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# The role of labeling in the stigmatization of mental illness.

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# THE ROLE OF LABELING IN THE STIGMATIZATION OF MENTAL ILLNESS

A Thesis Presented

by

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CONTENTS

Page

ACKNOWLEDGEMENTS ..... iii

LIST OF TABLES ..... v

CHAPTER

I. INTRODUCTION ..... 1

The Stigma of Mental Illness ..... 2
Effects of Stigmatization ..... 5
Goals of the Current Study ..... 8

II. METHODS ..... 10

Participants ..... 10
Procedure ..... 10
Measures ..... 11

III. RESULTS ..... 14

IV. DISCUSSION ..... 20

BIBLIOGRAPHY ..... 32

LIST OF TABLES

Table

Page

1. Mean Social Distancing Scores by Labeling Condition ..... 29

2. Mean Perceived Dangerousness Scores by Labeling Condition ..... 29

3. Mean Social Distancing Scores by Perceived Helpfulness of Psychotherapy ..... 30

4. Mean Social Distancing Scores by Perceived Helpfulness of 12-Step Groups ..... 30

5. Mean Perceived Dangerousness Scores by Perceived Helpfulness of Psychotherapy ..... 31

6. Mean Perceived Dangerousness Scores by Perceived Helpfulness of 12-Step Groups ..... 31

# CHAPTER I

## INTRODUCTION

The concept of mental illness has changed significantly in the last 50 years. Professionally, the mental health field has expanded to include a wider range of conditions from personality disorders to attachment disorders to mood disorders to psychosis. This expansion is reflected in larger diagnostic manuals, which have been retooled and refined. Treatment techniques for mental disorders have become more numerous, safer, more effective and more accessible.

The concept of mental illness has seen shifts among nonprofessionals as well. The general public has evidenced a significant shift away from viewing the concept of "mental illness" as synonymous with "psychosis" and toward a more enlightened stance that recognizes both the diversity of diagnoses and the difficulties faced by those dealing with mental health issues (Phelan, Link, Stueve & Pescosolido, 2000).

In stark contrast to the many positive professional developments in the field and the more enlightened understanding of mental health among the general public, people receiving mental health services, especially those considered "psychotic," continue to experience high levels of stigmatization (Link, Cullen, Frank, & Wozniak, 1987; Martin, Pescosolido, & Tuch, 2000; Phelan et al., 2000; Wahl, 1999). Consider, for example, a recent article in a New Jersey newspaper that covered a fire in a psychiatric hospital. The headline read, "Roasted Nuts" (Persichilli, 2002). Results of a recent study conducted by Phelan et al. (2000) indicated that perceptions that someone labeled "mentally ill" would be violent and/or dangerous increased 250% between 1950 and 1996, despite the fact that the vast majority of people currently dealing with a mental illness are not violent

(Monahan, 1992). In fact, the likelihood of violent behavior exists only among a small subgroup of people with mental illnesses. Within this subgroup, a correlation between mental illness and violence has been demonstrated only among those *currently* experiencing psychotic symptoms who are *not* in treatment (Martin, Pescosolido, & Tuch, 2000; Monahan, 1992). Other studies have found that severe mental illness is viewed as negatively as drug addiction, prostitution and criminality (Albrecht, Walker, & Levy, 1982; Skinner, Berry, Griffith, & Byers, 1995).

Stigma toward people with mental illnesses is not confined to the general public. Professionals trained in mental health issues also hold negative stereotypes (Lyons & Ziviani, 1995). Oppenheimer and Miller (1988), for example, found that program directors viewed medical school applicants with a history of psychological counseling as less competent, less reliable, more dependent and more emotional than applicants without such a history.

**The Stigma of Mental Illness**

Goffman (1963) laid the groundwork for stigma research by giving us the language to discuss the concept, as well as to make the distinction between discredited and discreditable stigma. Discredited stigma is stigma associated with a readily apparent difference, such as skin color, that cannot be hidden. On the other hand, discreditable stigma includes stigma associated with more concealable traits, such as a mental illness, that may be hidden during superficial interactions. Because discreditable stigma markers may be concealed, the stigma associated with it is decidedly more difficult to study.

Discreditable stigma must be inferred. In particular, mental illness must be inferred from four "signals" including labels (such as "mentally ill"), psychiatric

symptoms (such as talking to oneself aloud), social skill deficits or excesses (such as unusual body language or eye contact), and physical appearance (such as poor personal hygiene); (Penn & Marin, 1998). These signals are then given meaning by the stereotypes associated with them. Stereotypes are knowledge structures shared by most members of a social group. Stereotypes are not necessarily *negative* belief systems but are simply collectively agreed upon notions of groups of people that provide efficient ways of categorizing information. While most people can readily recall hundreds of stereotypes about different groups of people ("Mentally ill people are dangerous"), the mere ability to recall stereotypes does not imply that they agree with the generalizations or consider them to be valid representations. However, when a stereotype is paired with an evaluative, often negative component and is endorsed by the person recalling it, negative emotional reactions occur and a prejudice (or stigma) is formed. Whereas stereotypes are general beliefs about groups of people, prejudices add an attitudinal component ("Mentally ill people are dangerous and I am afraid of them"). Prejudices are often accompanied by a negative behavioral reaction, also known as discrimination ("I would never hire a mentally ill person to work for me").

Social psychologists involved in the study of mental illness stigma have identified three primary stereotypes associated with it. These stereotypes include viewing the mentally ill as childlike beings that need to be cared for ("benevolence"); viewing the mentally ill as rebellious, free-spirits incapable of making well-thought out decisions ("authoritarianism"); and viewing the mentally ill as dangerous, unpredictable criminals ("fear and exclusion"); (Brockington, Hall, Levings, & Murphy, 1993). These stereotypes are frequently displayed to the public through movies, news coverage,

commercial products, etc. For example, news reports frequently use selective reporting in criminal cases involving people with mental illnesses, portraying them as violent and unpredictable. Angermeyer and Matschinger (1996) found that the use of this selective reporting creates a significant negative impact on attitudes toward people with mental illnesses. Left unchallenged, these limiting stereotypes often lead to a general fear of people with mental illness, which in turn leads to socially distancing behavior (Corrigan, Green, Lundin, Kubiak, & Penn, 2001).

Research has sought to clarify when and how stigma towards people with mental illnesses occurs by examining the expectations of how the stigmatized person will behave and a report of the extent to which members of the general public would socially distance themselves from the stigmatized person. Some researchers have argued that while the public may grudgingly admit to stereotypic beliefs regarding mental illness, stereotypic or even prejudiced belief systems do not necessarily predict actual discriminatory behaviors (Weinstein, 1983). Others have supported the idea that it is a stigmatized person's behavior, not simply their label that matters the most in public opinion (Gove, 1982). Many researchers have found evidence that the perceived amount of personal responsibility that a person has for their disorder affects the amount of stigma attached to the label (Corrigan, River, Lundin, Wasowski, Campion, Mathisen, et al., 2000). For example, Mehta and Farina (1997) found that when mental illness is portrayed as a biologically based disease, less blame is attributed to the person. Martin, Pescosolido and Tuch (2000) report similar results, finding that people who view mental health problems as structurally based (e.g., genetically caused) are more willing to interact with a mentally ill person than are those who attribute mental illness to more personal choices (e.g., "bad

character"). However, other studies have found that regardless of the degree of perceived personal responsibility present, whenever one of the four signals of mental illness is readily apparent, stigma and resulting social distance is virtually inevitable (e.g., Link et al., 1987).

**Effects of Stigmatization**

Regardless of where stigmatizing beliefs originate or what groups endorse them, it has become apparent that the effects are devastating. In fact, in the Surgeon General's 1999 report on mental health, stigma was determined to be the "most formidable obstacle to future progress in the arena of mental illness and health" (Chapter 1). The report concluded "for our nation to reduce the burden of mental illness...stigma must no longer be tolerated" (Conclusion section). Three distinct groups remain powerfully affected by the negative stereotypes and the resulting discrimination surrounding mental illness: those involved in the mental health system, their friends and family, and those who fail to seek needed mental health services.

First, there are those who are already involved in the mental health system. Approximately 48% of all Americans will deal with a mental illness at some point in their lives, and mental illnesses currently account for more than 15% of diseases from all causes (Satcher, 1999). Clearly, then, huge numbers of people need to have services available to them. Despite this widespread need, stigma has been shown to eventuate in federal and state budget cuts to mental health care, as well as to instigate protests over the establishment of community health care facilities (Kolodziej & Johnson, 1996). On an individual level, stigma has been found to be associated with limitations in job, housing and educational opportunities. Stigma has also been shown to hamper and/or strain social

interactions and to constrict social networks (Corrigan & Penn, 1999; Corrigan & Watson, 2002; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Link et al., 1987). These social impacts often produce harmful emotional effects on the stigmatized person, such as feelings of hurt, anger, and disappointment and often a significant loss of self-esteem (Wahl, 1999). As one survivor of mental illness stated, "there is nothing more devastating, discrediting and disabling to an individual recovering from mental illness than stigma...to be a patient or even ex-client is to be discounted. Your label is a reality that never leaves you; it gradually shapes an identity that is hard to shed" (Leete, 1989, p. 199).

Lowered self-esteem among people dealing with the stigma of mental illness appears to be both common and highly disruptive to the treatment and recovery process. A few studies have documented a "righteous anger" response to stigma among a small percentage of the stigmatized group that actually proves to be beneficial in the healing process (Rosenfield, 1997; Hayward & Bright, 1997; Corrigan & Watson, 2002). However, the majority of studies have found that an increased experience of stigma strongly predicts a decrease in self-esteem and feelings of worthiness (e.g., Link et al, 2001), such that people with mental illness may come to believe that socially endorsed stigmas are correct and therefore that they are incapable of functioning in "normal" society (Link, Cullen, Streuning, Shrout, & Dohrenwend, 1989). Wright, Gronfein, and Owens (2000) found that stigma leads to self-deprecation among former mental patients, which in turn weakens their sense of mastery over life circumstances. Furthermore, when people with mental illness are aware that others know about their diagnoses, they feel less appreciated, perform more poorly and are more anxious than are their counterparts with

concealed diagnoses (Farina, Gliha, Boudreau, Allen and Sherman, 1971). Concealing diagnoses, however, is not a solution; people who attempt to avoid stigma by concealing their illness have often been found to become obsessively preoccupied with the cover up, a state which may well interfere with functioning (Smart & Wegner, 1999). Even when treatment improves symptoms and functioning to the point where there is nothing left to conceal, stigma has been shown to have an enduring negative effect on well-being (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997).

Stigmatization of the mentally ill affects a second group of people: the family and friends of people with mental illness. In a survey of 487 family members of people with mental illnesses, Wahl (1989) found that 89% reported stigma to be at least somewhat of a problem for family members of people with mental illnesses. More specifically, participants acknowledged lowered self-esteem and feelings of guilt, shame and embarrassment over the illness. Lefley (1992) also found that family members of mentally ill patients reported lower self-esteem due to stigma. Apparently, then, the stereotypes given to the mentally ill often spill over onto their closest family and friends.

The third group of people who are impacted by the stigma associated with mental illness are those who fail to utilize mental health services, at least partially because of the fear of experiencing stigmatization if they do so. Approximately two-thirds of Americans who suffer from a mental illness will not receive care (NIMH, 2003). The reasons for failing to access mental health services are many and include time, money, and mistrust. It seems obvious, however, that at least some of those who avoid treatment are likely to do so based on stigma alone. Stigma-induced avoidance of treatment may be significantly heightened among ethnic minorities and at least partially responsible for the

underutilization of mental health services by these groups (Atkinson & Gim, 1989; Nickerson, Helms & Terrell, 1994; Snowden & Cheung, 1990; Whaley, 1997).

**Goals of the Current Study**

It is clear that mental illness is stigmatized and that this stigma is associated with negative effects. The extent to which this stigma spreads to consumers of mental health services more generally is less clear. Also unclear is the basis for the stigma: what concerns lead people to have negative reactions to those labeled mentally ill? The present study was designed to evaluate whether stigma was associated with other segments of mental health service consumers and to explore what fundamental concerns seem to underlie prejudice and discrimination against this group.

The results of this study will be analyzed with several hypotheses in mind. First, it is hypothesized that the level of stigmatization can be predicted solely based upon the nature of a descriptive label used to introduce a person. More specifically, it is hypothesized that labels involving mental illness will predict higher levels of stigmatization than a benign label of "college student" and in the following order: people who are in a 12-step group, people who are in psychotherapy, people who are on psychiatric medication and people who are mentally ill.

Second, it is hypothesized that the level of perceived dangerousness will mediate the relationship between labeling and social distance. To clarify, it is hypothesized that the degree of dangerousness that a participant ascribes to a specific mental illness label is the mechanism by which that labeling condition results in the level of discrimination the participant exhibits towards a member of that group.

Third, it is hypothesized that a number of demographic factors will predict the relationship between perceived dangerousness/social distance and labeling condition. These factors include age, level of education, race/ethnicity and knowledge of someone involved with mental health services. More specifically, it is expected that lower levels of perceived dangerousness will be associated with younger participants due to the fact that today's youth have grown up in an era where mental illness is openly discussed and treated. In addition, it is believed that higher education levels will predict lower perceived levels of dangerousness. As participants are exposed to more education, it is likely that they will be exposed to more open schools of thought on mental illness. Also, it is more likely that they will have taken classes in the social sciences that discuss the realities of living with a mental illness. It is also believed that both identifying as European-American and contact with someone with a mental illness will result in lower levels of perceived dangerousness. Due to inaccessible services, ineffective treatments, and general underutilization of mental health services by minorities, it is believed that more European-Americans will know people involved in mental health services and therefore, be less likely to endorse stereotypes related to dangerousness.

# CHAPTER II

# METHODS

## Participants

A total of 394 participants were surveyed, including 206 women and 185 men (3 participants opted not to specify their gender). The mean age of the respondents was 28.9 years of age ($SD = 11.76$) with a range of 13 to 73 years of age. The majority of participants identified as European-American (72%), while the rest were fairly evenly distributed among African-American (9%), Hispanic-American (7%), Asian-American (5%) and "other" (7%). The mean level of education for the respondents was 14.48 years ($SD = 2.64$).

## Procedure

Twenty undergraduate researchers from an advanced psychology research methods class randomly approached potential participants in a variety of public places such as airports, highway rest stops, and shopping centers during their spring break. Potential participants were asked if they would participate in a study being conducted on attitudes and behaviors by members of a research methods class at the University of Massachusetts, Amherst. If a participant agreed, they were provided with one version of the survey and asked to respond to several questions and statements after reading it. To ensure confidentiality and anonymity, participants were allowed to move away from the researcher to complete the survey and to seal their answers in an envelope before returning them to the researcher.

Each survey began by asking the participant to carefully read a short vignette and form a basic impression of the person who wrote it. The vignette read as follows:

> Hello, my name is Ted and I am (*condition 1,2,3,4 or 5*). I'm 27 years old and I am majoring in Economics in college and hopefully going for my masters, but not right after I graduate. I enjoy fishing and hiking and usually go annually with my father up to the lakes in New Hampshire. My parents got divorced when I was 12, but I still keep in contact with both of them. I have one older brother and a younger sister who I remain fairly close to. Lately I've been feeling a bit down. I haven't been going out as much as I used to, but I've still remained close with some of my friends. I've been feeling a bit overwhelmed with my workload lately but hopefully, things will start to come together.

Each vignette was modified to have Ted identified as "a college student" (condition 1), "mentally ill" (condition 2), "in psychotherapy" (condition 3), "on psychiatric medication" (condition 4) or "in a 12-step group" (condition 5).

**Measures**

After reading the vignette, participants completed the Social Distance Scale (SDS) and the Perceived Dangerousness of Mental Patients Scale (PDMPS), both designed by Link et al. (1987). The SDS includes seven questions designed to assess social distancing behavior by measuring a respondent's willingness to associate with someone like Ted on a four-point, Likert scale. For example, participants read a question such as "how would you feel about renting a room in your home to someone like Ted?" and responded by circling a statement from 1 (*definitely willing*) to 4 (*definitely unwilling*). The PDMPS includes a series of eight questions designed to assess the perceived dangerousness of Ted by reporting their agreement with each statement on a six-point, Likert scale. For instance, respondents read a condition-specific statement such as, "although some people who are *mentally ill* (or *on psychiatric medication*, etc.) may seem alright, it is dangerous to forget for a moment that they are *mentally ill*." They were

then asked to indicate their attitude toward the statement by circling a response from 1 (*strongly disagree*) to 6 (*strongly agree*).

After completing the SDS and PDMPS, participants were asked to respond to a number of demographic questions, including age, gender, level of education, and race/ethnicity. Research in the field of social cognition has shown that contact among antagonistic members of minority and majority groups may lead to positive outcomes provided the contact situation affords participants equal status, sustained close contact, and intergroup cooperation (Allport, 1954). While empirical evidence is not strong for the contact hypothesis in less than perfect conditions, studies have shown that when group members are put on a level playing field, positive outcomes occur. For example, Desforges, Lord, Ramsey, Mason, Leeuwen, West, et al. (1991) conducted a study where they engaged college undergraduates in one hour dyadic learning sessions with a confederate portrayed as a former mental patient. Results indicated that participants in the structured cooperative learning conditions described the mental patient more positively, adopted more positive attitudes about people with mental illness, and showed more acceptance than those in the control (individual study) group after the contact. In addition, other studies have shown that individuals who are more familiar with mental illness are less likely to endorse prejudicial attitudes (such as perceived dangerousness) about the group (Corrigan, Edwards, Green, Diwan, & Penn, 2001; Corrigan et al., 2001). Therefore, it seems important to take into account a person's previous experience with persons with mental illness when measuring their attitudes and behavior towards that group. To probe this possibility, participants were asked if either they, or someone close to them, had participated in psychotherapy and/or a 12-step group. Participants were then

questioned about the perceived effectiveness of that treatment. Finally, participants were given an area for free response and asked to share any additional thoughts, feelings, or impressions they had about Ted that were not covered by the questionnaire.

# CHAPTER III

## RESULTS

To begin, each participant's answers to the attitudinal and behavioral questions of the SDS and PDMPS were individually summed and divided by the number of items to find the average. Each participant's average was then used to fill in any missing data. Next, the individual averages were summed and divided by the number of participants to find the group averages. The overall mean of the sample for the SDS was 2.30 ($SD$ = .68) with a range of 1 to 4. The overall mean of the sample for the PDMPS was 2.61 ($SD$ = 1.13) with a range of 1 to 6. A higher score indicated more stigmatization of the subject, while a lower score indicated less stigmatization. The SDS and PDMPS had internal consistencies of .91 and .88 (respectively) as indicated by Chronbach's Alpha in this study. Scores from both the SDS and the PDMPS were symmetric, although boxplots indicated the presence of five outliers. Outliers were defined as scores falling more than two standard deviations away from the mean. Tests were conducted with and without outliers, and results revealed no significant difference between them. Therefore, all reported analyses were conducted including all outliers.

Next, univariate analyses of variance (ANOVA) were conducted to test for a main effect of labeling condition on the two measures of stigma – social distance and perceived dangerousness. The ANOVA for the SDS yielded a significant main effect for labeling condition [$F_{(4,389)} = 9.05$, $p < .001$, $\eta^2 = .09$]. The means and standard deviations for each condition of the SDS are presented in Table 1. A Tukey HSD post-hoc analysis indicated a significant difference between the control condition label of "college student" and all other labels (all $p$'s $< .01$); there were no significant differences among the individual

mental illness labels. However, the order of the conditions was consistent with predictions.

A second ANOVA was conducted on the PDMPS. Again, the analysis yielded a significant main effect for labeling condition [$F_{(4, 389)} = 24.65$, $p < .001$, $\eta^2 = .20$]. The means and standard deviations for each condition of the PDMPS are presented in Table 2. A Tukey HSD post-hoc analysis indicated that the control condition label of "college student" mean was significantly lower than all other label conditions ($p < .001$). In addition, differences among conditions were found. More specifically, the labels "in a 12-step group" and "in psychotherapy" did not differ significantly from one another, but were significantly lower than the "mentally ill" label ($p < .01$). Interestingly, however, the label "in psychotherapy" does not appear to differ significantly from the label "on psychiatric medication." Additionally, the labels "on psychiatric medication" and "mentally ill" did not differ significantly from one another, but were significantly higher than any of the other labels ($p < .01$), with the exception involving psychotherapy and medication noted previously. Again, the pattern of scores was generally as predicted.

Next, bivariate regressions were conducted to investigate the nature of the observed stigmatization. As indicated by the analyses of variance conducted on the SDS and PDMPS, all noncontrol conditions were stigmatized. Therefore, all conditions were recoded into two categories reflecting the presence or absence of stigmatization. More specifically, the label of "college student" was categorized as "not stigmatized", while the other conditions were grouped together in a "stigmatized" category. All regressions were conducted using these two new categories.

To test the mediator hypothesis, first social distance was regressed on the stigma condition. This relationship was significant ($\beta = .27, p < .001$, Adj. $R^2 = .07$). Next, perceived dangerousness was regressed on the stigma condition. Again, this relationship was significant ($\beta = .40, p < .001$, Adj. $R^2 = .16$). Finally, social distance was regressed on the stigma condition while controlling for perceived dangerousness. The relationship between stigma condition and social distancing behavior became nonsignificant ($\beta = .02$, $p > .05$), while the relationship between perceived dangerousness and social distancing behavior remained significant ($\beta = .63, p < .001$, Adj. $R^2 = .41$), indicating that perceived dangerousness did in fact function as a mediator between stigma and social distancing behavior.

Finally, it was hypothesized that a number of demographic variables would be associated with level of stigma. First, it was believed that level of stigma would decrease with prior exposure to someone involved in mental health services. To test this hypothesis, analyses of variance were conducted on the SDS and PDMPS to examine the effect of knowing someone involved in psychotherapy or a twelve-step group. No main effect was found for either the psychotherapy condition [$F_{(1,392)} = .33, p = .566$]. The mean for people who indicated that they knew someone in the therapy ($M = 2.28$, $SD = .64$) was not significantly lower than the mean for people who indicated that they did not know anyone in therapy ($M = 2.32$, $SD = .74$). Similar results were found for the twelve-step condition [$F_{(1, 387)} = .73, p = .393$]. Again, the mean for people who knew someone in a 12-step group ($M = 2.26$, $SD = .62$) was not significantly lower than the mean for people who did not know anyone in a group ($M = 2.67$, $SD = .71$).

On the PDMPS, a main effect was not found for knowledge of someone in psychotherapy [$F_{(1, 3392)} = 1.94, p = .164$]. The mean for people who indicated that they knew someone in psychotherapy ($M = 2.54$, $SD = 1.07$) was not significantly lower than the mean for people who had no prior experience with someone involved in therapy ($M = 2.70$, $SD = 1.20$). In addition, knowledge of someone involved in a twelve-step group did not lead to significantly lower scores as predicted [$F_{(1,387)} = 1.79, p = .182$]. The mean for people who knew of someone in a 12-step program ($M = 2.51$, $SD = 1.08$) was not significantly lower than the mean for people who did not have prior experience with someone in a 12-step program ($M = 2.67$, $SD = 1.15$).

While on the surface the hypothesis was not supported, further investigation into this relationship did reveal a trend. An analysis of variance suggests that ethnicity may interact with prior knowledge of someone involved in mental health services (including both psychotherapy and 12-step group) and perceived dangerousness ($F_{(1,380)} = 3.17$, $p = .076$). While previous exposure led to lower mean scores on the PDMPS for non-minority participants, it led to higher mean scores for minority participants.

Despite the fact that knowledge of someone involved in mental health services did not affect level of stigmatization, the perceived success of that treatment did (see Tables 3-6 for means and standard deviations). Analyses of variance on the SDS indicate a main effect of perceived helpfulness of treatment for both psychotherapy [$F_{(5,240)} = 5.09, p < .001, \eta^2 = .10$] and twelve-step group [$F_{(5,161)} = 2.19, p = .05, \eta^2 = .07$]. Similarly, an ANOVA on the PDMPS also yielded a main effect for perceived success of treatment of psychotherapy [$F_{(5,240)} = 7.36, p < .001, \eta^2 = .14$] and twelve-step group [$F_{(5,161)} = 3.32, p$

$= .007, \eta^2 = .10]$. Therefore, it appears that it is not the knowledge that someone is in treatment, but rather the perceived success of that treatment that predicts level of stigma.

It was also hypothesized that overall level of stigma would decrease with higher levels of formal education but increase with the age of participant. To test these hypotheses, education and age were regressed simultaneously on both measures of stigmatization. Results were significant, and confirmed the hypotheses. Higher levels of formal education significantly reduced the amount of stigma shown by participants on both the SDS [$\beta = -.14, p = .006$, Adj. $R^2 = .01$] and the PDMPS [$\beta = -.18, p < .001$, Adj. $R^2 = .02$]. Additionally, an increase in age significantly increased the amount of stigma shown by participants on both the SDS [$\beta = .17, p = .001$, Adj. $R^2 = .02$] and PDMPS [$\beta = .14, p = .006$, Adj. $R^2 = .01$].

Lastly, it was hypothesized that people who identified as an ethnic minority would evidence higher levels of stigma on all labeling conditions. To test this hypothesis, the six racial categories were condensed into two categories indicating membership to either the dominant (majority) or non-dominant (minority) group. An analysis of variance was conducted on the SDS using the new group membership category and results were not significant [$F_{(1,387)} = .63, p = .427$]. The mean for minority participants ($M = 2.34$, $SD = .78$) was not significantly greater than the mean for nonminority participants ($M = 2.28$, $SD = .64$). Similarly, being a member of an ethnic minority group did not lead to significantly higher scores on the PDMPS [$F_{(1,387)} = 1.97$, $p = .161$]. Again, the mean for minority participants ($M = 2.73$, $SD = 1.17$) was not significantly greater than the mean for nonminority participants ($M = 2.55$, $SD = 1.11$).

While the hypothesis that ethnicity would be a predictor of stigma was not supported, the results are slightly more complex than the analyses of variance suggest. In the current sample, there is a small, but significant, negative correlation between education level and being an ethnic minority ($r = -.147$, $p = .004$). Additionally, an analysis of variance illustrates that the European-Americans in this sample had significantly more formal education than did the ethnic minorities [$F_{(1,382)} = 12.62$, $p < .001$, $\eta^2 = .03$]. The mean number of years of education for nonminority participants ($M = 14.75$, $SD = 3.40$) was significantly greater than the mean number of years for minority participants ($M = 13.68$, $SD = 2.27$). Previous analyses indicated that education significantly decreases the level of stigma shown by participants. Thus, it is unclear precisely what the roles of ethnicity and education are in the stigmatization of mental illness in this sample.

# CHAPTER IV

# DISCUSSION

This study contributes a number of significant findings to the literature on the stigmatization of mental illnesses. First, we know that people with mental illnesses are stigmatized. From the analyses it is clear that any indication of mental illness via a descriptive label elicits significantly more stigma than a more benign label of "college student." In addition, results form the PDMPS suggest that there may be hierarchy of stigmatization among various mental illness labels. In general, it appears that the labels reflecting participation in some form of therapy yield less stigma than labels indicating mental illness and/or the need for psychiatric medication. Perhaps participants, aware of the vast number of people who attend therapy for a variety of life problems, viewed psychotherapy as less indicative of a more severe, and therefore more unpredictable, mental illness.

While we may speculate about the differences between the labels, it should be made clear that this study was not designed to flush out differences between different mental illness labels, so much as it was designed to see if stigma occurs with modern mental illness labels. Knowing that stigma occurs significantly more with any modern mental illness label is what is important. The small differences that may occur among various labels within the mental illness category are arguably meaningless. To focus on the differences quantifies human suffering based on dysfunction and negates the fact that the effect of stigma, regardless of its size and/or form, is hurtful to all individuals. As Frankl (1959) writes, "man's suffering is similar to the behavior of gas. If a certain quantity of gas is pumped into an empty chamber, it will fill the chamber completely and

evenly, no matter how big the chamber. Thus suffering completely fills the human soul and conscious mind, no matter whether the suffering is great or little. Therefore the 'size' of human suffering is absolutely relative" (p.64).

The current study also demonstrates that fear of the unknown plays a primary role in the stigmatization of mental illness. As noted earlier, public perceptions of people with mental illnesses as violent and/or dangerous have increased 250% between 1950 and 1996 (Phelan et al., 2000). It appears that it is precisely this gap between reality and perceptions of the dangerousness of people with mental illnesses that is responsible for stigmatizing beliefs (Corrigan, Green, Lundin, Kubiak, & Penn, 2001; Link, Cullen, Frank, & Wozniak, 1987; Martin, Pescosolido, & Tuch, 2000). The current study demonstrates that perceived dangerousness of people with mental illnesses mediates the relationship between condition and social distancing behavior. In other words, the more dangerous a person believes someone in the mental health system to be, the more stigma they will demonstrate toward that person. This finding suggests that educational and intervention efforts to minimize stigma should focus on exposing the general public to the realities of living with a mental illness. A special effort should be made to target the largely inaccurate stereotypes surrounding mental illness that strongly contribute to the notion that people with mental illnesses are unpredictable and dangerous. While these stereotypes have some basis in reality (recall the correlation between violence and actively psychotic, untreated people with mental illnesses), they are limiting and deny the fact that approximately 20% (1 out of 5) of adult Americans will suffer from a diagnosable mental illness in a given year (NIMH, 2002) and will not be any more violent and/or dangerous as a result.

Next, as hypothesized, this study demonstrated that a number of different demographic variables are associated with higher scores (or more stigma) on both of the measures. More specifically, stigma increases as formal education decreases. While it is impossible to definitively identify the reason for this finding based on the information in the current study, it is likely that more formal education leads to more realistic perceptions of people with mental illnesses. The mean number of years of education in this sample was 14.48 years and the majority of college students in this country take an introductory psychology class where they are exposed to facts, rather than stereotypes, about the realities of psychological disorders.

The current study also demonstrates that stigma increases as the perceived effectiveness of psychological treatment decreases. This result may easily be interpreted considering the mediating role of perceived dangerousness. As a participant views mental health services as less beneficial, their perception of dangerousness increases, leading to higher stigmatization.

Finally, this study found that stigma increases as chronological age increases. The community mental health movement did not begin until the 1960s and it is likely that older generations are less familiar with the facts than with the stereotypes of mental illnesses. In addition, it is possible that older participants have had real-world experiences with people who have mental illnesses that have left them with negative general impressions of the group.

In addition to the significant findings among demographic variables, there were a few variables that did not appear to predict levels of stigmatization, including prior knowledge of someone with a mental illness and ethnicity. At first blush, it appears that

the lack of significant findings with regard to prior exposure contradicts past research. Yet it could be argued that the current study simply clarifies the relationship between prior exposure to mental illness and stigmatization. According to the current study, mere exposure to someone with a psychological disorder does not necessarily lead to lower scores on measures of stigma. However, if that treatment is viewed as beneficial or effective, participants acknowledge less stigmatizing beliefs. To clarify, it is not the knowledge that someone has received treatment, but the perceived effectiveness of that treatment that predicts stigmatization. Somewhat complicating these results, however, is the finding that this process may work differently depending on the participant's ethnicity. The current study suggests that ethnicity may moderate the relationship between prior exposure to mental illness and stigmatization. Marginally significant results indicated that while knowledge of someone in treatment lowered scores on the PDMPS for European-Americans, it raised the scores for minority participants. Further research is needed to clarify this relationship. Despite this finding, the current study failed to find a significant main effect for ethnicity and stigmatization. This finding is difficult to fully interpret, however, due to the significant negative correlation between ethnicity and education. Again, further research is needed to specifically examine the role of ethnicity in the stigmatization of mental illness.

Finally, participants were given an area for free response to give any positive or negative reactions to the vignette character that were not accessed by the social distance or perceived dangerousness scales. Participant responses centered largely around two themes including the need for more information and perceived dangerousness. First, the majority of respondents wanted more clarification about the vignette character's

identifying information. For example, one participant wrote, "I feel like the description of [Ted] is a little ambiguous. I would like to know a little more about the severity of his psychotherapy." Other participants commented that the information given was "too general," noting that they would feel "more comfortable" making judgments if they "knew the person." One participant pointed out the problematic nature of the descriptors, stating that "the definition of psychotherapy might have different connotations for different people." Other participants were more explicit, commenting that their opinions would differ based on the specific type of mental illness. For instance, one participant wrote, "if the illness was pedophilia, my responses would be quite different from a condition such as bipolar."

Participant responses in the free response section also involved the concept of perceived dangerousness, lending support to its function as a mediator. For many participants who received a noncontrol condition, the statement written by Ted confirmed their expectations that people with mental illnesses are impulsive and dangerous. For example, one participant wrote, "it was obvious that [Ted] was mentally ill because his writing was very random which sorta scares me because it shows that mentally ill people are sporadic!" Another participant described Ted as a "time bomb waiting to go off," while another viewed his statement as indicative of his "overt instability." Finally, one participant expressed concern over the idea of psychiatric medication in and of itself, commenting, "I would be afraid of [Ted] because of what I have heard about some medications and their effects."

The information obtained through the free response section suggests a hierarchy within modern mental illness labels. It was clear that many participants wanted specific

information about the exact nature of the mental illness and would apparently alter their responses as a result. However, it is difficult to asses exactly how or if more information would change participant responses. Despite how many participants acknowledged the need for more information, none failed to complete the survey and all were able to make judgments based on the few descriptors given. In other words, their desire for clarification did not appear to affect their ability to recall stereotypes and judge Ted. And while many people espoused the need for more accepting environments ("he seems like a guy that could use support and a chance, a good environment to turn to at the end of the day;" "he needs to be loved and understood by the people around him"), this was not reflected in their responses, as evidenced by the high rates of stigmatization. Thus, while more information may indicate a hierarchy among metal illnesses, it may also simply serve as a rationalization that allows participants to feel more comfortable being judgmental.

As with most studies, there are a number of limitations inherent to this project. First, the sample size for minority participants was quite small. Future studies should attempt to seek out larger percentages of minority participants to gain a more complete picture of how stigma works among different groups of people. However, the sample was considerably more representative of the general public than previous samples which have only surveyed college students. Second, the demographic question targeting previous knowledge of someone involved in mental health services was vague. By failing to distinguish between whether the participant knew of someone being treated for mental health issues or if they had personally experienced a mental illness, important data were lost, and the interpretability of the results correspondingly compromised.

Additionally, it would have been helpful to know how or why the person was in treatment. For example, the perceived effectiveness of the treatment may differ depending on whether the person was mandated to undergo treatment or did so voluntarily. Third, social distance was used as a proxy for discrimination. The decision to use social distance was based on both logic and the availability of a reliable, well-established measure. However, it may not have been the most valid measure of discrimination. In addition, it is difficult to know how honestly respondents answered the social distance questions. It is possible that they may have challenged their first instincts in an effort to answer in a socially desirable manner. Fourth, perceived dangerousness was used as the mediator for labeling conditions and social distance. Other plausible mediators were not considered. Fifth, a decision was made to categorize certain variables, that are perhaps more precisely measurable, including race and stigma. For race, participants were initially asked to classify themselves into one of six categories, which were then collapsed into two minority/non-minority categories. Results are not meant to be generalized to one particular group but rather illustrate the point that all ethnic minorities have considerably more difficulty accessing services and receiving appropriate and/or meaningful mental health treatments. In addition, stigma was categorized as either present or not present in the analysis using perceived dangerousness as a mediator. This decision was made to reflect reality (one is either discriminated against or not), as well as for ease of analysis. Finally, past research has indicated that social tolerance and perceived dangerousness responses differ according to the gender of the vignette character (Schnittker, 2000). This study used one specific example of a 29-

year-old college male. Therefore, caution should be used in interpreting and generalizing the results.

Future studies on the stigmatization of mental illness should account for the limitations of the current study. Most importantly, future research should focus on identifying other mediators and moderators of mental illness stigma to identify appropriate targets for intervention and educations efforts. In the same vein, it is crucial to better understand the intricacies involved in the concept of perceived dangerousness. Research should work to identify potential moderators of perceived dangerousness such as education, ethnicity, or exposure to anti-stigma campaigns as a way to guide intervention and education efforts. Similarly, future studies should address the issue of personal contact with mental illness. The current study attempted to assess the effects of prior exposure to someone with a mental illness. However, more work needs to be done to clarify this relationship. For example, does stigma vary with increased contact to someone with a mental illness? Does personal closeness (i.e., a casual acquaintance versus a family member or spouse) affect the relationship between contact and stigma? Does motivation (e.g., court-ordered therapy, involuntary commitment, personal drive) to be in treatment affect the relationship? In addition, work should be done to understand what factors may potentially protect people with mental illness from the negative effects of stigma. For example, does the stigmatized person's age, education level, socioeconomic status, or gender serve work to protect them from effects such as loss of self-esteem when they are exposed to prejudice or discrimination? Finally, the current study suggests that the level of stigma may vary according to how much information about the mental illness is given. For example, if a person is simply told someone is on

an "antidepressant," will they demonstrate less stigma than if they are told the reasons behind the need for psychiatric medication as the free response section suggests?

The broad goal of this study was to examine whether stigma is associated with various labels found within the current mental health system. While treatment may work to improve behavior, symptoms and appearance, as long as there is a label attached to someone with a mental illness, it appears that stigma will persist. Therefore, if people with mental illnesses are to ever truly and fully heal, the environment must be treated along with the person in an effort to challenge misperceptions of mental illness and prejudices. As both researching and practicing psychologists, we must work to "educate ourselves and others about mental health and mental illness, and thus to confront the attitudes, fear, and misunderstandings that remain as barriers before us" (Satcher, 1999, Preface section).

Finally, the knowledge gained from the literature on mental illness stigma should be transformed from discourse into action both on a societal level through policy work and prevention programs, as well as on an individual level through the empowerment of mental health consumers. There should be an emphasis on the application of the knowledge obtained through this study to educate the general public, increase the utilization of services (especially among minorities), and finally, empower individual clients through validating their daily experiences with stigmatization and giving them the tools necessary to deal with the negative effects of mental illness stigma. By failing to directly apply this knowledge and treat environments, we are agreeing that mental illness stigma is one of the last acceptable prejudices and devaluing the very people we are attempting to help.

Table 1: **Mean Social Distancing Scores by Labeling Condition**

| Labeling Condition | Mean | Standard Deviation | Sample Size |
|---|---|---|---|
| College Student | 1.93 | .71 | 77 |
| 12-Step Group | 2.28 | .66 | 79 |
| Psychotherapy | 2.36 | .53 | 80 |
| Mentally Ill | 2.45 | .75 | 79 |
| Medication | 2.49 | .60 | 79 |
| Total | 2.30 | .68 | 394 |

Table 2: **Mean Perceived Dangerousness Scores by Labeling Condition**

| Labeling Condition | Mean | Standard Deviation | Sample Size |
|---|---|---|---|
| College Student | 1.70 | .61 | 77 |
| 12-Step Group | 2.50 | .95 | 79 |
| Psychotherapy | 2.65 | 1.03 | 80 |
| Mentally Ill | 3.16 | 1.28 | 79 |
| Medication | 3.01 | 1.08 | 79 |
| Total | 2.61 | 1.13 | 394 |

Table 3: **Mean Social Distancing Scores by Perceived Helpfulness of Psychotherapy**

| Helpfulness Level | Mean | Standard Deviation | Sample Size |
|---|---|---|---|
| Extremely Helpful | 2.06 | .53 | 62 |
| Moderately Helpful | 2.23 | .56 | 101 |
| Slightly Helpful | 2.55 | .66 | 55 |
| Slightly Harmful | 2.30 | .84 | 17 |
| Moderately Harmful | 2.86 | .20 | 2 |
| Extremely Harmful | 2.83 | .88 | 4 |
| Total | 2.28 | .63 | 241 |

Table 4: **Mean Social Distancing Scores by Perceived Helpfulness of 12-Step Groups**

| Helpfulness Level | Mean | Standard Deviation | Sample Size |
|---|---|---|---|
| Extremely Helpful | 2.08 | .54 | 58 |
| Moderately Helpful | 2.29 | .68 | 49 |
| Slightly Helpful | 2.41 | .55 | 41 |
| Slightly Harmful | 2.51 | .87 | 9 |
| Moderately Harmful | 2.36 | .10 | 2 |
| Extremely Harmful | 2.67 | .79 | 3 |
| Total | 2.27 | .62 | 162 |

Table 5: **Mean Perceived Dangerousness Scores by Perceived Helpfulness of Psychotherapy**

| Helpfulness Level | Mean | Standard Deviation | Sample Size |
|---|---|---|---|
| Extremely Helpful | 2.14 | .74 | 62 |
| Moderately Helpful | 2.38 | 1.00 | 101 |
| Slightly Helpful | 3.09 | 1.13 | 55 |
| Slightly Harmful | 3.15 | 1.16 | 17 |
| Moderately Harmful | 2.44 | 1.68 | 2 |
| Extremely Harmful | 3.22 | 1.80 | 4 |
| Total | 2.55 | 1.07 | 241 |

Table 6: **Mean Perceived Dangerousness Scores by Perceived Helpfulness of 12-Step Groups**

| Helpfulness Level | Mean | Standard Deviation | Sample Size |
|---|---|---|---|
| Extremely Helpful | 2.14 | .89 | 58 |
| Moderately Helpful | 2.58 | 1.10 | 49 |
| Slightly Helpful | 2.91 | 1.08 | 41 |
| Slightly Harmful | 2.60 | 1.16 | 9 |
| Moderately Harmful | 3.81 | .44 | 2 |
| Extremely Harmful | 2.67 | 2.37 | 3 |
| Total | 2.52 | 1.08 | 162 |

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