Movies, newspapers, magazines, television shows, books, radio programs, and advertisements have all been vehicles for communicating the experience of severe mental illness. This has, however, tended to be a misrepresentation of the experience. Persons with psychiatric disability suffer societal scorn and discrimination because of the stigma that evolves out of these misrepresentations. This kind of rebuff frequently leads to diminished self-esteem, fear of pursuing one’s goals, and loss of social opportunities (e.g., landlords are hesitant to rent apartments to persons with severe mental illness). Social psychologists have developed a model of stereotype that frames stigma as a cognitive structure. Their social cognitive paradigm seems especially useful for a model of cognitive behavioral therapy for stigma. This model identifies three targets: (a) persons who hide their mental health experience from the public and suffer a private shame; (b) persons who have been publicly labeled as mentally ill and suffer societal scorn, and (c) society itself, which suffers fears and misinformation based on stigma and myth. Each of these three targets suggests specific behavioral interventions that may alleviate the impact of stigma.

Clinicians frequently understand the impact of severe mental illness in terms of symptoms like psychosis, the deficit syndrome, depression, and mania. Although these symptoms are painful and disruptive, severe mental illnesses like schizophrenia are distinguished by broad social disabilities that have a greater impact on the immediate outcome and long-term course of the person’s life. Many persons with disorders like schizophrenia suffer interpersonal, self-care, and cognitive deficits that prevent them from achieving their life goals. These persons are often unable to live independently, get competitive jobs, make a sat-
isfactory income, and develop long-term intumacces. Persons with severe psychi-
tric disabilities typically rate their quality of life as poor.

Research suggests that inability to meet the challenges of life and attain age-appropriate roles and goals develops as a result of disabling illnesses. However, the negative impact of severe mental illness is not entirely due to the ram-
ifications of a biological disorder. Society's reaction to the disease seems to have an equally harmful impact on the person's abilities to successfully achieve life goals. The public at large holds a variety of negative stereotypes about severe mental illness. "Mental patients are dangerous." "They can't live on their own." "There is no cure for mental illness." These stereotypes lead to expectations that persons with schizophrenia will fail when trying to live independently, get a job, or build a long-term relationship. Stigma and pessimistic expectations lead to discrimination. Landlords are less likely to rent apartments to persons with psychi-
tric disabilities. Employers do not want to hire persons with a long history of psychiatric hospitalization. Neighbors are afraid to visit with acquaintances who may be "dangerous ex-patients."

**Stigma and Behavior Therapy**

Behavior therapy needs to broaden its agenda to cover both disease and discrimination factors that affect the impact of severe mental illness. Practitioners must continue skills training and incentive therapies that assist persons in learning to cope with their biological illness; persons use these skills to get their interpersonal needs met as well as to deal with recurrent life stressors (Liber-
man, 1992). Researchers and practitioners also need to identify a menu of be-
havioral interventions that help persons with severe psychiatric disability deal with stigma. These strategies include decisions about disclosing one's history of mental illness or ways that empower the person during his or her treatment. So-
cietal change may be an equally important focus of behavior change. Behavior therapists should identify and implement strategies that improve public atti-
tudes about mental illness and that stop discrimination of people with psychiat-
ric disability.

This paper provides a model for a behavior therapy of stigma. The paper be-
gins with a distinction between disease and discrimination models of severe mental illness. The full impact of stigma and discrimination is then discussed; understanding the breadth of stigma is important for identifying targets of a

---

1 In this paper, I adhere to National Institute of Disability and Rehabilitation Research guidelines and refer to persons with severe mental illness rather than mentally ill patients (Blaska, 1993). Terms such as the latter promote stigmatizing views by reducing people to their roles as patients in the mental health system rather than individuals in the world who happen to suffer a psychiatric disability. This kind of person-first language reminds the reader that mental illness is only a small part of what is experienced by the people we serve.
corresponding behavior therapy. Social psychological research on the knowledge structures related to stereotype and discrimination provide important concepts for a cognitive behavior therapy of mental illness stigma. This research is reviewed in the paper. The paper ends with a model of behavior therapy that integrates information about the full impact of stigma with social cognitive concepts about prejudice.

What Happened to Mr. Goodman?

Sometimes stigma and discrimination are overt acts of a naive public. Other times, unfair treatment is posed in the guise of the patient’s best interest. A brief case history illustrates stigma’s obvious and insidious character.

Franklin Goodman had been recently released from an Illinois state hospital after a recent exacerbation of psychotic symptoms. At the time of admission, Mr. Goodman was highly agitated, yelling that the police were going to harm him because he’s the Boston Strangler’s brother. Mr. Goodman told the on-call psychiatrist in the emergency room that he was hearing voices of the devil preaching about his murderous relatives. This was the patient’s third hospitalization since schizophrenia was first diagnosed 12 years earlier at age 22. Mr. Goodman had made an excellent recovery from previous hospital stays: He had been working as a salesman at a hardware store for the past 6 years and lived nearby in a small, but comfortable, apartment. He visited a psychiatrist for medication about once a month at the community mental health center where he also met with a counselor to discuss strategies to cope with his mental illness. Mr. Goodman had several friends in the area and was fond of playing softball with them in park district leagues. He had been dating a woman in the group for about a year and reported he was “getting serious.” Franklin was also active in the local Baptist church, where he was co-leading Bible classes with the pastor. Clearly, the reappearance of his symptoms had derailed his job, apartment, and social life.

Recovering from this episode was not a function of remediating symptoms alone. The reactions of friends, family members, and professionals also affected what happened to him. The hardware store owner, Mr. Simpson, was frightened by Franklin’s “mental hospitalization.” He had heard that mentally ill people become violent and worried that the stress of the job might lead to a dangerous outburst in the shop. Franklin’s mother had other concerns. She worried that the demands of living alone were excessive: “He’s pushing himself much too hard trying to keep that apartment clean and do all his own cooking.” She feared Franklin might abandon his apartment and move to the streets just like other mentally ill people.

Mr. Goodman’s doctor was concerned that this hospitalization signaled an overall lack of stability. His doctor believed that schizophrenia was a progressively degenerative disease, a classic view of the disorder first promoted by Krae-
Psychiatric hospitalizations represented milestones that the disease was worsening. The doctor concluded that Franklin's ability to live independently would soon wane, it was better to prepare for this loss now rather than wait for the inevitable forfeiture of independent functioning. So, the doctor, with the help of Franklin's mother and boss, talked him into leaving his job, giving up his apartment, and moving back home. Franklin's mother lived across town, so he stopped attending the Baptist church. Mr. Goodman was also unable to meet with his friends and dropped out of league sports soon after. He stopped seeing his girlfriend. In 1 month's time, he lost his job, apartment, and friends.

The tragedy of these decisions is especially evident when contrasting Mr. Goodman's experience to that of Harriet Ogglesby. Like Franklin Goodman, Ms. Ogglesby had been diagnosed with a significant and chronic disease: diabetes. Ms. Ogglesby was a 34-year-old clerk-typist for a small insurance broker in Omaha. She had to carefully monitor her sugar intake and self-administer insulin each day. She watched her lifestyle closely for situations that might exacerbate her condition. Ms. Ogglesby also met regularly with a physician and dietician to discuss blood sugar, diet, and exercise. Despite these cautions, Harriet had an active social life. She belonged to a folk dancing club that she attended at a nearby high school. She was engaged to be married to an accountant at the insurance company.

Despite carefully watching her illness, Ms. Ogglesby suffered a few setbacks, the last occurring about a month ago when she required a 3-day hospitalization to adjust her medication. The doctor recommended a 2-week break from work after discharge and referred her to the dietician to discuss appropriate changes in lifestyle. Even though diabetes is a life-threatening disease (in her most recent episode, Harriet Ogglesby was near coma when wheeled into the hospital), no one suggested she consider some kind of institutional care where professionals could monitor her blood sugar and intervene appropriately when needed. No one recommended Harriet give up her job to avoid work-related stressors that might throw off her blood sugar.

What is the difference? How could Franklin lose his job, apartment, and friends while Harriet's situation remained relatively unchanged? It was not the illnesses; both persons had been living successfully with their afflictions for several years. Nor their severity. Both are biological in origin, chronic, and pervasive across several life domains. The difference seems to lie with the reactions of health professionals, friends, and family to each illness. Harriet's support system realized that recovery required a holistic understanding of the disease; work and social activities were vital. Franklin's family and doctors missed the importance of friends, work, independence, and recreation, instead basing their decisions on misconceptions about schizophrenia. Misconceptions like these are the fundamental underpinnings of stigma and discrimination.
Disease and Stigma Models of Severe Mental Illness

A better understanding of concepts related to disease and stigma is needed to identify misconceptions that underlie negative public attitudes. Once, prominent voices in mental health believed that viewing mental illness as a disease actually led to stigma. Thomas Szasz (1961) and R. D. Laing (1964) argued that psychiatry and mental illness were created by a conservative society trying to put down eccentric or bohemian lifestyles by calling them sick. Psychiatric disease was a mirage produced by a cultural tyrant. Szasz and Laing viewed the only solution to correcting stigma required rejecting mental illness as a disease entity.

More current conceptualizations of disease and stigma seem not to be at odds (Corrigan & Penn, 1997). As can be seen from Figure 1, models that explain the impact of disease and discrimination parallel one another (Corrigan, 1997). These simple linear models show how disease and discrimination processes cause the loss of opportunities commonly experienced by persons with severe mental illness. According to a disease model, biological events including genetic heritage (Asherson, Mant, & McGuffin, 1995) and in-utero insult

![Diagram](image)

**Figure 1** Simple linear models of disease and discrimination paradigms that outline their impact on severe mental illness
(Susser & Lin, 1992; Torrey, Bowler, & Rawlings, 1992; Wyatt, 1996) create a psychobiological vulnerability in some persons. These vulnerabilities combine with the stress of life events to produce psychotic symptoms, mood disorders, or social apathy in late adolescence or young adulthood (Bebbington et al., 1993; Nuechterlein et al., 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 (Green, 1998; 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 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: 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. Persons report a poor quality of life because of the losses.

A stigma and discrimination model of severe mental illness yields a different picture of the relationship between biological cause and failure to avail social opportunity (see the right panel in Figure 1). Proponents of a stigma and discrimination model acknowledge that biological agents cause psychiatric symptoms; the combination of symptoms and vulnerabilities, in turn, leads to diminished social skills and support networks. However, proponents of the stigma and discrimination model suggest stigmatizing attitudes about these symptoms have an equally damaging effect on social functioning (Corrigan & Penn, 1998; Fisher, 1994; Link, Cullen, Struening, Shroot, & Dohrenwend, 1989; Penn et al., 1994). Members of the general public who endorse these stigma are likely to discriminate against persons with severe mental illness. Because the public does not understand the impact 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, the 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.

The Stigma and Discrimination of Mental Illness

Movies, newspapers, radio programs, and television shows are obvious purveyors of misinformation and stigma about severe mental illness. Media analyses of film and print representations of mental illness have identified three common misconceptions: people with mental illness are homicidal maniacs who need to be feared; they have childlike perceptions of the world that should
be marveled; or they are rebellious, free spirits who should be cultivated (Hyler, Gabbard, & Schneider, 1991; Mayer & Barry, 1992; Wahl, 1995). Several examples from the popular media collected from Otto Wahl’s book *Medza Madness* depict sensational and misleading newspaper headlines (i.e., *NUTTY PSYCHIATRIC PATIENTS* and *FREED MENTAL PATIENT KILLS MOM*) and cartoons that falsely represent mental illness as a zany, childlike lifestyle. Despite flagrant examples like these, much of society is still insensitive to mental health stigma. Table 1 provides an exercise that sensitizes persons to what might seem to be relatively innocuous statements about mental illness.

Results of two factor analyses on more than 2,000 individuals from England and the U.S. revealed three common themes to Western attitudes about mental illness (Brockington, Hall, Levings, & Murphy, 1993; Taylor & Dear, 1980): (1) Fear and exclusion: persons with severe mental illness should be feared and, therefore, be kept out of most communities. (2) Authoritarianism: persons with severe mental illness are irresponsible; life decisions should be made by others; (3) Benevolence: persons with severe mental illness are childlike and need to be cared for.

Stigmatizing attitudes are not limited to mental illness. Persons with physical illness and disabilities are also the objects of disparaging opinion. However, the general public seems to disapprove of persons with severe mental illness significantly more than persons with physical disabilities like Alzheimer’s disease, blindness, or paraplegia (Piner & Kahle, 1984; Weiner, Perry, & Magnuson, 1988). Severe mental illness has been viewed as more similar to drug addiction, prostitution, and criminality than physical disability (Albrecht, Walker, & Levy, 1982; Skinner, Berry, Griffith, & Byers, 1995). Unlike physical disabilities, persons with mental illness are perceived to be in control of their illness and re-

**TABLE 1**

<table>
<thead>
<tr>
<th>AN EXERCISE THAT SENSITIZES PERSONS TO MENTAL ILLNESS STIGMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make a list of overgeneralizations and misattributions about mental illness on A M radio and network television</td>
</tr>
<tr>
<td>&quot;That person acts that way because he's crazy&quot;</td>
</tr>
<tr>
<td>&quot;All psychos are violent.&quot;</td>
</tr>
<tr>
<td>&quot;Crazy people can’t take care of themselves.&quot;</td>
</tr>
<tr>
<td>Replace terms like &quot;crazy&quot; and &quot;psycho&quot; with the name of an ethnic minority group</td>
</tr>
<tr>
<td>&quot;That person acts that way because he’s Black.&quot;</td>
</tr>
<tr>
<td>&quot;All Latinos are violent.&quot;</td>
</tr>
<tr>
<td>&quot;Irish people can’t take care of themselves.&quot;</td>
</tr>
</tbody>
</table>

Most citizens, who might have thought these were innocuous statements about mental illness, quickly become horrified at the similarity between disrespecting persons with mental illness and persons of color. In fact, some advocates for disability have equated the experience of mental health stigma with the injustice of disrespecting racial minorities (Ross, 1992; Stephens & Behlsle, 1993).
sponsible for causing it (Weiner et al., 1988). Furthermore, research respondents are less likely to pity persons with mental illness, instead reacting to psychiatric disability with anger and believing that help is not deserved (Weiner et al.).

The Impact of Stigma and Discrimination

Stigmatizing attitudes like these have a significant impact on mental illness. First-person accounts in Schizophrenia Bulletin, a NIMH-sponsored journal, repeatedly describe the pain of stigma and discrimination. More carefully sampled survey research supports these accounts; one study found that 75% of family members participating in a survey said that relatives with mental illness had been affected adversely by stigma (Wahl & Harman, 1989). Family members in this sample believed that stigma decreased self-esteem, hindered ability to make friends, and undermined success in obtaining employment. Persons with severe mental illness living in New York City viewed stigma with similar concern (Link et al., 1989). They believed the public would exclude them from close friendships or competitive jobs because of their mental illness.

The impact of stigma is not limited to the individual diagnosed with mental illness. One in five respondents in a family survey reported lowered self-esteem and strained relationships with other family members because of stigma (Wahl & Harman, 1989).

The impact of stigma is not limited to negative public attitudes (Corrigan & Penn, 1997). Several studies have documented the behavioral impact (or discrimination) that results from stigmatizing attitudes. Citizens are less likely to hire persons who are labeled mentally ill (Bordueri & Drehmer, 1986; Farina & Felner, 1973; Link, 1987), less likely to lease them apartments (Alisky & Iczkowski, 1990; Page, 1977, 1983), and more likely to falsely press charges for violent crimes (Sosowsky, 1980; Steadman, 1981). The detrimental impact of stigma is not limited to discrimination by others. Some persons with severe mental illness also endorse stigmatizing attitudes about psychiatric disability and, in essence, about themselves. These persons may experience diminished self-esteem, which correlates with a lower quality of life (Mechanic, McAlpine, Rosenfield, & Davis, 1994). Moreover, persons who self-stigmatize are less likely to be successful in work, housing, and relationships (Link et al., 1989). These individuals seem to convince themselves that socially endorsed stigmas are correct and that they are incapable of independent living.

Social Cognition, Stigma, and Discrimination

Researchers have identified three paradigms that explain stigma: sociocultural perspectives, motivational biases, and social cognitive theories (Crocker & Lutsky, 1986). The first two models are described in Table 2. The third model—social cognitive paradigm—is especially relevant for cognitive behav-
Table 2
Socio-cultural and Motivational Paradigms that Explain Stigma

<table>
<thead>
<tr>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio-cultural</td>
<td>Stigma develops to justify prevalent social injustices.</td>
</tr>
<tr>
<td></td>
<td>The belief that African Americans are inferior justifies slavery</td>
</tr>
<tr>
<td></td>
<td>The belief that Mexican Americans are not intelligent justifies economic disadvantage.</td>
</tr>
<tr>
<td>Motivational</td>
<td>Basic psychological needs that affect attitudes and prejudice</td>
</tr>
<tr>
<td></td>
<td>Just-world hypothesis</td>
</tr>
<tr>
<td></td>
<td>It is fundamentally a fair world. Poor people are often the victims of crime. Therefore, they must be inferior or aggressive</td>
</tr>
<tr>
<td></td>
<td>Self-enhancement theory</td>
</tr>
<tr>
<td></td>
<td>I feel better about myself when I compare myself against a bad group.</td>
</tr>
</tbody>
</table>

Adapted from Crocker & Lutsky, 1986

...oral approaches to changing stigma and is thus more fully discussed here. According to this view, stigmas are cognitive structures that individuals construct to make sense of their social world (Crocker & Lutsky). In this light, stigmas are examples of the natural propensity to categorize information in an effort to make sense of the relative infinity of data with which people are bombarded (Baddeley, 1982). For example, individuals make sense of a word list—dog, top, wrench, skates, hammer, horse, pig, cow, saw, puzzle, drill, ball—by organizing the words into three categories: animals, tools, and toys. They may organize experiences with police officers, co-workers, guards, friends, neighbors, ticket takers, bosses, and family members into two groups: authorities and personal associates.

Stereotypes are especially efficient means of categorizing information about social groups (Esses, Haddock, & Zanna, 1994; Judd & Park, 1993; Krueger, 1996; Mullen, Rozell, & Johnson, 1996). Stereotypes are considered "social" because they represent collectively agreed upon notions of groups of persons. They are efficient because people can quickly generate impressions and expectations of individuals who belong to a stereotyped group (Hamilton & Sherman, 1994; Nosofsky, Palmeri, & McKinley, 1994). For example, that man in the uniform is a police officer; he will likely be an authoritative person I can seek out when I need help. Stereotypes do not necessarily represent a group pejoratively; the police example above is evidence of this. Stigmas are stereotypes that reflect a group negatively (Devine, 1989; Krueger, 1996); for example, "persons with mental illness are dangerous or incapable of making their own decisions."

Social psychologists distinguish knowledge of stigmas from endorsement of
them (Devine, 1988, 1989; Jussim, Nelson, Manus, & Soffin, 1995; Krueger, 1996). Many people are familiar with the Irish American drinking stigma. However, they do not endorse it as a true reflection of Americans with Irish backgrounds. To endorse such negative attitudes would be prejudicial. The harmful effects of stigma come from its prejudicial endorsement. Hence, it is the endorsement of stigma, and not knowledge, that is the target of stigma-busting activities. This, of course, is a more reasonable goal. Knowledge of a cognitive structure can never be erased. However, the contingencies that affect agreement with these attitudes can be changed such that people are less willing to endorse the stigma, or at least act on the endorsement.

Learning Stigma

Stereotypes and stigma are learned in two ways (Crocker, 1983; Crocker & Lutsky, 1986). Cognitively constructed stereotypes are acquired through regular contact with members of a particular group. The public learns stereotypes about mental illness by directly interacting with persons who have a psychiatric disability. Socially given stereotypes represent cultural lore about a group handed down by community elders and other authorities. Socially given stereotypes often include attributes that are not easily observed, like motivations, morality, and intentions. As a result, socially given stereotypes are frequently more difficult to change because they do not rest on prior experience and, therefore, are not affected by subsequent, contrary evidence (Kunda & Oleson, 1995; Rothbart & Lewis, 1988).

Goffman (1963) made a distinction between discredited and discreditable groups that has implications for acquiring and challenging cognitively constructed and socially given stereotypes. Members of discredited groups have patently manifest stigma. They show a physical characteristic that signals group membership (e.g., skin color distinguishes African Americans and yarmulkes identify Jews). Mental illness is an example of discreditable stigma, which is relatively hidden from public view. Citizens do not realize an individual has a history of mental illness and psychiatric hospitalization unless that person reports it. Much of the mental health experience is private and the corresponding stigma discreditable.

Persons with obvious or discredited stigma are typically the objects of cognitively constructed stereotypes. The public can discern stereotypical characteristics of a group when these qualities are manifest. Physical characteristics that define race, culture, or physical disability are frequent sources of cognitively constructed stereotypes. Typically, stigma about mental illness is socially given. The public learns that persons with mental illness are dangerous or incompetent based on messages provided by authorities in the culture. Hence, mental health stigma tends to be more resilient to evidence that contradicts the stigma (Corrigan & Penn, 1998). For example, education campaigns aimed at discounting negative attitudes about mental illness have had limited impact (Holmes, Corrigan, Williams, Canar, & Kubiak, 1997).
Although much of the mental health experience is private, one aspect is public and discredited: the mentally ill label. Persons who are called "mentally ill" (e.g., through a diagnosis such as schizophrenia or hospitalization for psychiatric illness) frequently are the butt of societal stigma and discrimination (Link, 1987; Link et al., 1989). People with public labels are the source of cognitively constructed stereotypes. The public learns by observing the "crazy guy" at the end of the train platform that persons with mental illness are disheveled, drunk, and larcenous. However, cognitively constructed stigma based on labels may lead to even greater misinformation than typical stereotypes. Individuals who are not true members of a minority group (e.g., people who are not challenged by a psychiatric disability) are misidentified as members of that group because they have been mislabeled. For example, many homeless people are labeled mentally ill, leading to inaccurate beliefs about persons with mental illness choosing to be poor and live on the streets (Koegel, 1992; Koegel, Burnham, & Farr, 1988).

Stigma and Discrimination

Discrimination is the behavioral consequence of prejudice and stigma (Corrigan & Penn, 1998). People who act on stigma by withholding opportunities from minority group members, or by behaving aggressively against these minority members, are discriminatory. Perhaps the worst part of stereotypes and prejudice is this behavioral consequence. Although being viewed negatively by the majority may generate anguish, anger, or self-reproach, it is loss of jobs, unfair housing, diminished income, physical violence, and verbal abuse that cause the greater misery. Hence, understanding the relationship between the cognitive phenomenon of stigma and the behavioral phenomenon of discrimination is essential to discounting their harmful effects on persons with severe mental illness.

The relationship between attitudes and behaviors has been an important conundrum for psychologists. Fazio (1990) distinguished two models—automatic and deliberative—that explain the effect of stigma on discrimination. According to the automatic model, many social behaviors are elicited by the perception of social cues (Langer, 1978). For example, a passenger changes seats after seeing an unkempt person talking to himself on the train. These are well-learned responses that require little awareness and seem to occur in specifically defined situations. Automatic responses are fairly adaptive because they do not require much cognitive effort to accomplish; people are able to respond almost reflexively to the social situation as a result.

How does a cognitive structure like attitude or stigma affect automatic responses? Stereotypes govern automatic responses by affecting the perceptions of social cues that elicit these stereotypes (Crocker & Lutsky, 1986; Fazio, 1986). Stereotypes serve as the encoding template that gives meaning to the sensation and lead to a behavioral response. A disheveled person encountered on the
train may alternatively be perceived as a "dangerous mental patient" (based on a psychiatric stereotype) or "a person down on his luck" (based, perhaps, on an attitude of Christian charity). The first perception may lead the passenger to move to a different seat. The second may cause the passenger to ask whether the person needs help. Strategies that change the underlying stereotype will alter automatic responses by changing the cues that signal these responses. For example, changing the perceptions of homeless people from "dangerous patients" to "persons down on their luck" may lead to less distancing and more concern.

All behavioral responses to social situations do not occur automatically; the second model that describes the relationship between stereotypes and behavior is deliberative in nature (Ajzen, 1987; Ajzen & Fishbein, 1980; Fazio, 1990). In novel situations, individuals must construct responses from a variety of behavioral possibilities. For example, Mary Smith, trying to carry a large load of groceries from her car to the house, encounters a person acting mentally ill who asks to help her. This is a novel situation to which Mary must choose a response from a range of options: She could accept the person's help, send him away, or ignore him. According to the deliberative model, the individual is a rational being who weighs the costs and benefits of various options.

Costs and benefits are affected, in part, by stereotypes about the minority group member (e.g., "persons with mental illness are dangerous, so one cost of letting him help me with my groceries is he may attack me"). Costs and benefits are also influenced by external motivators. These might be immediate motivations (e.g., "one benefit of letting him help is I would get my groceries in the house easier"). Motivation may also occur at the institutional level. Institutions like schools, businesses, and governments may apply penalties for performing a stigmatizing behavior. For example, the Federal government passed the American with Disabilities Act of 1990 and the Fair Housing Act of 1988, which discourage employers and landlords from discriminating against persons with disabilities such as mental illness.

Suggestions for a Behavior Therapy of Stigma

The breadth of problems caused by mental illness stigma suggests targets for behavior therapy; social cognitive research on stigma and discrimination suggest human processes that mitigate a behavioral approach to these targets. Figure 2 summarizes a model of behavior therapy that combines the breadth of targets with social cognitive processes. As outlined in Figure 2, stigma comes from a variety of sources. The media, including newspapers, movies, and television, disperses various stigmatizing images and slogans about severe mental illness throughout our community. Messages from parents and other authorities teach children that persons with mental illness are dangerous or cannot care for themselves. Observations of labeled "patients," like the homeless, lead to biased attributions about mental illness. These various sources of stigma impact severe
mental illness through paths, numbered 1 through 3 in Figure 2, that are considered sequentially here.

1. Challenging the Private Shame of Discreditable Stigma Through Attitude Change
   
   Some people experience stigma and prejudice as a discreditable phenomenon, a private shame that diminishes the person's self-esteem. 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 (Link et al., 1989). Even though they may have mastered their symptoms and disabilities, persons with mental illness must overcome stigmatizing reminders that they fail to recover or do not become useful members of society.

Struggling with going in and out of the hospital and the depression and craziness was bad enough. And all the disapproval sure hurt too. My parents thinking I was lazy, especially because my brother was a doctor. My uncles no longer asking me to go fishing with them because I needed my rest.

But what really hurt was when my parents gave up. I think it was after my hospitalization in 1990 when I tried to kill myself. They stopped believing I would beat it. They stopped pushing me to get a job. They talked about me living in a home. They thought I was a mental patient and not their son. Mom and Dad had bought into all the societal stuff about mentally ill patients.

The loss of faith was much harder than my time in the hospital. I began to believe it too. I'm not going to be able to work. I'll never find someone to marry. I'll always live in homes.

—adult with severe mental illness

Behavior therapists might help persons with mental illness cope with the loss of self-esteem that results from stigma by using cognitive therapies. Persons who are depressed learn to reframe dysphoric thoughts about themselves ("I'll never be successful") and the world ("Everybody else is able to cope. Why can't I?") in a more positive light (Haaga & Davison, 1991). A variety of cognitive strategies help people challenge depressogenic thoughts and develop beliefs that counter the sadness. In a similar manner, persons can learn to challenge stigmatizing views of themselves and negative expectations about their future using cognitive therapies. For example, persons struggling with mental health stigma ("I'm mentally ill; I can't make it on my own") might learn to collect evidence that disputes the stigma ("Many people with worse disabilities have made it") and construct counters for subsequent times when bothered by the public ("If others can do it, so can I!"). Holmes and River (1998; in this series) write more fully about the role of cognitive therapies in dealing with the personal shame of stigma.

Some people may choose to deal with stigma by selectively disclosing their history with mental illness. They may decide to avoid public disapproval by not sharing their difficulties with others. Instead, they seek out a small number of persons who are likely to empathize with their challenges and support efforts in pursuit of their goals.
I felt like I was going to explode at work when I couldn’t tell someone. Co-workers would be talking about their college years, or their stretch in the Army, or that time they got their first job... years when I was in and out of the hospital. They’d turn to me and ask what I was up to and I’d have to excuse myself or make something up. I felt ashamed that I couldn’t be honest. But, I also felt angry that no one would understand. It’s not my fault I have this gap.

Then I met Beverly. It took several months, but eventually I figured she would be someone who could handle my disclosure. Beverly never seemed to get nervous when I failed to discuss my past. Instead, she had a charming way of teasing me about my life, just like a good friend. And she always responded with an open mind when I tested her views about mental illness. We saw this movie once where they presented a depressed person as a moral degenerate. Over coffee afterwards, Beverly actually got mad about it.

Beverly has known about my mental illness for about a year now. I thought she might pull away, you know, be scared of the crazy. But now, I can go to her desk and bitch about work and I feel she knows.

—adult with severe mental illness

Behavior therapists can help persons consider the costs and benefits of disclosure. Persons with disabilities need to weigh the benefits, for example, of letting their employer know (“She’ll be more patient with me”) versus the cost of disclosing (“The boss might not think I can handle my job”). Therapists can also help persons consider characteristics that signal a safe person to whom to disclose. Is a person likely to respond and be supportive like Beverly?

Behavior therapists need to be aware of the paradox in trying to help people decide whether to disclose. An unintended message could be given, namely, that mental illness is indeed something that should be hidden. This kind of message could reinforce attitudes of shame.

2. Challenging the Pain of Public Labels Through Empowerment

People who have been labeled as mentally ill experience additional harm from stigma. Labels frequently come from public knowledge that the person was hospitalized.

I know my family tried to keep it to themselves. But these things just get out. I went away for two weeks and it seemed that everyone knew I had been in a psych hospital. Whether it was genuine concern or the object of gossip,
people at church, at the store, at the local park all seemed to know and look at me differently.

—adult with severe mental illness

The label of mental illness may also come from misinformation. Many homeless or disheveled people are called mentally ill. Persons who are labeled mentally ill are unable to hide from public disapproval. As a result, they are more likely to experience societal hostility and discrimination, resulting in disenfranchisement.

Empowerment has been conceptualized as the opposite of the disenfranchisement experienced by persons who are stigmatized (Corrigan, Faber, Rashid, Leary, & Okeke, 1998; McLean, 1995; Rogers, Chamberlin, Ellison, & Crean, 1997). The impact of empowerment is significant; despite societal stigma, empowered consumers endorse positive attitudes about themselves. They have positive self-esteem, believe themselves to be self-efficacious, and are optimistic about the future. The impact of empowerment on the community is manifested by the person’s desire to affect his or her stigmatizing community. Persons believe they have some power within society, are interested in affecting change, and wish to promote community action.

Faith Dickerson (1998) writes about cognitive behavioral strategies that foster empowerment. Central to this effort is a behavioral definition of the construct. Empowerment includes any strategy that provides the person control over his or her treatment. For example, behavior therapists have developed training programs by surveying mental health consumers about skills they need to meet life goals (Corrigan & Holmes, 1994; Goldsmith & McFall, 1975). Practitioners have also turned the entire treatment enterprise over to consumers in the spirit of empowerment. For example, George Fairweather (1969) developed a residential program run by program participants. He believed that the symptoms and deficits of institutionalized persons would greatly diminish if these individuals were empowered to care for themselves in a lodge setting. In such a setting, persons benefit from the consensus-building process needed to design and maintain effective residential and vocational programs. Moreover, their sense of self-efficacy and self-esteem is enhanced by living and working with peers. Results of a 36-month follow-up of the Fairweather Lodge were promising; participants in this program showed a significantly lower rate of hospitalization and significantly greater rates of employment than participants in a control program.

An interesting paradox arises out of the empowerment movement. Rather than choosing to hide one’s mental illness, many persons fight stigma by coming out of the closet and grabbing public control of their lives. This is evidenced by the number of consumer advocacy and self-help groups that have been founded for persons with mental illness. These groups provide support for the person to fight the shame and discrimination that accompanies stigma.
3. Challenging Societal Ignorance Through Public Action

Society also suffers from stigma about severe mental illness. Citizens are misinformed about members of their community with psychiatric disabilities. This misinformation leads to unnecessary fears and worries. It also leads to misperceptions about the actions of fellow citizens. Fear and misinformation result in hostility and anger. Members act on this fear by robbing persons with mental illness of rightful opportunities. Employers fail to hire and landlords do not lease to persons with severe mental illness. Entire communities express outrage at the thought that a mental health residence might move into their neighborhood.

Social psychologists have developed a variety of strategies for trying to change attitudes about racial minorities. In this issue, David Penn (Mayville & Penn, 1998) discusses the relevance of these strategies for changing public attitudes about mental illness. These strategies include protest, education, and contact (Corrigan & Penn, 1998). Groups protest inaccurate and hostile representations of mental illness as a way to challenge the stigmas they represent. These efforts send two messages. To the media: Stop reporting inaccurate representations of mental illness. To the public: Stop believing negative views about mental illness. Protest is a reactive strategy; it diminishes negative attitudes about mental illness, but fails to promote more positive beliefs that are supported by facts. Education provides information so that citizens make more informed decisions about mental illness. Education also corrects the myths and misconceptions that underlie mental illness stigma. Education strategies are augmented by face-to-face contact. Stigma is diminished when members of the general public meet persons with severe mental illness who are able to hold down jobs or live as good neighbors in the community.

Unfortunately, research that has examined efforts to change racial prejudice has shown these stereotypes to be fairly resilient. It is likely that these limited effects define boundaries to busting mental illness stigma as well. For example, research suggests that attitude change that results from contact with persons from ethnic minority groups rarely generalizes to the group as a whole (Hewstone & Brown, 1986; Kunda & Oleson, 1995; Rothbart & Lewis, 1988). The disconfirming effects of the atypical group member have been shown to have no impact on the broader group stereotype. For example, members of the general public who view an individual with mental illness as friendly and capable will probably show no overall change in stigma about mental illness. They will conclude that this person is an outlier; most persons with mental illness are still seen as dangerous and incompetent.

Research suggests there are potent moderators of stigma-busting efforts (Corrigan & Penn, 1998). Cognitive behavior therapists, among others, have much work to complete before effective strategies are identified and packaged in ways that lead to substantive social change.
Conclusions

Behavior therapy is fundamentally a clinical enterprise that seeks to arm persons with ways of coping with problems caused by environmental, biological, or imagined agents. In this light, teaching persons who are plagued by psychiatric stigma how to cope with stigma makes sense. Attitude change to offset the loss of self-esteem common to the stigmatized is a familiar target to cognitive behavioral therapists. Helping people consider the costs and benefits of specific decisions provides another way to cope. Setting up therapy programs that empowers participants is also consistent with a behavioral approach. Perhaps the odd bedfellow in this armamentarium is trying to change public attitudes about mental illness. What business does behavior therapy have seeking societal change?

Actually, behaviorists have a long and distinguished history writing about the role of behavioral theory in affecting societal-level metamorphoses. B. F. Skinner (1953) wrote in *Science and Human Behavior*:

> Why should the design of a culture be left so largely to accident? Is it not possible to change the social environment deliberately so that the human product will meet acceptable specifications? . . . Once a given feature of an environment has been shown to have an effect upon human behavior which is reinforcing, either in itself or as an escape from a more aversive condition, constructing such an environment is as easily explained as building a fire or closing a window when a room grows cold . . . (pp. 426–427).

In his popular book *Walden Two*, Skinner (1948) presented an even grander image of behavioral theory as societal change agent. He describes the social agenda of an entire community based on principles of operant psychology.

Others have written more prosaically about the role of behavior therapy for social change. Cyril Franks (1984) believed that behavior therapists should not limit their work to clinical practice. We need to be advocates, innovators, activists, and planners to have a broad effect on persons’ problems. Behavior therapy is built on a model that represents the fit of person and environment factors in the cause of behavior and behavioral problems. Clinicians are exquisitely sensitive to individual factors that cause behaviors. They are able to change the environment to influence individual factors. A natural extension of this model is to affect the environment in its broadest sense—changing societal attitudes and behavioral responses to a specific group.

O’Donnell and Tharp (1982, 1990) have discussed this agenda in terms of community psychology. They have reviewed societal programs that have sought to change a variety of community concerns, including litter control, energy conservation, reducing the use of telephone assistance, lowering noise levels, using
dentists more, and improving the packaging of garbage. Recently, Jason, Billows, Schnopp-Wyatt, and King (1996) have shown the power of behavioral strategies for changing societal attitudes and behaviors related to smoking. Clearly, these methods are relevant to changing societal attitudes and behaviors toward persons with severe mental illness. The combination of cognitive behavioral strategies that target the person’s experience and the community’s endorsement of stigma offer the broadest armamentarium for reducing its impact.

References


Corrigan, P. W., & Penn, D L. (1997) Disease and discrimination. Two paradigms that describe severe mental illness Journal of Mental Health, 6, 355–366


Fairweather, G W (1969). *Community life for the mentally ill* An alternative to institutional care Chicago Aldine


Fisher, D B (1994) Health care reform based on an empowerment model of recovery by people with psychiatric disabilities *Hospital and Community Psychiatry, 45*, 913–915


Green, M F (1998) *Schizophrenia from a neurocognitive perspective* Probing the impenetrable darkness Boston Allyn and Bacon


Holmes, E P, Corrigan, P W, Williams, P, Canar, J, & Kubak, M. (1997, November) The relation of knowledge and attitudes about persons with a severe mental illness Poster session presented at the 31st annual convention of the Association for the Advancement of Behavior Therapy


Hyler, S E., Gabbard, G O, & Schneider, I (1991) Homicidal maniacs and narcissistic parasites *Schizophrenia of mentally ill persons in the movies Hospital and Community Psychiatry, 42*, 1044–1048


Address correspondence to Patrick Corrigan, University of Chicago Center for Psychiatric Rehabilitation, 7250 Arbor Drive, Tinley Park, IL 60477; 708-614-4770; fax: 708-614-4780; e-mail: pcorrigan@mcis.bsd.uchicago.edu

Received May 23, 1998

Accepted: July 15, 1998