A Literature Review of the Public Stigma of Mental Illness

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CERTIFICATE OF APPROVAL

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CAPSTONE PROJECT

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A Literature Review of the Public Stigma of Mental Illness

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Abstract

The public stigma of mental illness refers to an external evaluation that someone is violating the norms of society. The public stigma of mental illness effects those with a mental illness through the experiencing discrimination and micro aggressions, and often is a barrier to seeking help (Overton & Medina, 2008; Maier, Gentile, Vogel, & Kaplan, 2014). The public stigma of mental illness may also exacerbate mental health symptoms in individuals' who experience it (Kendra, Mohr, & Pollard, 2014). Social contact programs have been found to be the most effective way to combat the public stigma of mental illness. Additionally, mental health counselors also are not immune to the stigma of mental illness, especially when it comes to disorders such as Borderline Personality Disorder and Schizophrenia. Due to this, social contact programs, making efforts to work collaboratively with clients, and advocating for clients may be needed.

Keywords: public stigma, mental illness, social contact, counselors, interventions

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Individuals who are stigmatized are believed to have some attribute or characteristic that gives them an undesirable social identity (Brown, 2012). Each year, as few as 11% of individuals with a mental health condition seek help, and stigma has been cited as a main reason why individuals do not seek help (Maier et al., 2014; Overton & Medina, 2008). Stigma has a negative impact on the lives of those with a mental illness and is a barrier to seeking treatment, and so reducing the stigma that surrounds mental illness is an important public health initiative (Lauber, Carlos, & Wulf, 2005).

Review of the Literature

There are several types of stigma that exist. The three main types of stigma are self-stigma, public stigma, and structural stigma (Corrigan, Powell, & Rusch, 2012). For the purposes of this paper, public stigma is the type of stigma which will be primarily talked about. Public stigma is an external evaluation of someone else, which is based upon the norms of society (Overton & Medina, 2008). Stigmatizing attitudes are activated when someone recognizes a cue that someone has a mental illness. That cue could be a noticeable difference in behavior, the appearance of the person, or the knowledge that someone has received a mental health diagnosis. After a cue that someone has a mental illness has been recognized, stereotypes are then activated (Corrigan, 2004). One example of a prevalent stereotype pertaining to mental illness is that all people with a mental illness are violent. After a stereotype has been activated, what often follows is discrimination (Corrigan, 2004).

Effects of Stigma

The stigma of mental illness effects individuals with a mental illness in various ways. Individuals are often discriminated against and experience microaggressions. Stigma can also be

a barrier to seeking treatment, and can lead to worse treatment outcomes for those who do seek treatment.

Discrimination. Individuals with a mental illness are often discriminated against. According to Overton & Medina (2008), landlords are less likely to rent to an individual with a mental illness, and an employer is less likely to hire someone who has been labeled as mentally ill. Additionally, an individual who is employed and has been labeled as mentally ill is less likely to earn as much money as someone with the same mental health condition who has not been labeled as mentally ill (Overton & Medina, 2008). One study examining discrimination that people with a mental illness encounter found that the majority of their participants perceived experiencing discrimination due to their mental illness (Hansson, Stjernsward & Svensson, 2014). The settings where individuals reported the highest rates of discrimination were in mental health settings by mental health staff, within families, and within marriages (Hansson et al., 2014). Corroborating these findings, a study conducted by Sarkin et al. (2014) found that 89.7% of the participants had experienced discrimination due to their mental illness. A study conducted by Wright, Henderson, Thornicroft, Sharac, and McCrone (2015) found that about 1/3 of employed individuals with a mental illness had experienced discrimination at work.

Microaggressions. In addition to individuals with a mental illness experiencing overt discrimination, it is also common for individuals with a mental illness to experience implicit discrimination in the form of microaggressions (Gonzales, Davidoff, Nadal, & Yanos, 2015). A microaggression refers to a verbal, nonverbal, or environmental slight, snub, or insult (Sue, Bucceri, Lin, Nadal, & Torino, 2010). A microaggression can be either intentional or unintentional, and it communicates a hostile or negative message to a person based on their membership in a marginalized group (Gonzales et al., 2015). In a study conducted by Gonzales

et al. (2015), participants with a mental illness reported experiencing a range of microaggressions including having their mental illness invalidated, being perceived to have lower intelligence, being perceived to be helpless, and being perceived as dangerous. Participants also reported feeling that they were chastised for having a mental illness. Many participants were explicitly told that they should keep their illness a secret, which can be a barrier to receiving treatment (Gonzales et al., 2015). Lundberg, Hansson, Wentz, and Bjorkman (2009) found that the most commonly endorsed experiences of rejection included being avoided, being treated as less competent, and being treated differently by others.

Systematic and institutional discrimination. In addition to discrimination occurring on an individual level, people with a mental illness are often discrimination against on a systematic and institutional level, which is referred to as structural stigma (Hatzenbuchler, 2016). 1/3 of states in the United states restrict the rights of an individual with a mental illness to hold elective office, to participate in juries, and to vote. 40% of the states in the United States limit child custody rights of parents with a mental illness (Corrigan, Markowitz, & Watson, 2004). According to Corrigan et al. (2014), these restrictions are related to being labeled as mentally ill, rather than to incompetence, which refers to an individual failing to meet a set standard. This means that an individuals' child custody and voting rights are restricted on the basis of an arbitrary label rather than on the basis of incompetence and failure to meet an agreed upon standard.

Barrier to help seeking. The stigma of mental illness is also a barrier to seeking treatment. Individuals often do not seek help in order to prevent their peers from becoming aware of their mental illness (Corrigan, 2004). According to a survey conducted by the Center for Behavioral Health Statistics and Quality (2014), 11% cited a concern that seeking help would

cause neighbors to have a negative opinion of them, 8.7% reported not seeking help due to it having a negative effect on their job, and 6.8% cited not seeking help due to not wanting others to find out about their mental illness. A meta-analysis conducted by Li, Dorstyn, and Denson (2014) found that the stigma of mental illness and concerns with the negative consequences of seeking treatment were negatively correlated with help seeking in college students.

Worsening treatment outcomes and symptoms. When an individual does decide to seek treatment, the stigma of mental illness can harm treatment outcomes. Perceiving a high level of public stigma is associated with less engagement during therapy (Kendra et al., 2014). When individuals are already engaged in mental health treatment, experiencing microaggressions can play a part in deciding to discontinue mental health treatment services (Gonzales et al., 2015).

Stigma and discrimination can also exacerbate the manifestations of psychopathology (Levy, Celen-Demirtas, Surguladze, & Sweeney, 2014). Perceived stigma of mental illness has been found to be positively correlated with greater suicide risk in individuals who had difficulty identifying and understanding their emotional experiences (Wang, Weiss, Pachankis, & Link, 2016). Griffiths, Mond, Murray, Thornton, and Touyz (2015) found that being resistant to stigma, or having the capacity to be unaffected by the stigma of mental illness was found to be higher in individuals with an eating disorder who were in recovery as compared to individuals with an eating disorder who were currently symptomatic. This suggests that in individuals who experience stigma and are affected by stigma, stigma may play a role in poorer treatment outcomes. Further evidence for the negative effects of stigma and discrimination of mental illness was found in a study conducted by Griffiths et al. (2015), which found that in individuals

with an eating disorder, experiencing more stigmatization was associated with being more symptomatic and adversely associated with recovery time.

Stigmatization of Specific Types of Mental Illness

Although mental illness in general is associated with stigma, there are some mental illnesses that have more stigma attached to them than others (Boysen, Ebersole, Casner, & Coston, 2014). A study by Feldman and Crandall (2007), which studied the perceptions that undergraduate students in an introductory psychology course had about 40 different mental illnesses, found that the disorders that had the most stigma attached to them were antisocial personality disorder, several of the paraphilic disorders (pedophilia, exhibitionism, voyeurism, and frotteurism), factitious disorder, kleptomania, and narcissistic personality disorder. The disorders that had the least amount of stigma attached to them were autism spectrum disorders, social phobia, PTSD, female sexual arousal disorder, and narcolepsy (Feldman & Crandall, 2007). It is important to note, however, that this study may not be generalizable to the larger U.S. population as a whole because the amount of stigma attached to each disorder may differ within different social groups (Crandall, Eshleman, & O'Brien, 2002).

A study conducted by Sarkin et al. (2014) which examined the stigma of mental illness experienced by individuals who were seeking mental health treatment in San Diego County found that individuals with mood disorders reported experiencing less discrimination than individuals with schizophrenia, which may suggest that schizophrenia is a diagnosis which has more stigma attached to it than mood disorders do. According to a study done by Mannarini and Boffo (2014) which used a sample of 366 university students and examined their attitudes towards general anxiety disorder, drug and alcohol addiction, depression, and schizophrenia found that drug and and alcohol addictions were the most highly stigmatized.

According to Sarkin et al. (2014), there is more stigma surrounding a diagnosis of bipolar disorder and schizophrenia than there is around anxiety disorders. Fear of and desire for social distance has also been found to be greater for disorders that are considered to be masculine disorders, which includes alcohol use disorder, antisocial personality disorder, and pedophilic disorder (Boysen, 2016). The disorders considered feminine are anorexia nervosa, dependent personality disorder, and histrionic personality disorder. These disorders were associated with less fear and desire for social distance, although it is important to note that this does not mean that there was no fear or desire for social distance (Boysen, 2016). Although the stigma varies based upon the population being studied, it is important to continue to keep in mind that different amounts of stigma are attached to various diagnosis. In general, it seems that Schizophrenia, Bipolar Disorder, Paraphilic Disorders, and Antisocial personality disorder are disorders which carry a large amount of stigma with them.

Interventions

There are three main types of interventions which are used to combat the stigma of mental illness. These interventions are protest, education, and social contact based interventions (Michaels et al., 2013). The purpose of protest and advocacy is to suppress negative attitudes and representations of mental illness (Corrigan et al., 2001). Education interventions involve educating others on mental illness, and social contact based interventions involve having contact with someone with a mental illness.

Protest and advocacy. One common type of intervention used to combat mental health stigma is protest and advocacy. It is important to note, however, that although this is a popular method of combating stigma, little research has been done to empirically validate its

effectiveness for reducing the stigma of mental illness. Therefore, it is unknown how effective this method is in producing an enlightened view of mental illness (Corrigan et al., 2001).

Education. The education method of combating the stigma of mental illness involves educating people about mental illness. Having a realistic and informed opinion about the causes and the treatment of schizophrenia, anxiety, bulimia, and depression has been associated with having lower prejudicial attitudes and lower social rejection of individuals with those disorders (Mannarini & Bofo, 2014). Kosyluk et al. (2016) found that education was effective in reducing stigmatizing attitudes among college students. This suggests that having accurate information about mental illness may lead to lower levels of prejudicial attitudes.

Social contact. Social contact based interventions involve participants having face to face contact with someone with a mental illness. Commonly, social contact interventions also contain an educational component. Although education based interventions do seem to be promising, social contact based interventions have had the most successful results. Social contact programs have been found to be successful in changing attitudes and behaviors, whereas education has been found to change attitudes but not behaviors (Overton & Medina, 2008). Additionally, results of studies done on anti-stigma campaigns have shown that programs that include social contact have had much larger effect sizes than education programs (Corrigan, et al., 2014). Hackler, Cornish, and Vogel (2016) found that watching a video that depicted the experiences of friends and family members of persons with a mental reduced desire for social distance from those with a mental illness, and reduced perceptions of devaluating those with a mental illness.

Research has demonstrated that individuals who have had greater contact with individuals with a mental illness often perceive individuals with a mental illness as less

dangerous (Brown, 2012). For example, Brown (2012) found that individuals with a friend that had severe mental illness or individuals who worked with someone with a severe mental illness held less stigmatizing attitudes towards people with a mental illness than individuals who had limited social contact with people with a severe mental illness. Also supporting these results is a study conducted by Feeg, Prager, Moylan, Smith, and Cullinan (2014) who found that college students who held prejudicial attitudes towards mental illness endorsed having low contact with individuals with a mental illness. These findings suggest that the amount of contact someone has with an individual with a mental illness is associated with less prejudicial attitudes, and supports the effectiveness of social contact based stigma reduction programs.

In order for a social contact based stigma reduction intervention to be effective, there are several key ingredients that should be included (Corrigan et al., 2013). The contact individual in the program should be similar to the audience that the anti-stigma program is targeting (Corrigan & Kosyluk, 2013). For example, when trying to change the stigma towards mental illness on a college campus, having a program where college students with a mental illness discusses their experience with mental illness would be effective. Having a presenter who is similar to the target audience can lead to an "us" mentality where the mentally ill person is seen as an equal (Overton & Medina, 2008). Corrigan et al. (2013) found that some key ingredients for social contact programs include a face to face presentation, identifying specific target groups, presenters being people with lived experience of mental illness, messages that including uplifting stories of success over a mental illness, and having a discussion component. Corrigan et al. (2014) surveyed one hundred mental health advocates with lived experience of mental illness, and had them rank the key ingredients of social contact based interventions. Findings from this survey corroborated that having a face to face presentation, having a specific target group, presenters

having lived experience, and having an uplifting message are essential to having a successful anti stigma campaign.

Mental Health Professionals and Stigma

Due to the potential negative effects and widespread nature of the stigma of mental illness, addressing the stigma of mental illness is an important objective for mental health professionals. However, mental health professionals themselves are not immune to stigmatizing attitudes and beliefs about individuals with a mental illness. Although studies have demonstrated that typically, individuals with more contact with individuals with a mental illness hold less stigmatizing beliefs, it is important to note that coming into contact with someone with a mental illness who is considered to be "typical" of those with a mental illness can reinforce stereotypes of mental illness instead of working to combat it, and can cause stigmatizing beliefs to continue and to potentially worsen (Overton & Medina, 2008; Reinke, Corrigan, Leanhard, Lundin, & Kubiak, 2004). Studies have demonstrated that many mental health disciplines subscribe to stereotypes that exist about mental illness, and many providers endorse the belief that people with a serious mental illness are doomed to poor outcomes (Corrigan, 2002; Keane, 1990; Lyons & Ziviani, 1995; Mirabi, Weinman,Magnetti, & Keppler, 1985). Additionally, according to a survey of one thousand clinical psychologists, psychologists reported viewing people with symptoms of borderline personality disorder as undesirable, and viewed people with schizophrenia as the most dissimilar to themselves (Servias & Saunders, 2007).

In addition to stigmatizing attitudes towards mental illness, the stigma of mental illness often plays out within the context of a therapeutic relationship in the form of microaggressions. Microaggressions are subtle and often unintentional, yet have the potential to negatively impact the therapeutic alliance (Gonzales et al., 2015; Nemec, Swarbrick, & Legere, 2015). Examples of

microaggressions that may play out in the context of a therapeutic relationship are using a condescending tone of voice, expressed concerns about peer support staff, who are individuals with a mental illness that are in recovery, and worries about not wanting to raise false hopes of recovery while not being concerned about creating false despair (Nemec et al., 2015). According to a study of individuals with a mental illness who live in New York, many of the participants reported experiencing a micro aggression from a trained treatment professional (Gonzales et al., 2015). It is important to note, however, that the specific professions that were being referred to as trained treatment professionals were not identified.

It is also important to note that although there is evidence that mental health professionals hold stigmatizing beliefs, there is evidence that psychologists hold less stigmatizing beliefs when compared with other health professionals. A study conducted by Smith, Mittal, Chekuri, Han, and Sullivan (2016) found that when comparing the attitudes towards schizophrenia that psychologists, mental health nurses, primary care nurses, primary care physicians, and psychiatrists held, psychologists and mental health nurses endorsed the least stigmatizing beliefs and attitudes. Primary care physicians, primary care nurses, and and psychiatrists held the most stigmatizing views of schizophrenia (Smith et al., 2016). Although a variety of studies have investigated mental health professionals' attitudes and stigmatizing beliefs of mental illness, the quantity of studies is less than studies looking at the stigma of mental illness in the general population, and therefore, this is an area greatly in need of further research (Schulze, 2007).

Implications for mental health professionals. Since studies have shown that mental health professionals may also hold stigmatizing attitudes towards individuals with a mental illness, it would be beneficial for mental health treatment professionals to be the target of interventions meant to reduce the stigma of mental illness. Since research has demonstrated the

effectiveness of social contact programs, inviting a mental health professional with lived experience of mental illness to speak to other mental health professionals may be an effective way to reduce the stigma of mental illness among these professionals. Michaels et al. (2014) examined the effectiveness of the Anti-Stigma Project workshop, an education and contact based stigma reduction program in Maryland, and found that this program was effective in decreasing prejudice and increased belief in recovery in providers of mental health services.

Specific diagnoses. Just as certain mental health diagnosis can carry more stigma than other diagnosis in the general population, mental health professionals also attach more stigma to certain mental health disorders. One example of this is Borderline Personality Disorder (BPD). A therapist may bring into sessions the assumption that a client with BPD is overreacting or being manipulative (Aviram, Brodsky, & Stanley, 2006). This may be valid in some situations, but it is also important to take into account that the counselor may be prejudiced by the stigma of BPD, and it is important to examine the concerns of a client without making assumptions first and asking questions later (Aviram et al., 2006).

Agency environment. The cultural climate of the agency that a counselor is working in can influence the attitudes towards mental illness that service providers in the agency hold (Nemec et al., 2015). Clinical assessments and progress notes often emphasize the limitations, barriers, symptoms, and problematic behaviors of clients, which can make it difficult for service providers to uncover the strengths, successes, and individual characteristics that a client has. Clinicians can work to develop positive views of the individuals that they work with by documenting the interests, preferences, and goals of the client in order to see more of the unique and human aspects of the client (Nemec et al., 2015). Additionally, clinicians can work to

reframe their impersonal and negatively orientated goal statements to goal statements that are individualized and positively stated (Nemec et al., 2015).

Self- Stigma of Mental illness

Public stigma is just one type of stigma that exists. Another type of stigma is self-stigma. Although it is beyond the scope of this paper to go into a comprehensive discussion of the self-stigma of mental illness, understanding self-stigma of mental illness as a construct and its potential effects on clients is important to the discussion of the stigma of mental illness. Self-stigma occurs when individuals with a mental illness internalize the public stigma of mental illness. Essentially, self-stigma exists when an individual believes the negative stereotypes about mental illness and mentally ill individuals and feels that they apply to themselves (Yanos, Lucksted, Drapalski, Roe, & Lysaker, 2014).

When individuals feel that they do not live up to social norms, they may experience self-hate and shame (Overton & Medina, 2008). This shame may diminish self-esteem and cause self-doubt in that individual about their ability to function, and may fuel depressive-like symptoms and reduce the rate of progress in therapy (Kendra et al., 2014). Individuals who internalize the stigma do not respond as well to evidenced based interventions (Yanos, Roe, West, Smith, & Lysaker, 2012). A study conducted by Corrigan et al. (2012) found that individuals with a mental illness who had internalized stigma were less likely to attempt to find a job. Due to the negative effects that internalized stigma can have on an individual's life and on their treatment outcomes, it is important for clinicians to be aware of the existence of self-stigma in order to be recognize when clients have internalized stigma so that they can address this effectively in counseling.

Discussion

Due to the effects that the stigma of mental illness has on individuals that have a mental illness, combating the public stigma of mental illness is an important initiative for counselors to engage in. The stigma of mental illness prevents many individuals from ever seeking help, and when they do, can harm their treatment outcomes. Additionally, individuals with a mental illness often experience microaggressions and discrimination, both on the institutional and individual level. The literature to date suggests that the most effective intervention used to combat public stigma of mental illness are social contact programs, which suggests that it may be helpful for counselors to engage in and organize social contact programs, which their clients and other individuals with a mental illness would indirectly benefit from (Corrigan et al., 2014; Overton & Medina, 2008).

Mental health professionals are not immune when it comes to the public stigma of mental illness, with studies demonstrating that individuals with a mental illness have endorsed experiencing microaggressions within the context of the therapeutic relationship (Gonzales et al., 2015; Nemec et al., 2015) Studies have also demonstrated that mental health counselors often endorse stigmatizing views of mental illness (Corrigan, 2002; Keane, 1990; Lyons & Ziviani, 1995, Mirabi et al., 1985). This means that in order for counselors and psychologists to continue to work with clients effectively, engaging in social contact programs themselves may be helpful in order to decrease stigmatizing views. Additionally, it is important for counselors to make efforts to create treatment goals collaboratively with clients, and to write goals which are positively stated. Although mental health counselors do hold stigmatizing views of mental illness, there is evidence that clinicians hold less stigmatizing views than other health professionals. This means that mental health counselors may need to be prepared to advocate for

their clients to other health professionals when client are being stigmatized due to their mental illness.

Directions for Future Research

In recent years, the stigma of mental illness has become of increasing interest. However, there are still many areas in which the research is lacking. Compared to the number of studies done on stigmatizing attitudes in the general population, there is a lack of studies examining stigmatizing attitudes among mental health professionals (Schulze, 2007). In the literature that does exist, professionals are often referred to as mental health professionals, with a lack of specify in the exact profession of the mental health professionals being studied. Additionally, due to the evidence that mental health professionals do hold stigmatizing attitudes towards mental illness, there is also a need for studies examining the effectiveness of interventions used to combat the stigma of mental illness with clinicians.

References

Aviram, R. B., Brodsky, B. S., & Stanley, B. (2006). Borderline personality disorder, stigma, and treatment implications. *Harvard Review of Psychiatry, 14*(5), 249-256. doi:10.1080/10673220600975121

Boysen, G.A. (2016). Using student evaluations to improve teaching: Evidence-based recommendations. *Scholarship of Teaching and Learning in Psychology*, 2 (4).

Boysen, G., Ebersole, A., Casner, R., & Coston, N. (2014). Gendered mental disorders: Masculine and feminine stereotypes about mental disorders and their relation to stigma. *The Journal of Social Psychology*, *154*(6), 546-565. doi:10.1080/00224545.2014.953028

Brown, S. A. (2012). The contribution of previous contact and personality traits to severe mental illness stigma. *American Journal of Psychiatric Rehabilitation*, *15*(3), 274-289.

Center for Behavioral Health Statistics and Quality. (2014). 2013 National Survey on Drug Use and Health. *Substance Abuse and Mental Health Services Administration.*

Corrigan, P. W. (2002). Empowerment and serious mental illness: Treatment partnerships and community opportunities. *Psychiatric Quarterly*, *73*(3), 217-228. doi:10.1023/A:1016040805432

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist, 59*, 614–625.

Corrigan, P. W., & Kosyluk, K. A. (2013). Erasing the stigma: where science meets advocacy. *Basic & Applied Social Psychology*, *35*(1), 131-140. doi:10.1080/01973533.2012.746598

Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Public levels of mental illness stigma and discrimination. *Schizophrenia Bulletin*, *30*(3), 481-491.

Corrigan, P. W., Michaels, P. J., Vega, E., Gause, M., Larson, J., Krzyzanowski, R., & Botcheva, L. (2014). Key ingredients to contact-based stigma change: A cross-validation. *Psychiatric Rehabilitation Journal*, *37*(1), 62-64. doi:10.1037/prj0000038

Corrigan, P. W., Powell, K. J., & Rüsch, N. (2012). How does stigma affect work in people with serious mental illnesses? *Psychiatric Rehabilitation Journal*, *35*(5), 381-384. doi:10.1037/h0094497

Corrigan, P.W., River, L.P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., & Kubiak, M. A.(2001). Three strategies of changing attributions about severe mental illness. *Schizophrenia Bulletin, 27*(2), 187-195.

Corrigan, P.W., Vega, E., Larson, J., Michaels, P.J., McClintock, G., Kryzanowski, R., & Buchholz, B. (2013). The California schedule of key ingredients for contact-based antistigma programs. Psychiatric Rehabilitation Journal, 36(3), 173-179.

Crandall, C. S., Eshleman, A., & O'Brien, L. T. (2002). Social norms and the expression and suppression of prejudice: The struggle for internalization. *Journal of Personality and Social Psychology, 82*, 359–378

Feeg, V.D., Prager, L.S., Moylan, L.B., Smith, K. M., & Cullinan, M. (2014). Predictors of mental illness stigma and attitudes among college students: Using vignettes from a campus common reading program. *Issues in Mental Health Nursing, 35*(9), 694-703.

Feldman, D. B., & Crandall, C.S. (2007). Dimensions of mental illness stigma: What about mental illness causes social rejection? *Journal of Social and Clinical Psychology, 26*(2), 137-154.

Gonzales, L., Davidoff, K. C., Nadal, K. L., & Yanos, P. T. (2015). Microaggressions

experienced by persons with mental illnesses: An exploratory study. *Psychiatric Rehabilitation Journal, 38*(3), 234-241. doi:10.1037/prj0000096

Griffiths, S., Mond, J. M., Murray, S. B., & Touyz, S. (2015). The prevalence and adverse associations of stigmatization in people with eating disorders. *International Journal of Eating Disorders, 48*(6), 767-774. doi:10.1002/eat.22353

Hackler, A. H., Cornish, M. A., & Vogel, D. L. (2016). Reducing mental illness stigma: Effectiveness of hearing about the normative experiences of others. *Stigma and Health, 1*(3), 201-205. doi:10.1037/sah0000028

Hansson, L., Stjernswärd, S., & Svensson, B. (2014). Perceived and anticipated discrimination in people with mental illness—An interview study. *Nordic Journal of Psychiatry, 68*(2), 100-106. doi:10.3109/08039488.2013.775339

Keane, M. (1990). Contemporary beliefs about mental illness among medical students: Implications for education and practice. *Academic Psychiatry, 14*(3), 172–177.

Kendra, M. S., Mohr, J. J., & Pollard, J. W. (2014). The stigma of having psychological problems: Relations with engagement, working alliance, and depression in psychotherapy. *Psychotherapy, 51*(4), 563-573. doi:10.1037/a0036586

Kosyluk, K. A., Al-Khouja, M., Bink, A., Buchholz, B., Ellefson, S., Fokuo, K., Goldberg, D., Kraus, D., Leon, A., Michaels, P., Powell, K., Schmidt, A., Corrigan, P. W. (2016). Challenging the stigma of mental illness among college students. *Journal of Adolescent Health, 59*(3), 325-331.

Lauber, C., Carlos, N., & Wulf, R. (2005). Lay beliefs about treatments for people with mental illness and their implications for antistigma strategies. *The Canadian Journal of Psychiatry / La Revue Canadienne De Psychiatrie, 50*(12), 745-752.

Levy, B., Celen-Demirtas, S., Surguladze, T., & Sweeney, K. K. (2014). Stigma and discrimination: A socio-cultural etiology of mental illness. *The Humanistic Psychologist*, *42*(2), 199-214. doi:10.1080/08873267.2014.893513

Li, W., Dorstyn, D. S., & Denson, L. A. (2014). Psychosocial correlates of college students' help-seeking intention: A meta-analysis. *Professional Psychology: Research and Practice*, *45*(3), 163-170. doi:10.1037/a0037118

Lundberg, B., Hansson, L., Wentz, E., & Bjorkman, T. (2009). Are stigma experiences among person with a mental illness related to perceptions of self-esteem, empowerment, and a sense of coherence? *Journal of Psychiatric and Mental Health Nursing*, *16*(6), 516-522

Lyons M, Ziviani J. (1995). Stereotypes, stigma and mental illness: Learning from fieldwork experiences. *American Journal of Occupational Therapy 49*(10), 1002–1008.

Overton, S. L., & Medina, S. L. (2008). The stigma of mental illness. *Journal of Counseling and Development*, *86*(2), 143-151. doi:10.1002/j.1556-6678.2008.tb00491.x

Reinke, R. R., Corrigan, P.W., Leonhard, C., Lundin, R.K., & Kubiak, M.A. (2004). Examining two aspects of contact on the stigma of mental illness. *Journal of Social and Clinical Psychology*, 23(3), 377-389.

Sarkin, A., Lale, R., Sklar, M., Center, K. C., Gilmer, T., Fowler, C., & Ojeda, V. D. (2015). Stigma experienced by people using mental health services in San Diego County. *Social Psychiatry and Psychiatric Epidemiology*, *50*(5), 747-756. doi:10.1007/s00127-014-0979-9

Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry*, *19*(2), 137-155. doi:10.1080/09540260701278929

Servais, L. M., & Saunders, S. M. (2007). Clinical psychologists' perceptions of persons with mental illness. *Professional Psychology: Research and Practice, 38*(2), 214-219. doi:10.1037/0735-7028.38.2.214

Sue, D. W., Bucceri, J. M., Lin, A. I., Nadal, K. L., & Torino, G. C. (2010). Racial microaggressions and the Asian American experience. *Asian American Journal of Psychology, 13*(1), 88–101.

Smith, J. D., Mittal, D., Chekuri, L., Han, X., & Sullivan, G. (2016) A Comparison of Provider Attitudes Towards Serious Mental Illness Across Different Health Care Disciplines. *Stigma and Health.*

Maier, J. A., Gentile, D. A., Vogel, D. L., & Kaplan, S. A. (2014). Media influences on self-stigma of seeking psychological services: The importance of media portrayals and person perception. *Psychology of Popular Media Culture*, *3*(4), 239-256. doi:10.1037/a0034504

Mannarini, S., & Boffo, M. (2014). The relevance of security: A latent domain of attachment relationships. *Scandinavian Journal of Psychology, 55*(1), 53-59.

Michaels, P.J., Corrigan, P.W., Buchholz, B., Brown, J., Arthur, T., Netter, C., & MacDonald-Wilson, K. L. (2014), Changing stigma through a consumer-based stigma reduction program. *Community Mental Health Journal, 50* (4), 395-401.

Mirabi, M., Weinman, M.L., Magnetti, S.M., & Keppler, K.N. (1985). Professional attitudes toward the chronic mentally ill. *Hospital & community Psychiatry, 36*(4), 404-405.

Nemec, P. B., Swarbrick, M., & Legere, L. (2015). Prejudice and discrimination from mental health service providers. *Psychiatric Rehabilitation Journal, 38*(2), 203-206. doi:10.1037/prj000014

Wang, K., Weiss, N. H., Pachankis, J. E., & Link, B. G. (2016). Emotional clarity as a buffer in the association between perceived mental illness stigma and suicide risk. *Stigma And Health*, *1*(4), 252-262. doi:10.1037/sah0000032

Wright, S., Henderson, C., Thornicroft, G., Sharac, J., & McCrone, P. (2015). Measuring the economic costs of discrimination experienced by people with mental health problems: Development of the Costs of Discrimination Assessment (CODA). *Social Psychiatry And Psychiatric Epidemiology*, *50*(5), 787-795.

Yanos, P. T., Lucksted, A., Drapalski, A. L., Roe, D., & Lysaker, P. (2014). Interventions Targeting Mental Health Self-Stigma: A Review and Comparison. *Psychiatric Rehabilitation Journal*, *38*(2), doi:10.1037/prj0000100

Yanos, P. T., Roe, D., West, M. L., Smith, S. M., & Lysaker, P. H. (2012). Group-based treatment for internalized stigma among persons with severe mental illness: Findings from a randomized controlled trial. *Psychological Services*, *9*(3), 248-258. doi:10.1037/a0028048