

The Impact of Stigma on Service Access and Participation

A guideline developed for the Behavioral Health Recovery Management project.

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Research has shown that the psychiatric symptoms, psychological distress, and life disabilities caused by many mental illnesses are significantly remedied by a variety of evidence-based practices (EBPs). Central to the success of these treatments is an obvious rule: people with psychiatric disorders must participate in treatment to enjoy its benefits. Unfortunately, research suggests many people who meet criteria for treatment, and who are likely to improve after participation, either opt not to access services or fail to fully adhere to treatments once they are prescribed. Health belief theorists have shown that a rational consideration of the costs and benefits of participating in specific treatments will directly impact whether a certain route of intervention is pursued. A significant cost to engaging in mental health treatment is the stigma associated with it. Many people choose to not pursue mental health services because they do not want to be labeled a “mental patient” nor do they wish to suffer the prejudice and discrimination this label entails.¹

The purpose of these BHRM guidelines is to review the research literature that outlines the relationship between mental illness stigma and participation in care. We begin with a review of the nature of the problem showing that many people who might potentially benefit from treatment either never access services or fail to adhere fully to treatments once they are begun. After describing this problem, we present stigma as a putative reason why treatment options are not pursued by many and present strategies for addressing the stigma of mental illness, thereby enhancing access to care.

¹ It is important to note that health beliefs are not the only possible barriers to treatment participation or access to care (financial constraints and availability of services are also essential factors). Moreover, stigma is not the only social element effecting health beliefs (knowledge about illness and treatments are potent factors that also affect health beliefs).

This initial discussion is meant to provide a brief conceptual base for understanding the phenomena of stigma, prejudice, and discrimination that lead to incomplete treatment participation. The subsequent sections will summarize specific strategies for dealing with the stigma of mental illness thereby enhancing access to care. The strategies are more thoroughly discussed in our recent book, *Don't Call Me Nuts: Coping with the Stigma of Mental Illness* (Corrigan & Lundin, 2001) published by Recovery Press, which can be obtained by using the order form in appendix A or through Amazon.com.

The Nature of the Problem

Those concerned with services research are familiar with two significant problems: many people with mental illness never access treatment while others begin treatment but fail to adhere to services as prescribed. Research from the Epidemiological Catchment Area (ECA) study illustrates the first. Results from this study showed that less than 30% of people with psychiatric disorders seek treatment (Regier et al., 1993). One might think that this ratio represents those with relatively minor adjustment disorders who choose to withstand relatively brief psychiatric discomfort rather than be immersed in mental health treatment. However, findings from the ECA study showed that only 60% of people with schizophrenia participated in treatment (Regier et al., 1993) and that people with serious mental illness were no more likely to participate in treatment than those with relatively minor disorders (Narrow et al., 2000). Equal difficulties are found on the substance abuse side with many who might benefit from treatment choosing not to participate (Sturm & Sherbourne, 2000).

These problems are further compounded by the number of people who access mental health services but fail to fully adhere to component prescriptions (Corrigan et al., 1990). A recent review of 34 studies of compliance with psychiatric medication regimens found that, on average,

more than 40% of persons receiving anti-psychotic medication failed to fully comply with prescribed regimens (Cramer & Rosenbeck, 1998). Failure to adhere to anti-psychotic regimens increased rehospitalization by three fold, accounting for an 800 million dollar increase in hospital costs world wide (Weiden & Olfson, 1995). Noncompliance may also emerge as failure to attend outpatient appointments. About half of outpatient appointments following discharge are not attended by persons with serious mental illness (Chameides & Yamamoto, 1975). In addition, many persons drop out of psychosocial interventions before they are complete (Falloon et al., 1977; Jaffe & Carlson 1976; Tarrier et al., 1998).

Health belief models are frequently used to explain poor access to, participation in, and adherence to mental health services (Corrigan, in press; Fenton et al., 1997, Ruesch & Corrigan, in press). Health belief models originally developed out of public health theories from the 1950s (Rosenstock, 1975) to examine value expectancies related to health. These models view humans as rational beings that behave in ways that diminish perceived threats (disease symptoms) and enhance perceived benefits (e.g., diminished symptoms and psychological distress after treatment). A key component in the rational equations that make up health beliefs are the deleterious effects of treatment. These might include medication side effects (Aquila et al., 1999) and the over-stimulation that results from some psychosocial treatments (Drake et al., 1986). We argue that a third type of unintended and negative effect that results from treatment is stigma.

Stigma and the Goals of Evidence-Based Practice

We describe the psychology of stigma, before describing the relationship between it and treatment access/participation/adherence. Researchers distinguish between public stigma (ways in which the general public reacts to a group based on stigma about that group) and self-stigma

(the reactions which individuals turn against themselves because they are members of a stigmatized group). As outlined in Figure 1 on the next page, social psychologists have identified various cognitive and behavioral structures that comprise stigma; understanding these theoretical structures is important for designing strategies to reduce stigma and improve access to care. Stereotypes are efficient knowledge structures that govern understanding of a social group (Augoustinos & Ahrens, 1994; Esses, Haddock, & Zanna, 1994; Hamilton & Sherman, 1994; Hilton & von Hippel, 1996; Judd & Park, 1993; Krueger, 1996; Mullen, Rozell, & Johnson, 1996); e.g., all police officers are good people to seek out when you are in trouble. Research has identified four sets of stereotypes that are especially problematic for mental illness (Brockington et al., 1993; Taylor & Dear, 1980). (1) People with mental illness are dangerous and should be avoided. (2) People with mental illness are to blame for their disabilities that arise from weak character. (3) They are incompetent and require authority figures to make decisions for them. (4) They are viewed as childlike and profit from parental figures to care for them. This last one is called the “benevolence stereotype” and parallels the third view that arises from perceptions about people with mental illness as incompetent.

Prejudice is agreement with negative stereotypes (“That’s right; all people with mental illness are dangerous!”) that leads to an emotional reaction (“I am afraid of all the dangerous mentally ill people!”) (Devine, 1988, 1989, 1995; Hilton & von Hippel, 1996; Krueger, 1996). Discrimination is the behavioral consequence of prejudice (Crocker, Major, & Steele, 1998); for example, “I am going to avoid dangerous mentally ill people because they scare me!” The range of contemporary behavioral responses to the public stigma of mental illness has been categorized into four groups: withholding help (choosing not to assist a person with mental illness because he or she is believed to be responsible for their lot in life); avoidance (common examples of social

Figure 1. Three levels of psychological structures that comprise public and self-stigma.

Public Stigma

- **Stereotype:**
Negative belief about a group
e.g., dangerousness
incompetence
character weakness
- **Prejudice:**
Agreement with belief and/or
negative emotional reaction
e.g., anger
fear
- **Discrimination:**
Behavior response to prejudice

e.g., avoidance of work and
housing opportunities
withhold help

Self-Stigma

- **Stereotype:**
Negative belief about the self
e.g., character weakness
incompetence
- **Prejudice:**
Agreement with belief
Negative emotional reaction
e.g., low self-esteem
low self-efficacy
- **Discrimination:**
Behavior response to prejudice

e.g., fails to pursue work
and housing
opportunities

avoidance include landlords who do not lease to people with mental illness or employers who do not hire them); segregation (actions that promote moving people away from their community into institutions where they can be better treated or controlled); and coercion (mandatory treatment or criminal justice behaviors based on the belief that people with mental illness are not able to make competent life decisions) (Corrigan et al., 2001; Corrigan & Watson, in press b).

In terms of self-stigma, many people with mental illness are aware of the stigma about their group (Bowden, Schoenfield, & Adams, 1980; Kahn, Obstfeld, & Heiman, 1979; Shurka, 1983; Wright, Gronfein, & Owens, 2000). Like the public, some of these individuals will agree with the stigma (Hayward & Bright, 1997) and apply it against themselves suffering diminished self-esteem and self-efficacy as a result (Corrigan & Watson, in press a). People with diminished self-efficacy due to self-stigma are less likely to apply for jobs or apartments (“Someone who is mentally ill like me can’t handle a regular job!”).

The public typically cannot tell that a person is mentally ill by interacting with him or her. Potential consumers may be labeled mentally ill as the result of several social processes; dominant among these is participating in psychiatric services. Hence, potential consumers may opt to not access care as a way to avoid this label and the resulting discrimination. Our model suggests several targets for diminishing stigma and increasing a person’s comfort with participation in treatment.

Strategies for Diminishing Stigma to Improve Access/Adherence

Strategies for diminishing the impact of stigma have been grouped according to their relevance to public or self-stigma. These are briefly reviewed here with a special emphasis on how they might be relevant to changing stereotypes and prejudices so that the potential consumer adopts health beliefs that support participation in and ongoing adherence to psychiatric services.

Changing public stigma

We have argued that people may not access or adhere to mental health treatments because of perceived costs that relate to stigma. They do not wish to be labeled with identifiers that suggest they are incompetent, have weak moral character, or are potentially dangerous. Hence, broadly changing public attitudes about mental illness will diminish perceived costs to mental health treatment. The various approaches to changing public stigma have been grouped into three change processes: protest, education, and contact (Corrigan & Penn, 1999). Protest strategies highlight the injustice of specific stigmas and lead to a moral appeal for people to stop thinking that way: “shame on us for holding such disrespectful ideas about mental illness!” Anecdotal evidence suggests that this approach may prove successful in getting stigmatizing images of mental illness removed from the advertisements, television, film and other media outlets (Wahl, 1995). However, this kind of attitude suppression has been found to lead to a rebound effect so that prejudices about a group remain unchanged or actually become worse (MacRae, et al., 1994 ; Corrigan, River et al., 2001). Hence, while protest may be effective in getting media outlets to stop portraying stigmatizing images of mental illness, which further reinforce public stigma, it should be used judiciously.

There are a variety of avenues available for protesting public stigma:

Writing Campaigns. Frequently, members of the entertainment industry, news media and other groups stigmatize mental illness without considering its implications. In these cases, a letter specifically addressing the problem and indicating a remedy may be sufficient to derail the practice. Several of the advocacy groups listed in the resources section have anti-stigma campaigns which sponsor letter writing campaigns.

Phone calls. If letter writing is not effective, phone calls may get more immediate attention. The same guidelines apply: be prepared to specifically address the problem and suggest a solution.

Public denunciation. Making a public expression of disapproval of a stigmatizing practice can be effective when private letters and phone calls have failed. One method of “going public” is to write a letter to the editor of the local newspaper. Agencies, advocacy groups and professional associations seeking a broader impact might send out a press release detailing the issue and the group’s stance. Press releases can be sent to print, television, and radio media outlets. Be prepared to provide more information if the story gets covered.

Marches and Sit-ins. Many of us remember the sit-ins and marches of the 1960s and 1970s. They were tremendously effective in shaping attitudes about racial inequality and the Vietnam War. Both require good organization and a committed group of protesters. Be sure to notify police of your plans and obtain a permit if required.

Boycotts. Boycotting the products of companies that produce stigmatizing products, their advertisers and the media source that carries their ads can send a particularly painful economic message. Do not boycott a single product; boycotting all products that the offending company produces sends a stronger message. Be sure to notify the company that you are engaged in a boycott, and let them know it will continue until your requests are addressed. Be sure to publicize your boycott via press releases, newsletters, and phone calls to your constituency.

Education Programs and Stigma

In contrast to protest strategies, education and contact have led to significant improvement in public attitudes about mental illness (Corrigan & Penn, 1999). Results of research on adult education strategies have shown that relatively brief education programs can lead to significantly improved attitudes about mental illness (Corrigan & Penn, 1999). Education

programs help people identify the inaccurate stereotypes about mental illness and replace these stereotypes with factual information. This can be accomplished by providing basic facts about mental illness to an audience, or by contrasting myths and facts about mental illness. The goal is not to make the audience experts on mental illness, but rather to provide simple facts so that many of the myths about mental illness crumble.

A factual presentation about mental illness should address what the experience of mental illness is like, and describe how it is diagnosed and effectively treated. The following information should be covered.

The experience of severe mental illness

1. Defining severe mental illness. The three diagnoses commonly associated with severe mental illness are schizophrenia, major depressive disorder, and manic depression.

Breadth and length of disability resulting from mental illness should be discussed.

2. Prevalence of diagnosis: schizophrenia (1 in 100), manic–depression (3 in 200) and depression (25% of women and 12% of men have a depressive episode at some point in their lives).

3. Examples of key symptoms. Describe psychotic, negative, depressive, manic, and anxiety symptoms.

4. Development and course of mental illness. Describe illness acquisition, onset, course and long-term outcome or prognosis.

5. The biology of severe mental illness. Discuss brain chemistry and nerve cell communication.

Assessment and Treatment

1. Diagnosing the disorder. Describe the DSM-IV and how diagnoses are made.

2. Medication. Goals of medication are to reduce symptoms and prevent relapse. Discuss antipsychotics, antidepressants, mood stabilizers, and side effects.
3. Rehabilitation and support. Discuss goal assessment and motivation, community support, skills training, cognitive rehabilitation, family education and support, and mutual help.

A more forceful education approach involves challenging the common myths about mental illness with the corresponding facts. Table 1 lists eight myths and the corresponding facts. Such a point-by-point contrast can be presented by a consumer or family member who also shares his or her personal experiences, combining the benefits of contact discussed below.

Table 1. Eight Myths and Corresponding Realities About Mental Illness

1. Once crazy, always crazy. People don't get over it. Long-term follow-up research suggests that many, many persons with the worst types of schizophrenia and other severe mental illness are able to live productive lives.

2. All persons with mental illness are alike. Persons with mental illness are as diverse a group of people as any other. Saying all persons with mental illness are similar is akin to saying all Latinos are the same. Not true!

3. Severe mental illnesses are rare, just like lepers. Actually severe mental illnesses like schizophrenia, manic-depression, and major depression may account for up to 8 to 10% of the population. That is about 640,000 people in a metropolitan area the size of Chicago, enough folks to fill Omaha, Nebraska and Des Moines, Iowa combined.

4. The mentally ill are dangerous, one step away from a maniacal killing spree. Very, very few people with mental illness ever murder someone. In fact, persons with mental illness are usually no more violent than the rest of the population.

5. The mentally ill can never survive outside the hospital. The vast majority of persons with mental illness live personally successful lives in their community.

6. The mentally ill will never benefit from psychotherapy. Carefully controlled research has shown that support and rehabilitation has significant impact on the lives of persons with mental illness.

7. The mentally ill are unable to do anything but the lowest level jobs. Persons with mental illness perform at all levels of work, just like the rest of the population.

8. Bad parents and poor upbringing cause severe mental illness. Schizophrenia and the other severe mental illnesses are biological diseases. They are caused by genetic or other embryological factors, not mom and dad.

This Table was adopted in part from an excellent paper by Courtney Harding and James Zahniser (1994) entitled *Empirical Correction of Seven Myths About Schizophrenia With Implications for Treatment*. The paper was published in the *Acta Psychiatrica Scandinavica* in Volume 90, Supplement 384, pages 140 to 146.

Contact and Changing Stigma

Contact with people with mental illness also yields significant improvements in attitudes about mental illness. Research shows that members of the general public who are more familiar with mental illness are less likely to endorse prejudicial attitudes (Corrigan & Penn, 1999).

Moreover, members of the general public who engage with a person with mental illness as part of an anti-stigma program show significant changes in their attitudes about mental illness (Corrigan, River et al., 2001; Corrigan, Rowan et al., in press). These studies have shown that attitude change which results from contact maintains over time and is related to a change in behavior.

Facilitating contact between persons with mental illness and others may seem like a difficult task. Many individuals with mental illness are rightfully hesitant to share their stories for fear of rejection. However, organizations such as the National Alliance for the Mentally Ill have speakers' bureaus through their local affiliates. These bureaus provide individuals willing to discuss their experiences with mental illness to churches, civic groups, schools and businesses. Additionally, they provide outlets for individuals desiring to share their stories.

An effective presentation about personal experiences with mental illness should be concrete and to the point, but not too formal. When professional terms are used, they should be defined to avoid confusion. The speaker should be truthful, but only discuss things he or she is

comfortable talking about. The presentation should be short and focused, with specific examples of the illness used to illustrate specific points. The impact of stigma should be addressed directly; the speaker should describe how stigma made the experience of mental illness significantly worse. Providing an opportunity for questions and discussion is also very helpful. The take home point should be that persons with mental illness work, live and play just like everyone else.

Several factors may enhance the effects of contact interventions on public attitudes. It is important that contact MILDLY disconfirm stereotypes about mental illness. Stories that differ radically from public stereotypes (i.e., despite my mental illness, I graduated at the top of my law school class and am now judge in federal court) may be viewed as irrelevant to the issue of mental illness or simply disbelieved. Stories that are consistent with stereotypes are equally as problematic as they are likely to strengthen existing stereotypes. Thus, it is important that stories are presented in a way that both acknowledges common concerns about mental illness and challenges the stigma. For example, a speaker may discuss his or her struggles and need for ongoing treatment and support, and his or her participation in family, employment and leisure activities. Other factors that may enhance the benefits of contact include presenting to established groups with the endorsement of the group's leaders, and promoting regular opportunities for frequent "real world" contact.

Changing self-stigma

People may also fail to pursue mental health treatment because they have internalized self-stigma; e.g., they concur with stereotypic statements that undermine their sense of self-efficacy (Corrigan & Watson, in press a). For example, some people may believe their state to be hopeless, such that treatment will not yield any real benefits. Therefore, why participate in or

adhere to services? There are only a few studies that have sought to diminish self-stigma. In one approach, Kingdon and Turkington (1991) used a cognitive behavioral approach to help people reframe stigma as a normal event. The interventions were well-received by consumers and seemed to yield more acceptance of their illness. Unfortunately, the 1991 paper does not report a test of the normalization strategy in a random-controlled study. Subsequent studies have more carefully examined the impact of similar cognitive therapies on psychotic symptoms, self-statements and service utilization (Beck & Rector, 2000; Gould, Mueser et al., 2001; Turkington & Kingdon, 2000). Although the body of research has not specifically focused on changing self-stigma like the 1991 study by Kingdon and Turkington, trends suggest cognitive reframing may offer a useful tool for changing self-stigma.

Self-stigma is weakened when people learn research-based information that counters it. Thus, educating individuals who self-stigmatize about mental illness can help them challenge their negative beliefs. The eight myths and corresponding facts listed in Table 1 are useful tools to start. However, even after learning the facts about mental illness, some individuals continue to feel badly about themselves as a result of self-stigma. We have incorporated Beck's (Alford & Beck, 1997) approach that directly challenges hurtful attitudes about the self and replaces them with beliefs that do not undermine the person's self-esteem into the Stop Self – Stigma Worksheet (appendix B). The worksheet asks the person to list the hurtful belief; define the assumptions behind the belief; challenge the assumptions by asking trusted others if they believe them; collect and list evidence that challenges the assumptions, and restate the attitude in a non-harmful manner that counters the original belief.

This worksheet can be completed privately or with a counselor or therapist. It may be especially useful to complete and discuss the worksheet in peer groups. Individuals who self-

stigmatize can share their beliefs and counters and help each other. Moreover, this kind of group activity facilitates a sense of personal power.

Strategies that foster empowerment may also reduce self-stigma. We conceptualize personal empowerment as the affirmative way in which individuals view themselves and in which they interact with the community. Empowered individuals have good self-esteem, believe they are effective in life, and are optimistic about their future. They may also show righteous anger against prejudice and advocate for themselves in the community and the mental health service system. Clinicians can take an empowerment approach to service design and provision. They can also encourage consumers to become involved in groups and activities that foster empowerment. Table 2 lists seven ways to foster empowerment that are useful for both clinicians and consumers.

Table 2 The Seven Ways to Foster Empowerment.

1. From Noncompliance to Collaboration: A change in perspective from expecting consumers to blindly comply with treatment to making care-plans that are user-friendly.
2. Consumer Satisfaction and Other Input on Services: At the absolute minimum, programs that empower participants need to be satisfactory to those participants. Moreover, these programs need to obtain input from consumers to assure that program design reflects their interests.
3. Lodges and Clubhouses: For more than three decades, the mental health system has supported treatment programs that were largely operated by persons with mental illness. Lodges are residential programs in this mold; clubhouses are social and work programs.
4. Assertive Community Treatment and Supported Employment: Instead of the consumer going to the professional, the best treatment occurs when the professional travels to the consumer, and all the places in which consumers need assistance. Provision of services in the person's home or community is the hallmark of Assertive Community Treatment (or ACT). Services in real-world job sites is supported employment.
5. Consumers as Providers: Many persons with mental illness are deciding to return to school, obtain necessary credentials, and assume jobs in the mental health system as providers. In this way, they can change the system from the inside.
6. Self-Help, Mutual Assistance, and Other Consumer Operated Services: There is almost a fifty year history of programs developed by persons with mental illness to help peers. These programs provide places where people can provide and receive help from individuals with similar concerns.
7. Participatory Action Research: Much of the current research on psychiatric disability and rehabilitation reflects the perspective of the existing mental health system. Persons with mental illness must be equal partners in the research enterprise for future studies to represent the differing interests of consumers.

Disclosure and self-stigma

While personal empowerment and self-advocacy tend to have positive effects in terms of reducing self-stigma, clinicians should use caution when advising consumers about disclosing mental illness. Link and colleagues (1991) conjectured that the effects of self-stigma might be resolved by teaching consumers coping techniques. The coping program focused on decisions about keeping one's mental health history a secret, effective ways of educating others about their experiences, and avoiding situations where rejection might occur. Unfortunately, the intervention

yielded no significant changes in such important variables as the stigma-induced problems of social awkwardness, demoralization, and unemployment. Link and colleagues argued that stigma is powerfully reinforced by culture; its effects are not easily overcome by the coping actions of individuals. Citing C. Wright Mills' (1967) distinction, they conclude that labeling and stigma are "social problems" that need to be addressed by public approaches not "individual troubles" that are addressed by individual therapy.

Unfortunately, while we wait for the public approaches to reduce stigma, consumers regularly have to make decisions to disclose or not disclose. They may choose to keep their illness a secret or avoid people and places that may stigmatize. The costs of this approach are the loss of opportunities to receive support and the stress and guilt of keeping a secret. Selective disclosure exposes consumers to the risk of rejection, but also allows them to find a small group of people that understand and provide support. Full disclosure takes away the worry of being "found out" and fosters a sense of empowerment. However, some people may use this information to stigmatize and reject consumers. Clinicians can support consumers in making disclosure decisions by reviewing the costs and benefits of disclosing in various situations. Table 3 lists some of the costs and benefits of disclosure that clinicians can discuss with consumers.

Table 3. The Costs and Benefits of Disclosing Mental Illness

Benefits	Costs
-you don't have to worry about hiding your mental illness	-others may disapprove of your mental illness or your disclosure
-you can be more open about your day-to-day affairs	-others may gossip about you
-others may express approval	-others may exclude you from social gatherings
-others may have similar experiences	-others may exclude you from work, housing, and other opportunities
-you may find someone who can help you in the future	-you may worry more about what people are thinking of you
-you are promoting your sense of personal power	-you may worry that others will pity you
-you are living testimony against stigma	-future relapses may be more stressful because everyone will be watching
-you may help others by sharing your experiences	-family members and others may be angry you disclosed

Legal remedies to stigma and discrimination

The effects of stigma far exceed the loss of esteem and personal hurt felt by individuals with mental illness. They are also legal matters. The Americans with Disabilities Act (1990) forbids discrimination against persons with disabilities in nearly every domain of public life: employment, transportation, communication and recreation. Title I of the ADA specifically forbids employment discrimination because of disability and requires employers to provide reasonable accommodations that allow persons with disabilities to perform essential job functions. The definition of reasonable accommodation is somewhat vague, but may include

allowing a person to wear headphones to block out distractions, adjusting supervision styles, and providing extra training materials.

Persons with mental illness are also protected from housing discrimination by the Fair Housing Act. The FHA prohibits unfair housing practices and requires landlords to make reasonable accommodations to policies and procedures governing their property. Reasonable accommodations for housing needs of persons with mental illness are still uncharted waters. However, they might include allowing co-signers on a lease; allowing a third party to pay rent, or allowing service providers unlimited access to the property. Clinicians may wish to direct consumers who feel their rights have been violated according to the ADA or FHA to the information and organizations listed in the *Resources* section.

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Resources

Books and Videos

Don't Call Me Nuts! Coping with the Stigma of Mental Illness. By Patrick Corrigan & Robert Lundin (2001). Recovery Press: Tinley Park, IL.

Don't Call Me Nuts! Explores all facets of the stigma faced by persons with mental illness. It is a handbook for dealing with stigma on all levels. A must have for clinicians, consumers and advocates! Available from www.Amazon.com, or directly from Recovery Press, 7230 Arbor Drive, Tinley Park, IL 60477. (708) 614-2496.

Media Madness: Public Images of Mental Illness By Otto Wahl (1995). New Brunswick, NJ: Rutgers University Press.

Mental Health: A Report of the Surgeon General Department of Health and Human Services (1999). Available at www.osophs.dhhs.gov/library/mentalhealth/index.html or at 1-877-9MHEALTH.

Stigma: in Our Work, in Our Lives Video produced by the Anti-Stigma Project of On Our Own of Maryland, Inc. 1521 South Edgewood Street, Suite C, Baltimore, Maryland 21227-1139. 1-800-704-0262. www.onourown@frontiernet.net

Organizations

Chicago Consortium for Stigma Research

www.StigmaResearch.org

7230 Arbor Drive

Tinley Park, IL 60477

708-614-4770 Fax 708-614-4780

CCSR is dedicated toward understanding the phenomenon of stigma, developing and testing models that explain why it occurs, and evaluating strategies to help diminish its effects.

Judge David L. Bazelon Center for Mental Health Law

www.bazelon.org

1101 15th Street, NW

Suite 1212

Washington, DC 20005

202-467-5730

A non-profit legal organization that advocates for the civil rights and human dignity of persons with mental disabilities. Provides many links to state advocacy resources.

Knowledge Exchange Network (KEN)

www.mentalhealth.org

P O Box 42490

Washington, DC 20015

800-789-2647

Sponsored by the Center for Mental Health Services, part of SAMHSA (Substance Abuse and Mental Health Services Administration). A one-stop national clearinghouse for free information about mental health, including publications references and referrals to local and national resources and organizations.

National Alliance for the Mentally Ill

www.nami.org

Colonial Place Three

2107 Wilson BLVD.

Suite 300

Arlington, VA 22201-3041

800-950-6264 TDD 703-516-7227

Fax 703-524-9094

An organization founded by parents of people with mental illness, NAMI now boasts substantial participation by family members and consumers alike. The NAMI network stretches across the U.S., with the Washington D.C. office being particularly skilled at following and influencing national political initiatives.

National Empowerment Center

www.power2u.org

599 Canal Street

Lawrence, MA 01840

800-769-3728

The empowerment center provides a variety of services, such as referrals, networking, conference, lectures, workshops, and consultations. Its mission is "to carry a message of recovery, empowerment, hope, and healing to people who have been diagnosed with mental illness." The Center also publishes the NEC Newsletter about advocacy, recovery, and self-help.

National Mental Health Association

www.nmha.org

1021 Prince Street

Alexandria, VA 22314-2971

703-684-7722 Fax 703-684-5968

The legacy of Clifford Beers, the goals of the NMHA are to spread tolerance and awareness, improve mental health services, prevent mental illness, and promote mental health. Register with their web site and receive legislative alerts and news releases via e-mail. Their site also provides discussion boards, information on affiliates, and an events calendar.

National Mental Health Awareness Campaign

www.nostigma.org

Created in order to educate the public about mental health issues and eradicate the fear, shame and stigma commonly associated with mental illness, NMHAC has as its primary goal the development of a nationwide, public service, multi-media education initiative. By taking a lifespan approach, NMHAC creates public service ads targeting three distinct groups — youth, adults and seniors.

National Mental Health Self-Help Clearinghouse

www.mhselfhelp.org

1211 Chestnut Street, Suite 1207

Philadelphia, PA 19107

1-800-553-4539, 1-215-751-1810

Fax 1-215-636-6312

This is a consumer run national technical assistance center funded by the Center for Mental Health Services. Their focus is on helping consumers plan, provide, and evaluate mental health and community support services.

National Stigma Clearing House

<http://community-2.webtv.net/stigmanet/STIGMAHOMEPAGE/index.html>

245 Eighth Avenue

Suite 213

New York, NY 10011

212-255-4411

Provides free materials and information on combating stigma.

World Federation for Mental Health

www.wfmh.org

1021 Prince Street

Alexandria, VA 22314-2971

703-838-7543 Fax 703 519-7648

An international organization whose missions include improving the quality of mental health services, reducing stigma and protecting human rights of persons with mental illness, as well as encouraging campaigns for public education. Its web site features a quarterly newsletter, information on conferences, and "World Mental Health Day."

Federal Agencies

National Institute of Mental Health

www.nimh.nih.gov

Public Inquiries

6001 Executive Blvd.

Room 8184, MSC 9663

Bethesda, MD 20892-9663

301-443-4513 Fax 301-443-4279

Substance Abuse and Mental Health Services Administration

www.samhsa.gov

5600 Fishers Lane

Rockville, MD 20857

ADA Information

Americans with Disabilities Act Handbook

www.ada.handbook.homepage.com

The *Americans with Disabilities Act Handbook* is published by the Equal Employment Opportunity Commission and the U.S. Department of Justice. It can be purchased online from the Government Printing Office.

Americans with Disabilities Act Information

www.usdoj.gov/crt/ada

The US Department of Justice's resource page for the ADA.

The Americans with Disabilities Act- full text document

www.robson.org.capfaq/ada.txt

Appendix A

Don't Call Me Nuts! Order Form

Don't Call Me Nuts! addresses one of the pressing issues in psychiatry today, indeed in the larger scope of civil rights in society -the stigma of mental illness. In its 456 pages, Corrigan and Lundin explore all facets of the stigma which persons with mental illnesses face. Don't Call Me Nuts! is both a valuable resource, a history lesson, and a gaze into the future of a stigma-less community.

Send me _____ copies of Don't Call Me Nuts!

Name _____

Address _____

City _____

State _____

Country _____

Zip/Postal Code _____

Cost:
\$26.50 each (\$35.00 Canadian)

Shipping and Handling
Orders will be shipped USPS Priority Mail
\$5.00 for the first book. Plus \$2.00 for each additional book.
For orders shipped outside the United States and Canada, add
\$9.00 for the first book and \$5.00 for each additional book.

Cost of book(s): _____ Shipping _____ Total _____

Send Check or Money Order with this form to:
Recovery Press
University of Chicago
Center for Psychiatric Rehabilitation
7230 Arbor Drive
Tinley Park, IL 60477

Appendix B

Stop Self-Stigma Worksheet: Complete All Five Steps

1. State the hurtful belief.

Example “***I MUST BE a weak person BECAUSE I have a mental illness.***”

I MUST BE _____ BECAUSE _____.

2. Define the True-False Assumptions.

Example “*Strong people don't have mental illnesses.*”

3. Challenge the assumptions by checking with whom?

Example “*My older sister. She is smart and always tells me the truth.*”

4. Collect evidence that challenges the assumptions.

Example “*My sister said dealing with psychiatric problems is a sure sign of strength, not weakness.*”

5. Restate the attitude so it does not injure me. This is a counter.

Example “*I'm not weak or bad because of my mental illness. In fact, I'm a hero for hanging on.*”
