 1995). The rate of aggression in persons with remitted psychiatric symptoms seems to be no higher than the population as a whole.</td>
</tr>
<tr>
<td>Persons who experience psychotic symptoms are incapable of making responsible decisions.</td>
<td>Psychotic symptoms and social functioning are not always correlated (Corrigan et al., 1994). Many persons who demonstrate hallucinations, delusions, or formal thought disorder have been able to conduct social interactions competently.</td>
</tr>
<tr>
<td>Persons with severe mental illness require intensive custodial care.</td>
<td>Conventional wisdom used to hold that many persons with severe mental illness could only be treated in institutional settings. Most of these persons are able to live in their community with appropriate support (Test, 1992).</td>
</tr>
</tbody>
</table>

have a much more damaging effect on social functioning (Fisher, 1994; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Penn et al., 1994). Several common misconceptions about persons with severe mental illness are summarized in Table 1. The corresponding facts show the error of these misconceptions: Most persons with severe mental illness do not experience an inevitable downhill course, are not dangerous, and can live successfully and responsibly in their community.

The effects of stigma and misconception lead to societal discrimination. Because the public does not understand the effect of severe mental illness and frequently fears persons with these disorders, members of society withhold opportunities related to housing, work, and income (Monahan, 1992; Nagler, 1994; Riger, 1994; Stephens & Belisle, 1993). Thus loss of social opportunity that accompanies severe mental illness is due as much to the injustices of societal stigma as to the effects of biology. A primary way to “treat” such injustice is for persons with severe mental illness to obtain power over their lives in their community. Empowerment has been generically described as
a process of increasing or enhancing interpersonal and political power so that individuals can take actions to meet their life goals (Anthony, 1993; Deegan, 1992; Fisher, 1994; Unzicker, 1989). Persons with severe mental illness expect society to recognize their rights to economic opportunity and to make political and cultural changes so that these rights are guaranteed. These individuals have sought power in several ways including fostering advocacy groups (Chamberlin, 1984) and promoting rehabilitation programs that are developed and operated by persons with severe mental illness (Chamberlin, Rogers, & Sneed, 1989).

From a behavioral perspective, empowerment may be defined as individuals making decisions about their treatment, work, recreation, and living arrangements. Decisions can be observed as verbal behavior (e.g., “I decide I do not want to take Haldol anymore.”) and corresponding action (e.g., the person stops taking Haldol). Situations where others make these decisions (e.g., family members want the person to continue his Haldol, psychiatrists want the person to be discharged to a group home rather than an apartment, community members do not want persons with severe mental illness living in their neighborhood) are “disempowering.”

AGGRESSIVELY IMPLEMENTED THERAPIES CAN DIEMPOWERS PERSONS

Aggressively implemented, behavioral and pharmacological therapies may actually disempower persons with psychiatric disability (Deegan, 1992; Fisher, 1994). These therapies include interventions that impede the person’s ability to make decisions or that give decision-making power to someone else. For example, a psychiatrist, concerned about her acutely psychotic patient, has decided that the patient should begin a high dose of an antipsychotic medication regardless of the side effects. Aggressive interventions like these rest on some of the misconceptions reviewed in Table 1. Namely, persons with severe mental illness are unable to make responsible decisions and, therefore, must have treatment and living decisions made for them.

Behavioral interventions have been accused of coercing participants rather than encouraging them to make independent decisions
(Corrigan, Liberman, & Engel, 1990). Operant strategies, in particular, have been blamed for taking away the individual's decision-making power (Corrigan, 1995). Instead, this power is assumed by staff who abuse program participants with aversive contingencies (e.g., put patients into seclusion when they exhibit an inappropriate behavior) or make them earn reinforcers to which they are legally entitled (e.g., work for their meals each day). These critiques are reminiscent of the battle between behaviorism and phenomenology that flourished in the 1950s and 1960s (Giorgi, 1970; Rogers, 1961; Skinner, 1953; Wann, 1964). Phenomenologists of that period reacted strongly to assertions of contemporary behaviorists; namely, because the cause of all behavior was found in the environment, control of this environment was necessary for changing human behavior. This position seems to promote external control over the individual rather than assuring that the person held on to decision making. Hence, behavioral interventions take away individual control over life decisions.

EMPOWERMENT AND BEHAVIOR THERAPY

Arguments that assert that behavioral interventions undermine independent decision making are wrong and arise from misunderstanding and stereotypes about behavior therapy. Many behavioral interventions have fallen into disuse as a result of these stereotypes and prejudices (Corrigan & McCracken, 1995; Glynn, 1990). This is both ironic and unfortunate because behavioral interventions actually facilitate the decision-making abilities of many persons with severe psychiatric disorders. Therefore, it is important that misunderstandings be corrected so that behavior therapy continues to serve a prominent role in the treatment of persons with severe psychiatric disorders.

Empowerment is a much vaguer term than behavior therapists typically use. More than likely, these vagaries are one reason why misunderstandings and stereotypes about behavior therapy recur. To make this term more concrete, empowerment is defined in this article as the ability of individuals to make independent decisions about their treatment and living situation. Five factors of psychosocial interventions (listed in Table 2) facilitate independent decision making; interventions that show these factors enhance the individual's empow-
TABLE 2
Factors of Psychosocial Interventions That Support Empowerment

Empowering interventions provide a safe place for decision making to occur.
Empowering interventions provide the person with more choices.
Empowering interventions enable the person to live independently.
Empowering interventions provide resources that support individual decision making.
Empowering interventions foster self-control over the person’s decision making.

...ermanent. First, empowering interventions provide a safe place for the person to make decisions. Persons living, or otherwise interacting, in chaotic or frightening milieus are not able to make careful decisions.

Next, empowering interventions clarify choices; persons with severe mental illness are better able to understand their social world when it is described in concrete behavioral terms. These interventions also help persons with severe mental illness learn skills to live independently by providing resources and social support needed for independent living. Last, psychosocial interventions foster empowerment when they teach self-control strategies.

When independent decision making is framed in this light, it is apparent that behavior therapy actually facilitates empowerment rather than hampers it. Behavior therapy by its nature is concrete and directed toward independent living. Behavioral strategies have been shown to promote each of the factors in Table 2. A closer look at behavioral strategies that have been evaluated on persons with severe mental illness will support this assertion.

EMPOWERMENT AND OPERANT STRATEGIES

Operant interventions like the token economy have been used extensively in caring for persons with severe mental illness (Atthowe & Krasner, 1968; Ayllon & Azrin, 1968; Corrigan, 1995; Glynn, 1990; Paul & Lentz, 1977). Comprehensive token economies comprise three components. First, a list of target behaviors is identified; these typically include social, coping, and self-care skills. Second, point contingencies are defined for each target behavior. The number of points for each behavior varies with the importance and difficulty of that behavior. For example, an “easy” behavior like brushing teeth receives 5 points, whereas a more “difficult” behavior like monitoring psychiatric warning signs receives 10 points. Finally, rules for cashing in points
are defined. Typically, participants in a token economy exchange their points each day for a smorgasbord of commodities (e.g., hygiene products, snacks, stationery) and privileges (e.g., the Friday night pizza party).

Token economies facilitate two of the factors listed in Table 2. First, they provide a safe and structured milieu for individuals to consider their options. Research has clearly shown that the rate of chaos and aggression decreases significantly when token economies are instituted in the milieu (Dickerson, Ringel, Parente, & Boronow, 1994; Paul & Lentz, 1977). The importance of a safe milieu should not be underestimated. Several studies have suggested that many treatment programs are noisy and chaotic places that actually exacerbate agitation and psychotic symptoms (Drake & Sederer, 1986; Linn, Klett, & Caffey, 1980; Moos, 1974; Palmstierna, Huitfeldt, & Wistedt, 1991). Persons with severe mental illness place survival ahead of making life decisions when they are dealing with the demands of an overstimulating or out-of-control environment.

Second, token economies facilitate empowerment by clarifying options that a person may consider in a particular environment. Social exchange theorists argue that all interpersonal interactions are governed by the exchange of rewards and punishers (Kelley & Thibaut, 1978; LaValle, 1994; Molm, 1994). However, rules governing this exchange are frequently subtle such that persons with social cognitive deficits are likely to miss them (Argyle, 1986; Trower, 1982). Token economies make explicit the contingencies in a social exchange. For example, rather than the vague statement "Your friends will be happy if you try to be clean," participants in a token economy are told, "You will receive 5 points for brushing your teeth, 8 points for bathing with soap, and 12 points for putting on clean clothes." Persons living in a residential program may choose to do any or none of these behaviors. The token economy specifies individual choices from which the program participant might choose to be clean.

The power of the token economy is especially important for persons with severe psychiatric disorders who also experience cognitive deficits. The cognitive deficits further undermine their ability to accurately comprehend the interpersonal contingencies that define their social environment (Bellack, Mueser, Wade, Sayers, & Morrison, 1992;
Corrigan & Green, 1993). Token economies help persons with cognitive deficits overcome these deficits by highlighting the environmental contingencies that govern these interactions.

SKILLS TRAINING AND COGNITIVE REHABILITATION

Frequently, persons with severe mental illness are not able to live independently because they lack various social, coping, and self-care skills. Training programs have been developed and tested that show that persons with severe mental illness readily learn these skills and use them to live independently and improve their quality of life (Dobson, McDougall, Busheikin, & Aldous, 1993; Eckman et al., 1992; Hogarty, Anderson, Reiss, Kornblith, Greenwald, Javna, et al., 1986; Hogarty, Anderson, Reiss, Kornblith, Greenwald, Ulrich, et al., 1991; Wallace & Liberman, 1985). Persons who have mastered these skills are better able to make independent decisions, meet interpersonal needs, and deal with day-to-day stressors.

Social and coping skills trainers use a variety of learning activities to help program participants learn new skills. These include actors modeling the skill, program participants rehearsing the skill in structured role plays, trainers providing feedback and reinforcement for successful rehearsals, and trainers assigning homework at which time program participants practice the skill outside the training milieu. These learning activities have been used to teach basic conversation, assertiveness, symptom management, medication management, street smarts, and job readiness skills (Corrigan & Holmes, 1994; Jacobs, Collier, & Wissusik, 1992; Liberman & Corrigan, 1993; Wallace, Liberman, MacKain, Blackwell, & Eckman, 1992).

The cognitive deficits that prevent many persons with severe psychiatric disorders from accurately understanding the social world also undermine their ability to learn, and subsequently use, social and coping skills. For example, attentional and memory deficits that are common to severe psychiatric disorders have been shown to be significantly correlated with skill learning and performance (Corrigan, Wallace, Schade, & Green, 1994; Kern, Green, & Satz, 1992; Mueser, Bellack, Douglas, & Wade, 1991). Clinical investigators have developed and tested various cognitive rehabilitation methods that help
persons with severe mental illness learn social and coping skills (Brenner, Hodel, Roder, & Corrigan, 1992; Green, 1993; Storzbach & Corrigan, 1996). Once again, behavior therapy has provided a technology that can help persons to overcome their cognitive deficits so that they are better able to address their day-to-day decisions.

**BEHAVIOR FAMILY MANAGEMENT**

One of the most important resources for persons with severe mental illness is the person's family. Parents, siblings, and other relatives are a potential source of financial and emotional support. Unfortunately, family members are frequently overwhelmed by the burden of dealing with their loved one's mental illness (Hooley, Richters, Weintraub, & Neale, 1987; Spaniol, 1987). Some family members dealing with the financial and emotional burden of a loved one's mental illness may unintentionally exacerbate psychotic symptoms with their angry and hostile reactions to the person (Coyne et al., 1987; Jackson, Smith, & McCorry, 1990). As a result, some family members are not able to provide support to the person with severe mental illness. Persons with severe mental illness lacking this and other social support find managing their illness, and making independent decisions, more difficult.

Behavior family therapy programs have been developed to help family members deal with their loved one's mental illness (Anderson, Reiss, & Hogarty, 1986; Falloon, Boyd, & McGill, 1984; Mueser & Glynn, 1995). These programs include educational components in which family members learn about biological and phenomenological aspects of the disease and about various interventions that treat these aspects. Behavior family therapy also teaches family members and persons with severe mental illness communication and problem-solving skills. Both the person with severe mental illness and his or her family members are better able to handle future stressors when they have mastered familial communication and problem solving.

Research on the effects of behavior family therapy have been impressive in its ability to improve family members' understanding of their relative's illness (Mueser & Bellack, 1995; Penn & Mueser, 1996). Short-term improvements in perceived family burden were also observed. As a result, family members were better able to support their
relatives; the independent functioning of relatives with mental illness subsequently improved.

SELF-CONTROL STRATEGIES

Perhaps the epitome of procedures that enhance independent decision making are those that facilitate self-control. Behavior therapists have developed a range of self-control techniques that may help persons with severe mental illness manage their disorder (Corrigan, Schade, & Liberman, 1992). Self-control techniques include self-monitoring, self-evaluation, and self-reinforcement.

Persons with severe mental illness are taught to self-monitor their behavior, the situations in which these behaviors occur, and the consequences that follow. Targets of self-monitoring may include observable behaviors like conversing with a friend, as well as internal states like feeling anxious about this interaction. Persons are then taught to evaluate behaviors they are monitoring in terms of internal or external criteria. These criteria need to be reasonably attainable (e.g., “I will try to have a 5-minute conversation with one acquaintance each week.”). Initiation of successful behavior should be attributed to internal causes (e.g., “Wow! I talked to my co-worker well.”) rather than external ones (e.g., “That conversation only went well because he is so nice.”). Persons are then taught to reward themselves for meeting these criteria. The rewards need to be meaningful to the individual and might include some material reinforcer (e.g., “I’m going to give myself an ice cream treat tonight for talking to my co-worker.”) and, more important, a positive self-statement (“I have really helped myself toward recovery by talking to my co-worker today.”).

Self-control techniques have been used successfully to help persons with severe mental illness, especially those with depressive disorders (Rehm & Kaslow, 1984). Research studies have found that program participants show better interpersonal skills and a higher quality of life (Becker, Heimberg, & Bellack, 1987; Miller, Norman, & Keitner, 1989; Piatkowska & Farnill, 1993; Van Dam-Baggen & Kraaimaat, 1986). This kind of improvement leads to more independent decision making and greater personal empowerment.
EMPOWERMENT AND THE BEHAVIOR THERAPIST

Behavior therapy clearly seems to empower persons with severe mental illness. Contrary to the concerns of the phenomenologists, behavioral interventions do not control people, they help people to better control their environments. Token economies help to provide a safe place for persons to consider their life decisions. Token economies also clarify the range of choices that comprise many of these decisions. Skills training and cognitive rehabilitation teach persons with severe mental illness the skills necessary to meet the demands of independent decision making and community living. Behavior family therapy teaches family members skills so that they can provide more resources to persons with severe mental illness. Persons with these resources are better able to live independently. Finally, self-management techniques give persons more control over their behaviors and the settings in which they occur.

Behavior therapy facilitates empowerment. This does not mean, however, that individual behavior therapists will always use these interventions to empower their clients. Behavior therapists might misuse these interventions and turn a potent strategy into an intervention that promotes stigma and discrimination. Any intervention that has the power to help, if misused, also has the power to harm. For example, staff running operant programs might establish reinforcing or punishing contingencies that seek to keep the participant docile and that discourage independent decision making. Behavior therapists need to make sure that behavioral strategies are not abused, abuse that adds to the societal discrimination and stigma experienced by persons with severe mental illness.

The potential for abusing behavioral strategies can be diminished if clinicians foster a collaborative relationship with their clients. Several strategies facilitate collaboration between therapist and client (Corrigan et al., 1990; Meichenbaum & Turk, 1987). Frequently, persons with severe mental illness are not able to make informed decisions about behavioral interventions because these interventions are couched in complicated jargon. Moreover, many clients are confused by complex treatment regimens (e.g., one client was overwhelmed by a treatment protocol that included behavioral contracts for managing smoking and exercise, skills training to improve the
client's interactions with his wife, imaginal rehearsal of the newly learned skills, self-control strategies to monitor the effects of skills training, and positive self-talk to counter negative expectations about interactions with his wife). Clinicians need to make treatment plans understandable so that persons with severe mental illness can be brought into the decision-making process.

Another major barrier to collaboration is the behavior therapist who ignores client satisfaction with treatment. Clients are unlikely to continue interventions that they perceive do not meet their needs. Clients show their dissatisfaction in several ways: They stop coming to therapy, they do not complete therapy homework, or they become angry with the therapist. One of the best ways to assure that a specific intervention is effective is to make it satisfactory to the client.

CONCLUSION

In some ways, arguing that "behavior therapy empowers persons with severe mental illness" to readers of Behavior Modification is like preaching to the converted. Most readers of the journal endorse the efficacy of behavioral interventions for severe mental illness. It is important, however, for behavior therapists to recognize that societal forces also affect the course of severe mental illness. In particular, stigma and discrimination are likely to have a significant effect on the course of severe psychiatric disorders. Behavior therapists need to be aware of the dangers of discrimination and stigma if they do not want to unwittingly commit these errors by misusing behavioral interventions.

Behavior therapists also need to be aware of how concerns about stigma and discrimination have led to misconceptions and stereotypes about behavior therapy. These concerns have turned many clinicians and clients away from behavioral interventions. This is unfortunate given the power of behavior therapies for the symptoms and dysfunctions of severe mental illness. This is also unfortunate because behavior therapies actually empower persons with severe mental illness. Behavior therapists need to educate the public about such misconceptions so that consumers of mental health services willingly seek out these potent interventions for their life problems.
REFERENCES


Dobson, D.J.C., McDougall, G., Busheikin, J., & Aldous, J. (1993, November). *Social skills training and symptomatology in schizophrenia*. Paper presented at the 27th annual convention of the Association for the Advancement of Behavior Therapy, Atlanta, GA.


Patrick W. Corrigan is associate professor of psychiatry and director of the University of Chicago Center for Psychiatric Rehabilitation.