

**TARGET-SPECIFIC STIGMA
CHANGE: A STRATEGY
FOR IMPACTING MENTAL
ILLNESS STIGMA**

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In the past decade, mental health advocates and researchers have sought to better understand stigma so that the harm it causes can be erased. In this paper, we propose a target-specific stigma change model to organize the diversity of information into a cogent framework. "Target" here has a double meaning: the power groups that have some authority over the life goals of people with mental illness and specific discriminatory behaviors which power groups might produce that interfere with these goals. Key power groups in the model include landlords, employers, health care providers, criminal justice professionals, policy makers, and the media. Examples are provided of stigmatizing attitudes that influence the discriminatory behavior and social context in which the power group interacts with people with mental illness. Stigma change is most effective when it includes all the components that describe how a specific power group impacts people with mental illness.

**Target-Specific Stigma Change:
A Strategy for Impacting
Mental Illness Stigma**

During the past decade, advocates and researchers have realized the importance of mental illness stigma as barriers to the life goals of people with mental illness. The U.S. Surgeon General eloquently summed up the concern in his 1999 report:

Stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders,

especially severe disorders such as schizophrenia (Satcher, 1999, Chapter 1).

Advocacy groups like the National Alliance for the Mentally Ill, the National Mental Health Association, and the World Health Organization have echoed concerns about the harm caused by stigma and have called for programs that challenge the prejudice and discrimination that result. In this paper, we follow a brief review of mental illness stigma with a summary of the ways in which advocacy groups and researchers have developed,

implemented, and evaluated anti-stigma programs. Some commonalities are evident across this body of information that may be organized according to a target-specific stigma change model. *Target-specific* stigma change means crafting anti-stigma programs that specifically aim at the key groups that have power in the lives of people with mental illness—e.g., landlords and employers; members of the criminal justice system; health care providers and administrators; policy makers; and the media—and the specific discriminating behaviors of these groups: not hiring or renting, withholding health services, or coercive treatment. The paper ends with a review of the model and its implications for stigma change.

A Brief Review of the Impact of Stigma

When trying to understand the impact of mental illness stigma, researchers distinguish between public stigma (ways in which the 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) (Corrigan, 2000; Corrigan & Watson, in press). This paper limits discussion to changing stigma in the public arena. As outlined in Figure 1, social psychologists have identified various cognitive and behavioral structures that comprise stigma; understanding these theoretical structures is important for designing research programs that examine the impact of anti-stigma programs. According to the model, *stereotypes* are efficient knowledge structures about groups of people (Hilton & von Hippel, 1996; Judd & Park, 1993); e.g., all police are good people to seek out when in trouble. Stereotypes are considered efficient because they are relatively effortless and accessible

FIGURE 1—SOCIAL COGNITIVE STRUCTURES THAT COMPRISE 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, without help)

processes that govern understanding of a social group (Hamilton & Sherman, 1994). Factor analytic research has identified several stereotypes that are especially problematic for mental illness (Brockington, Hall & Levings, 1993; Taylor & Dear, 1980).

1. People with mental illness are dangerous and should be avoided.
2. People with mental illness are to blame for the disabilities that arise from weak character
3. People with mental illness are incompetent and require authority figures to make decisions for them.

Personal awareness of a stereotype does not necessarily mean agreement with it (Jussim, Nelson & Manis, 1995). Many people are aware of the stereotypes about mental illness but do not endorse them. *Prejudice* is agreement with negative stereotypes (“That’s right; all people with mental illness are dangerous...”) that leads to an emotional reaction (“...and I am afraid of all the dangerous mentally ill people!”) (Devine, 1989, 1995). *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 they are believed to be responsible for their lot in life); avoidance (common examples of social 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 responses based on the belief that people with mental illness are not able to make competent life decisions) (Corrigan, Markowitz, Watson, Rowan & Kubiak, 2002).

Research suggests most members of the public are aware of mental illness stereotypes (Bhugra, 1989; Link, 1987). Those who endorse these stereotypes are likely to react in a discriminatory manner. Of special concern to advocates is the discriminatory behavior of key power groups (Fiske, 1993) including landlords, employers, and professionals of the criminal justice system, legislators, and health care providers. Not only do members of these power groups make decisions that directly impact the opportunities available to per-

sons with mental illness, but, because of their positions of power, they may be particularly likely to rely on stereotypes (Fiske, 1993). The attitudes and behaviors of individuals acting within these power positions are significantly influenced by institutional and organizational factors that define these positions (Link & Phelan, 2001; Oliver & Shapiro, 1995; Pincus, 1999). These institutional/organizational factors lead to differential access to the goods, services, and opportunities of a society such that people in certain minority groups are disadvantaged in terms of such fundamental rights as health care (Jones, 2000). It would seem reasonable that institutional forces would lead to similar discriminations of people diagnosed with mental illness. Hence, targeting these positions is essential for advancing the opportunities of people with mental illness.

Changing Stigma: Advocacy and Research

Advocates and researchers have taken different paths to changing stigma. Advocacy-based programs have been largely affected by the immediate and pressing needs that result from prejudice and discrimination. These programs borrow heavily from grass root experiences of the civil rights movement in America and elsewhere in the world. The goal is to stop stigma now! Examples of these programs are discussed more fully below. First, however, we consider what research has told us about stigma change.

Although most researchers share the same sense of mission as advocates, their work in this area has been guided by the kind of methodological cautions that yield valid findings and generalizable results. Translational research designs have been fundamental to this effort; namely, using the technical and theoretical wisdoms developed by

basic behavioral research on other stigmatized groups (e.g., people of color, women, gay men and lesbians) to develop and test similar programs for the stigma of mental illness (Corrigan et al., 2002). Based on our review of this literature, we grouped the various approaches to changing public stigma into three 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 you for holding such disrespectful ideas about mental illness!" Ironically, this kind of attitude suppression may yield a rebound effect so that prejudices about a group remain unchanged or actually become worse (Corrigan, River, Lundin et al., 2001; MacRae, Bodenhausen, Milne & Jetten, 1994). Although there are both cognitive and social explanations of this kind of rebound, perhaps the simplest is the construct of psychological reactance (Brehm & Jones, 1970); "don't tell me what to think!" Hence, protest may not be a viable strategy for changing public *attitudes* about people with mental illness.

This does not mean protest has no role in affecting stigma. There is largely anecdotal evidence that protest can change some *behaviors* significantly (Wahl, 1995); e.g., when a television network chooses to stop a stigmatizing program rather than alienate an important advertising demographic. Hence, research might show protest to be effective as a punishing consequence to discriminatory behavior that decreases the likelihood that people will repeat this behavior. This is especially relevant for examining the effects of legal penalties prescribed by the Americans with Disabilities Act and the Fair Housing Act. In like manner, research might identify reinforcing consequences to affirmative actions that un-

dermine stigma and encourage more public opportunities for people with mental illness; e.g., government tax credits for employers who hire and provide reasonable accommodations to people with psychiatric disabilities.

Research on adult education strategies has largely focused on replacing the emotionally charged myths of mental illness (e.g., "Most people with mental illness are highly dangerous!") with facts that counter the myths (e.g., On average, people with mental illness are no more dangerous than the rest of the population). Results have shown that relatively brief education programs can lead to significantly improved attitudes about mental illness (Holmes, Corrigan, Williams, Canar & Kubiak, 1999; Keane, 1990; Morrison, 1980; Penn, Guynan, Daily & Spaulding, 1994). However, research has yet to show that such change in attitudes is maintained over time or that improved attitudes lead to fewer discriminatory behaviors.

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 individuals labeled mentally ill are less likely to endorse prejudicial attitudes (Holmes et al., 1999; Link & Cullen, 1986; Penn et al., 1994; Penn, Kommana, Mansfield & Link, 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 (Corrigan, River, Lundin, et al., 2001). These studies have shown that attitude change that results from contact maintains over time and is related to a change in behavior (Corrigan, Rowan, Green, et al., in press).

Efforts by Advocacy Groups

The number of programs hoping to change mental illness stigma has in-

creased exponentially in the past few years. Major advocacy groups in the United States such as the National Alliance for the Mentally Ill and the National Mental Health Association have prioritized stigma as an important concern. Additional groups have made the stigma of mental illness a prime focus, including the National Stigma Clearinghouse and the Resource Center to Address Discrimination and Stigma Associated with Mental Illnesses. Both federal and state governments have joined the fray. In the past few years, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute of Mental Health have supported nationwide conferences on stigma. SAMHSA produced and disseminated an anti-stigma kit that included posters and brochures challenging common stereotypes. Tipper Gore and Alma Powell joined with other national leaders to form the National Mental Health Awareness Campaign that developed a multi-level effort to challenge stigma.

Similar efforts are evident elsewhere in the world. The World Psychiatric Association has launched "Schizophrenia: Open the Doors." The program is currently active on three continents: Asia, Europe, and South America. Prominent among these efforts is "Changing Minds" by the British Royal College of Psychiatrists. Like other efforts of its ilk, Changing Minds includes multiple levels of public education to change stigma about mental illness. Central to this effort is focusing on family education as key to changing stigma.

The goals and tactics of these advocacy groups neatly fall into the education, protest, and contact distinctions described by researchers. Many of these programs rely on public education to dispel the stigma of mental illness. Television and other media has be-

come a central vehicle for these education programs. The National Mental Health Awareness Campaign, for example, developed 30-second public service announcements (PSAs) concentrating on the attitudes of adolescents (<http://www.nostigma.org>). Called "Change Your Mind," the PSAs send two messages that challenge important stereotypes: people with mental illness are not responsible for their problems and they are "just like everyone else." Being mindful of their audience, the NMHAC has widely aired the PSAs on such teen outlets as MTV, since June of 2001, as well as VH1, ESPN, ABC, Fox, and Channel One. The specific goal of this NMHAC program is to increase adolescent use of mental health services when needed. The PSAs end with a web address where interested teens can learn more about mental illness and corresponding services. As of October 2001, the website reported more than 12 million hits.

Now numbering more than 4,000 members, NAMI StigmaBusters have been an important source of protest (<http://www.nami.org/campaign/20000405.htm>). Among its many efforts, Stigma Busters identifies disrespectful and inaccurate images of mental illness in the popular media and coordinates letter-writing campaigns to get producers of these images to stop. Common among these kinds of representations is the notion that people with mental illness are dangerous and unpredictable. The NAMI group had a prominent role in removing an ABC show called "Wonderland" from the air in 2000. The first episode of the television program depicted a person with mental illness shooting and killing several New York police officers and then attacking a pregnant psychiatrist in the emergency room. StigmaBuster efforts not only targeted the show's producers and several management levels of ABC, they also encouraged communication

with commercial sponsors including the CEOs of Mitsubishi, Sears, and the Scott Company. As a result of efforts like these, ABC pulled the show after a couple of episodes at a substantial financial loss.

There are also several examples of state governments using contact to diminish stigma and enhance consumer empowerment. New York (Blanch, Fisher, Tucker, Walsh & Chassman, 1993; Knight & Blanch, 1993a, 1993b), Florida (Loder & Glover, 1992), and Illinois (Corrigan, Lickey, Schmook, Virgil & Juricek, 1999) have arranged formal dialogues between persons with mental illness and mental health care professionals as a way to change insidious attitudes in the mental health system that undermine empowerment. These dialogues provided a forum for consumers and health care professionals to exchange perspectives about mental illness and challenge latent stigmatizing attitudes. Moreover, the U.S. Center for Mental Health Services has an intramural office on consumer empowerment and funds consumer-based, extramural projects that attempt to discount stigma. Many state departments of mental health hire consumer advocates whose job, in part, includes vigilance to misrepresentations of mental health issues.

These are just some of the examples of how education, protest, and contact may lead to significant changes in prejudice and discrimination. The reader should note the common feature to these examples that further augments program impact: *each program targets a specific group and corresponding behaviors for change*. The NMHAC is attempting to increase service use among adolescents who may be experiencing mental health-related problems. NAMI's StigmaBusters seeks to stop the popular media from perpetuating disrespectful images in its TV shows and movies. States are trying to

FIGURE 2— THE COMPONENTS OF A TARGET-SPECIFIC STIGMA CHANGE MODEL*

Targets	Discriminatory Behavior	Corresponding Attitudes	Social Context	Change Strategies
Landlords	<ul style="list-style-type: none"> • Fail to lease • No reasonable accommodation 			
Employers	<ul style="list-style-type: none"> • Fail to hire • No reasonable accommodation 	<ul style="list-style-type: none"> • Dangerousness • Incompetence 	<ul style="list-style-type: none"> • Economy • Hiring pool 	<ul style="list-style-type: none"> • ADA • Erasing the stigma
Health Care Providers	<ul style="list-style-type: none"> • Withhold some services • Unnecessarily coercive treatment 			
Criminal Justice Professionals	<ul style="list-style-type: none"> • Unnecessarily coercive • Fail to use mental health services 			
Policy Makers	<ul style="list-style-type: none"> • Insufficient resource allocation • Unfriendly interpretation of regulations 			
The Media	<ul style="list-style-type: none"> • Perpetuation and dissemination of stigmatizing images 			

Note: The model is only partially developed with the discriminatory behaviors that arise from specific targeted power groups. As an example, all components of the model for employers were provided. The ADA is the Americans with Disabilities Act.

change entrenched and disempowering attitudes in its mental health system by pairing consumers with providers. The logic of a target-specific approach is all the more compelling when compared to the alternative; a generic effort to change the attitudes of the population as a whole. Consider, for example, a video that promotes the idea that mental illness affects 20% of the citizenry and hence is neither rare nor bizarre. Although this effort is well intentioned and poignant, such mass appeals suffer because they are not particularly relevant to specific elements of the populace. It is unclear who exactly is supposed to take note of this message. Moreover, the expected products of these efforts are fuzzy; it is unclear exactly how the population should change given the highlighted stereotypes and prejudice. "Okay, so 20% of the population may be mentally ill in their lifetime. Now, what should I do about it?"

Target-Specific Stigma Change

Our paradigm rests on the assumption that stigma change is more effective when it is targeted. "Target" has a double meaning here. It is first defined in terms of specific social groups who are powerful vis-à-vis people with mental illness. Examples of these groups are listed in Figure 2. Power here is based on functional relationships (Fiske, 1993); the groups in Figure 2 are frequently in positions of control and authority relative to the life decisions of people with mental illness. In particular, they can exercise behavioral options that curtail the life opportunities of individuals with mental illness. These are the second set of targets for anti-stigma programs and are highlighted in Figure 2 as specific discriminatory behaviors. Let us more fully consider how certain power groups may specifically harm people with mental illness.

Two important life goals for people with mental illness are living independently and obtaining good jobs. By virtue of their social position, landlords and employers are in the position to influence these goals (Corrigan, Bodenhausen, et al., 2002). Landlords and employers who believe stereotypes about mental illness may respond in a discriminatory manner. Landlords may be afraid of people with mental illness and decide not to rent property to them (Farina, Thaw, Lovern & Mangone, 1974; Hogan, 1985; Page, 1995; Segal, Baumohl & Moyles, 1980; Wahl, 1999). Employers might believe people with mental illness are incapable of competent work and therefore not hire them (Bordieri & Drehmer, 1986; Farina & Felner, 1973; Farina, Felner & Boudreau, 1973; Link, 1982, 1987; Wahl, 1999). Hence, stigma programs need to generate change strategies that target the specific discriminatory behaviors of these two power groups to advance the empower-

ment and life opportunities of people with mental illness. This kind of cross-walk between discriminatory behavior and attitude change strategies echoes what is generally known about attitude change in basic behavioral research; namely, behaviors are more likely to change when strategies target attitudes that directly correspond with the behavior (Azjen & Fishbein, 1977; Cacioppo, Petty, Feinstein, Jarvis & Blair, 1996). Correspondence is a function of several elements including participating actors and the context in which a specific event is likely to occur. Hence, changing the prejudice and discrimination of mental illness is likely to be more successful when specific power groups are targeted in the settings in which they might discriminate.

Consider some of the other important targets for stigma change listed in Figure 2. Health care providers and administrators may endorse stigma about mental illness. As a result, general medical providers may fail to provide necessary treatments that would otherwise be prescribed to people (Felker, Yazel & Short, 1996). For example, research has shown that people with mental illness are less likely to receive appropriate cardiovascular procedures after myocardial infarct compared to a demographically matched group that is not labeled mentally ill (Druss, Bradford, Rosenheck, Radford & Krumholz, 2000, 2001). Alternatively, mental health providers may endorse coercive or other mandatory treatments when the person's current profile of needs fails to show these kinds of interventions are warranted. Several levels of the criminal justice system may be impacted by stigma (Watson, Hanrahan, Luchins & Lurigio, 2001). Police, overestimating the risk of violence, may respond with unnecessary force to people labeled mentally ill. The judiciary, holding individuals with mental illness responsible for their

symptoms, may fail to divert offenders to appropriate services in the mental health system.

Two sets of discriminatory behaviors seem to be relevant to legislators and policy makers. First, members of this group seem to be unwilling to allocate sufficient resources to mental health services. This is evidenced by 1990s levels of funding having dropped more than 8% from the preceding decade even though service needs did not change (Willis, Willis, Male, Henderson, Manderscheid, 1998). Also, legislators have been unwilling to pass a parity bill that equalizes insurance benefits for mental and physical health (Gitterman, Sturm, Pacula & Scheffler, 2001). Second, policy makers and legislators seem unwilling to interpret existing legislation in a manner that is friendly to mental health. Note that it took more than 5 years for the Equal Employment Opportunity Commission to issue an interpretation of the Americans with Disabilities Act (ADA) that is sensitive to the needs of people with psychiatric disabilities. Finally, many aspects of the entertainment media show discriminatory behavior. Content analyses have shown that television, movies, magazines, and newspapers often portray people with mental illness as dangerous or child-like (Wahl, 1995).

Two additional elements in Figure 2 influence the relationship between discriminatory behavior and change strategies: corresponding attitudes and social context. As an example, consider their relevance to employers and discriminatory behaviors. According to a social cognitive perspective, stigmatizing attitudes precede discriminatory behaviors (Corrigan, 2000). Path analytic research has shown that believing people with mental illness are dangerous leads to such socially avoidant behavior as unwillingness to work

alongside individuals labeled mentally ill (Corrigan, Markowitz et al., 2002). We hypothesize that incompetence may be an additional attitude that will influence discriminatory behaviors. This is the belief that people with mental illness are not able to work effectively or with peers so employers may refuse to hire them or provide reasonable accommodations.

The context in which targets behave may also influence the form of discriminatory behaviors (Liska, 1990; Newman, 2001). In particular, the socioeconomic context in which employers operate may affect the likelihood of hiring people with mental illness beyond the stereotypes of those doing the hiring. Some studies suggest that persons discharged from psychiatric hospitals often find employment in less desirable parts of cities, sometimes called "socially disorganized" neighborhoods (Silver, 1999, 2000). The likelihood of employers hiring persons with mental illness may depend on the economic context of the neighborhood in which the job site is located. Employers in more desirable parts of the city may conform to norms regarding the "appropriateness" of employees. However, employers in more economically disadvantaged and less desirable parts of the city may not be under community pressure to restrict their hiring practices and, therefore, less likely to be as greatly influenced by stigma.

Implications for Stigma Change

The model in Figure 2 is meant to serve as a heuristic for ongoing development of anti-stigma programs that are specific to the targets in columns one and two. There are already examples of these kinds of programs. Consider employment, for example. First, Title I of the Americans with Disabilities Act de-

finer hiring and supervisory practices that should increase individual goals in the employment arena. The Equal Employment Opportunity Commission provides guidance on what individuals with disabilities might do should they believe they were discriminated against in hiring or were not provided reasonable accommodations. Second, a Rotary Club in the San Diego area provides an example of a stigma change strategy crafted specifically to employers. Called "Erasing the Stigma," the program seeks to educate business leaders about an important myth: people with mental illness are unable to work. Education is followed up by action. Rotary members are informed of qualified individuals who have completed psychiatric rehabilitation and are ready to return to the work force.

These two examples illustrate the point of target-specific stigma change; these kinds of programs yield the biggest change when they are crafted with specific power groups and discriminatory behaviors in mind. We did not mean to imply that the list of power groups in the Figure is an exhaustive list of public stigmatizers. Two groups noticeably absent from the Figure are teachers and parents. Children may acquire common prejudices and discriminations of mental illness when their parents and teachers endorse the stigma of mental illness in statement and deed (Adler & Wahl, 1998). The point here was to illustrate the nature of functional relationships that leads to a power differential and discriminatory behavior. Nor, for that matter, do we believe the data exists to complete the rest of the cells. For this reason, the model was developed only for employers. Future researchers need to posit other groups whose authority vis-à-vis people with mental illness might perpetuate stigma.

Recall that we differentiated public stigma from self-stigma with the target-specific stigma change model only focusing on the implications of the former in this paper. However, it is equally likely that people with mental illness have power over certain goals and behaviors that reflect stigma. For example, people who are *potentially* consumers of mental health services may endorse some of the negative attitudes about mental illness and, as a result, avoid seeking services when they are indicated (Corrigan & Rüschi, 2002). The NMHAC public service announcements target this group. Alternatively, people with mental illness may endorse such notions as "the mentally ill are incapable of successful living" and therefore not pursue independent living goals such as competitive employment and housing (Link, 1987). Of course, many of these points are hypothetical and require additional research that examines the effects of target-specific versus generic change strategies. The investigatory process however, provides a step-by-step program for implementing and testing stigma programs that target the prejudice and discrimination that are experienced by people with mental illness.

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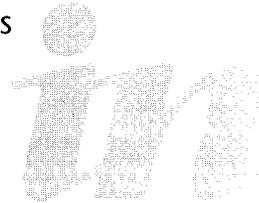
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