EMPOWERMENT AND SERIOUS MENTAL ILLNESS: TREATMENT PARTNERSHIPS AND COMMUNITY OPPORTUNITIES

Patrick W. Corrigan, Psy.D.

The health goals of persons with serious mental illness are greatly improved when their personal power is advanced. Two targets of empowerment are discussed in this paper: treatment partnerships and community opportunities. Strategies that enhance treatment partnerships include provider endorsement of recovery rather than promoting an approach that suggests poor prognoses, treatment plans that are collaborative rather than unilateral decision making that is perceived as coercive, and treatment services provided in the person's community rather than geographically or psychological distant institutions. Approaches that focus on the person and treatment relationship are not sufficient however. Stigma and discrimination are significant barriers to the kind of community opportunities that are necessary to help people attain life goals. Communities that substitute stigmatizing attitudes and discriminatory behaviors with realistic views of mental illness are more likely to provide the kind of reasonable accommodations that some people need for work and independent living opportunities.

KEY WORDS: consumer empowerment; stigma; serious mental illness.

Center for Psychiatric Rehabilitation, University of Chicago.
Address correspondence to Patrick Corrigan, University of Chicago Center for Psychiatric Rehabilitation, 7230 Arbor Drive, Tinley Park, IL 60477; e-mail: p-corri@u.uchicago.edu; www.ucpsychrehab.org.
For almost all of recorded history, people with such serious mental illnesses as schizophrenia, bipolar disorder, and major depression have struggled with maintaining personal power over their lives. The ancient Greeks first gave voice to the concept of stigma noting that those who were marked with mental illness were often shunned, locked up, or, on rare occasions, put to death (1). During the Middle Ages, persons with mental illness were viewed as living examples of the weakness of humankind, what goes wrong when people are unable to remain morally strong (2). This kind of attitude led to hiding away those with psychiatric disabilities in the family’s closet. Not until the 18th century did asylums and treatment centers arise for mental illness. Before that time, those with serious and persistent mental illness were often locked up with criminals.

Although the struggle for personal power has vastly improved during the last century, people with mental illness still encounter stigma and disempowerment; two sources of disempowerment are the focus of this paper. (1) Treatment providers who endorse disempowering notions about mental illness are likely to undermine collaborative relationships with persons who consume their services. (2) Communities that promote stigma will fail to provide the rights and opportunities to which all adults are entitled. This paper reviews these sources of disempowerment and ways to overcome them. A model that describes how empowerment leads to improved outcomes is provided in Figure 1.

THE GOALS OF MENTAL HEALTH SERVICES

What are the goals of programs that serve persons with serious mental illness? The answer to this question is essential to understand how empowerment affects the health of people with these disorders. First, treatment programs seek to decrease psychiatric symptoms so persons can obtain some relief from the various symptoms that may plague them; e.g., dysphoria, anhedonia, agitation, confusion, and rage. State-of-the-art practice guidelines instruct providers to mix supportive psychotherapy, symptom monitoring, medication management, and skills training to help people obtain symptom relief (3–5). Many professionals and advocates believe that this kind of treatment package requires a mutually respectful and optimistic collaboration between consumers of psychiatric services and their providers. According to this view, consumers who are empowered in these collaborative relationships will benefit more from treatment and be more successful in controlling their symptoms.
FIGURE 1. A heuristic model of how empowerment leads to improved mental health outcomes in persons with psychiatric disabilities.

Symptom relief is by no means where service for people with serious mental illness ends. According to the DSM-IV, the key to what makes any mental illness "serious" is a significant portion of time since the onset of the disorder where one or more major areas of functioning—work, independent living, and self care—is markedly below expected levels (3). It is this kind of persistent disabilities that make mental illnesses severe. Rehabilitation counselors seek a two-tiered approach towards remediating these disabilities (6,7): (1) helping consumers learn the necessary skills to overcome their disabilities (a treatment-based approach similar to symptom remediation), and (2) changing the environment so persons can obtain reasonable accommodations that support them at work and home. In terms of the latter, communities that endorse the stigma of mental illness are not going to support an individual’s right to self-determination in his or her community; the right to determine the kind of job they should pursue, the neighborhood they will live in, and the people with whom they will consort (8). Problems posed by this kind of stigma and discrimination require
public action to provide persons with serious mental illness the kind of opportunities needed to overcome their disabilities.

Readers may notice that terms like empowerment and disempowerment are frequently interchanged in this paper. In part, this interchange represents empowerment as a continuum (9,10). At the positive end of the continuum is the person with serious mental illness who, despite their disability, has positive self-esteem and is not significantly encumbered by a stigmatizing community. At the negative end, is the person who reports being unable to overcome all the pessimistic expectations about mental illness. One might think that a paper about empowerment, health, and mental illness would be presented in the affirmative voice; what might people with mental illness, service providers, and the community at large do to promote personal power. Unfortunately, much of the research and literature on empowerment looks at the negative impact of its absence; what happens when a person with mental illness is disempowered (11,12). Hence, I have chosen to intertwine what is known about disempowerment with what is the vision of empowerment to address the two themes of this paper: treatment partnerships and community opportunities.

THE EFFECTS OF EMPOWERMENT ON TREATMENT PARTNERSHIPS

Clinical trials and effectiveness research have identified several pharmacological and psychosocial treatments for remediating symptoms and helping persons attain goals that are blocked by psychiatric disabilities. As suggested in Figure 1, many believe a partnership with the treatment team is central to these interventions; a mutual exchange between practitioners (who are expert in the interventions that improve symptoms and disabilities) and consumers (who are expert in their disability and life goals). Unfortunately, several barriers that result from disempowerment undermine this partnership; some of these are reviewed here. These are contrasted to ways that promote personal empowerment.

Focus on Recovery, Not Poor Prognosis

The traditional prognosis for serious mental illness had been poor. Kraepelin (13) voiced the most notable of these ideas; i.e., persons with schizophrenia and other serious mental illnesses will inevitably experience a progressive downhill course, ending up demented and
incompetent. The impact this has on treatment is insidious; why try
valiant interventions if the person is going to eventually end up on a
back ward? Longitudinal research, however, fails to support Kraepelin’s
assertion. For example, researchers in Vermont and Switzerland
followed several hundred adults with severe mental illness for thirty
years or more to find out how mental illness impacted the long-term
course of the disorder (14). If Kraepelin was right, the majority of
these people should end up on the back wards of state hospitals.
Instead, research discovered that between half to almost two thirds
of the samples no longer required hospitalization, were able to work
in some capacity, and lived comfortably with family or friends; they
recovered. Recovery signals a revolution in mental health services. It
clearly reinstates hope and potential in the life course of a person with
severe mental illness.

Unfortunately, the practices and perspectives of mental health
practitioners often lag behind innovative ideas (15). For example,
research has shown that well-trained professionals from most mental
health disciplines subscribe to stereotypes about mental illness
(16–20). Many providers endorse the pessimistic notion that persons
with serious mental illness are doomed to poor outcomes. Hence, an
essential process for promoting empowerment is changing attitudes
among health care providers.

Replace Coercive Treatment with Collaboration

Many persons with serious mental illness experience treatment pro-
grams as coercive, forcing “patients” to comply with an intervention
which they either do not fully understand or, which they do not be-
lieve to be beneficial (10,11,21). Perceived coercion may occur for
several reasons. Confusing or complex treatment regimens may be mis-
understood, leading to mistaken assumptions that practitioners are
making unilateral decisions without the consumer’s participation.
Treatment regimens for chronic disorders, that seem to continue in-
determinably, are often experienced as coercive (22). Concerns about
violence by persons with serious mental illness often lead to recommend-
dations for mandatory inpatient and outpatient interventions (23).

Social psychologists have defined reactance as the common response
to perceived coercion; namely, persons behave contrary to the intent
of a threat (24–26). For example, consumers who believe medications
are forced on them may decide not to comply with their prescription.
Researchers have argued that this kind of reactance may be a
central reason why persons with mental illness do not comply with
medication and other treatment regimens (22,27). Actually, the term compliance used in the previous sentence also promotes attitudes of disempowerment in its own right. The notion of compliance perpetuates the misconception that adherence derives primarily from patient motivation or resistance; the clinician is to overcome resistance and take the lead in influencing this behavior.

Rather than viewing the consumer as a passive receptacle for treatment, clinicians must partner with them to design treatment programs that meet the person's goals. In an earlier paper, we specified strategies that foster this collaboration (28). We divided this list into strategies that facilitate clinician-consumer relationships, those that make the treatment delivery system more pleasing to consumers, and approaches that make the treatment techniques themselves less aversive.

Service in the Community Not Institutions

During the first half of the 20th century, services were typically provided in institutions that were removed from the consumer's community. This practice, in part, developed out of the notion of asylum, a place where persons with mental illness can escape the demands of everyday living to recoup their strengths and abilities (29). Despite this noble intent, sending people away to hospitals was soon identified as the prototype of disempowerment. Mental health advocates realized that quality of life was rooted in fully experiencing the opportunities and problems of one's neighborhood (30,31). Practitioners followed the lead by calling for community-based treatment of mental illness. A small step towards this goal was achieved in 1963 when John Kennedy signed the Community Mental Health Centers Act. The intent of the act was to move inpatient, outpatient, and emergency care services to the neighborhoods from which consumers hail.

A major leap in community-based services that empower people with serious mental illness was demonstrated in the 1970's research program of Stein and Test (32). They advanced the notion of community-based care by removing services from centrally located centers and bringing them to the consumers themselves. Stein and Test surmised that the impact of medication management, skills training, and support would be greatly improved when provided in the person's home, workplace or other meaningful setting, real places where personal goals are intimately experienced. A recent review of more than 75 studies that have examined the impact of Stein and Test's Assertive
Community Treatment (ACT) show the intervention has moderate to
good effects on hospitalization, housing stability, symptoms, and quality
of life (33). The spirit of community-based interventions has further
expanded with the integration of consumer-operated services into this
armamentarium (34).

STIGMA AND THE LOSS OF
COMMUNITY OPPORTUNITIES

Stigma is the societal embodiment of disempowerment (see Figure 1); it
promotes expectations in both the public at large and many individual
consumers that people with serious mental illness are incapable of the
responsibilities commensurate with living independently. Results of
two factor analyses on more than 2000 English and Americans revealed
three common themes to stereotypic attitudes about mental illness that
endorse this assertion (35,36). (1) Fear and exclusion: persons with
severe mental illness should be feared because they are dangerous.
As a result, they should be kept out of the community and housed in
institutions. (2) Authoritarianism: persons with severe mental illness
are irresponsible; life decisions should be made for them by others.
(3) Benevolence: persons with severe mental illness are childlike and
need to be cared for.

These kind of widespread attitudes have two effects on the power of
persons with mental illness. First, they rob people of the opportunities
that are central to recovery and a quality life; e.g., good jobs, comfortable
income, nice housing, and good friends. Perhaps of equal concern are
the effects which stigma has on some people with mental illness.
People living with serious mental illness who are immersed in a culture
that endorses psychiatric stigma (37) begin to believe this stigma and
question their own capabilities for independent living. Because self-
stigma has such an insidious impact, its effects on empowerment are
examined first.

The Effects of Self Stigma

Some people experience stigma as a private shame that diminishes
the person’s self-esteem (38,39). This kind of shame leads to self-doubt
about whether the person is able to live independently, hold jobs, earn
a livelihood, or find life mates. Even though they may have mastered
their symptoms and disabilities, persons with mental illness must
also overcome stigmatizing reminders that they fail to recover or are
not useful members of society. One recent study showed the breadth of discrimination experienced by mental health consumers (40). The majority of 1300 respondents reported discouragement, hurt, anger, and lowered self-esteem as a result of their experiences. An earlier study by Bruce Link (41) showed the loss of self-esteem that results from stigma also has practical consequences. Participants in their study reported that being publicly labeled with a psychiatric illness had a negative impact on work and income.

Research is yet to examine strategies for overcoming self-stigma, but several candidates show promise (39). Internalizing the kind of messages embodied in recovery may help to diminish self-stigma. Cognitive restructuring may also prove useful in helping people learn to challenge stigmatizing views of themselves (38,42). Ultimately, self-stigma will change when common stigmatizing attitudes of the public are stopped.

**Societal Stigma and the Loss of Opportunities**

As we stated earlier in this paper, one of the central goals of mental health service is to help persons overcome the disabilities that prevent them from achieving life goals. In part, this means helping persons take advantage of the opportunities available to most adults in their community; good jobs, safe housing, reasonable income, and diverse friends. Unfortunately, research shows that stigma steals these opportunities from persons labeled mentally ill. Citizens are less likely to hire persons who are labeled mentally ill (43–46), less likely to lease them apartments (47–49), and more likely to falsely press charges for violent crimes (50,51).

This kind of injustice requires community change. Social psychologists have identified three ways to change stigmatizing attitudes and discriminatory behaviors in the general public: protest, education, and contact (8). Protest seeks to suppress stigmatizing attitudes of mental illness and behaviors that promote these attitudes through appeals to moral indignation. “Shame on you for thinking about mental illness in a disrespectful way.” Unfortunately, research suggests protest has little effect on negative attitudes about mental illness (52). This does not, however, mean protest yields no benefits as far as discrimination is concerned. Businesses that are the object of protest because of stigmatizing media representations (e.g., an advertisement that says, “We must be NUTS to sell cars so cheaply!”) may cease these ads rather than face economic boycotts (37).
Several research studies have examined the effects of education on stigmatizing attitudes and discriminatory behavior (52–56). Typically, education programs contrast key myths about mental illness with corresponding facts. These studies show significant changes in attitudes but little effects on behavior. Contact seems to yield better effects. Contact challenges public attitudes about mental illness through direct interactions among the general public and persons who have these disorders. Myths are directly challenged when members of the general population experience persons with mental illness as no different than the rest of the population. Two recent studies have shown that contact yields greater improvements in attitude change than education; contact also facilitates helping behaviors (52,53). Consider the implications of contact for empowerment; this research suggests one of the greatest resources for challenging the stereotypes that undermine opportunities is the person with mental illness.

CONCLUSIONS

Persons with mental illness, who experience personal power over their immediate life decisions, seem to demonstrate better mental health outcomes. Making sense of the path between empowerment and mental health began with description of the goals of mental health treatment. Two goals were distinguished: providing relief from the painful symptoms of serious mental illness and attaining life goals that are blocked by psychiatric disabilities. Attitudes and behaviors that foster disempowerment will block attainment of these goals; conversely, strategies that promote empowerment and challenge stigma facilitate health goals.

Several strategies were identified that seem to promote empowering treatments and treatment partnerships. Providers that adopt an attitude of recovery encourage an optimistic approach towards dealing with symptoms and disabilities. This kind of approach is further facilitated when providers work collaboratively with consumers, being vigilant to such issues as the quality of consumer-clinician relationships, the treatment system ambience, and the perception that specific techniques are perceived to be coercive. The treatment partnership is also augmented by providing services in the person’s community, rather than some geographically or psychologically distant institution.

The impact of empowerment does not end there. Health goals, especially related to those that are diminished by disabilities, are
facilitated when the stigma and discrimination that have been used to describe these disabilities are challenged. Hence, persons who replace self-stigmatizing attitudes with positive expectations about work and independent living goals will be more successful in pursuit of those goals. Moreover, communities that replace the myths of mental illness with accurate information will be more apt to provide the kind of reasonable accommodations that people need to successfully attain work and independent living opportunities. We have only just begun to outline and test the hypotheses outlined in this paper. It is up to future research to determine the veracity of these assertions and to amend them as more is learned.

REFERENCES


