

Changing Societal Attitudes Toward Persons With Severe Mental Illness

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Persons with severe mental illness are often stigmatized as a result of their psychiatric condition, which likely contributes to their difficulties in interpersonal relations, occupational functioning, and self-esteem. Given the pervasive effects of stigma on the adjustment of persons with severe mental illness, it is necessary to identify potential strategies for reducing barriers that interfere with their acceptance into the community. In this article, we briefly review research on the stigma of severe mental illness, followed by suggestions on how mental health professionals might best approach the problem of reducing the stigma associated with severe mental illness. Potential strategies of stigma reduction include education about severe mental illness, promoting contact between the community and persons with severe mental illness, and "value self-confrontation," a technique used to reduce prejudice toward persons in ethnic minorities. The article concludes with a discussion of future directions for research in this area.

Persons with severe mental illnesses like schizophrenia are presented with a difficult task. First, they must deal with the debilitating primary effects of their illness, such as psychotic symptoms and impaired social functioning and support. However, a secondary, and perhaps equally pernicious, problem results from the stigma associated with such illnesses. Research has shown that persons with severe mental illness are generally considered by the public to be dangerous and irresponsible, and are more disapproved of than persons with physical conditions such as Alzheimer's disease, blindness, or paraplegia (Albrecht, Walker, & Levy, 1982; Brockington, Hall, Levings, & Murphy, 1993; Taylor & Dear, 1980; Weiner, Perry, & Magnusson, 1988). Such stigmatization is an en-

cumbrance to both the private and public realms of functioning for the person with severe mental illness (i.e., decreased self-esteem, reduced ability to make friends, and decreased success in finding and maintaining housing and employment; see Farina, 1998, for a review). It has also been suggested that the friends and family of persons with severe mental illness are likely to be subjected to similar negative reactions via their association with their mentally ill family member, what Goffman (1963) called a "courtesy stigma." Such courtesy stigmas may cause mental hardship for family members as well as strain the emotional ties between them, their relative with severe mental illness, and the community (Farina; Phelan, Bromet, & Link, 1998; see also Neuberg, Smith, Hoffman, & Russell, 1994, for an example using homosexuals as the stigmatized group).

The problem of stigma appears to be as obstinate as it is deleterious to those who are stigmatized. As summarized by Farina (1998), there is evidence that attitudes toward persons with mental illness have not improved over time. For example, Olmstead and Durham (1976; as cited in Farina, 1998), in their replication of a study conducted in 1961, reported that negative attitudes toward persons with severe mental illness were found to persist over a 10-year period. Interestingly, Brockman and D'Arcy (1978), in a replication of a 1957 study by Cumming and Cumming, found that attitudes toward those with severe mental illness may actually become more negative over time. Using the same cities and some of the same participants that were studied 20 years earlier, they found that participants who were under 40 in the first study, and held positive attitudes toward persons with severe mental illness, had more negative views toward persons with severe mental illness in the second study.

Clearly, the task facing mental health professionals in reducing stigma is a great one: namely, to improve the prognosis for persons with severe mental illness by decreasing, or eliminating, adverse community reactions to them. The focus of this paper is on presentation of several models of attitude change and stigma reduction that appear most promising and applicable to persons with severe mental illness. Three main strategies will be described: education about misconceptions regarding severe mental illness, promoting contact between members of the community and persons with severe mental illness, and changing negative attitudes and behavior directly through value self-confrontation.

Education About the Misconceptions of Severe Mental Illness

Devine (1995) indicated that efforts to decrease racial prejudice through education have employed the use of presentations, written materials, and movies. Such methods have been used in confronting and correcting incorrect assumptions about the capabilities and limitations of persons with various disabilities and/or from particular minority groups (Bookbinder, 1978; Pate, 1988; Shapiro & Margolis, 1988; Smith, 1990). With respect to severe mental illness, several made-for-TV movies have been broadcast since 1986 that have described the ex-

periences of persons with severe mental illness. James Garner and James Woods starred in a 1986 CBS TV-movie entitled *The Promise*, which deals with a man's struggle with schizophrenia and his brother's efforts to care for him (discussed in Wahl, 1995). This movie impressed many mental health advocacy groups; in fact, they assisted CBS and Hallmark in creating a schizophrenia fact sheet to accompany the film's promotional materials (Wahl). In 1987, NBC broadcast a TV movie entitled *Strange Voices*, the story of a young woman who experiences a schizophrenic breakdown (Wahl). This film portrayed a sympathetic view of mental illness, impressing many members of the National Alliance for the Mentally Ill (NAMI) who saw an advance screening of the movie. These individuals subsequently became unpaid publicists for the movie, and their efforts created an expanded audience for the movie's national showing in October 1987 (Wahl). Such productions are very important given the large body of literature documenting the negative portrayal of persons with severe mental illness by the media (Hyler, Gabbard, & Schneider, 1991; Nunnally, 1961; Signorielli, 1989; Wahl).

Experiential techniques have also been employed to provide the participant with firsthand experience regarding the plight of persons with mental illness (discussed in Corrigan & Penn, 1998). For example, to simulate the experience of auditory hallucinations, Patricia Deegan and the National Empowerment Center have devised a technique that requires participants to listen to an audiotape of irrelevant and mixed-up voices. While listening to the voices, participants are given a series of exercises that they must complete in the presence of the distracting stimuli. Winstrom (1987) described a theatrical approach in which a group of actors known as "mental health players" role play scenarios involving issues related to stigma. The actors, all mental health professionals themselves, encourage interaction from the audience and answer questions regarding mental illness. One of the scenarios involves the plight of "Joan," a person with mental illness who is reentering the community following her release from the regional psychiatric hospital. Joan is prompted by her "caseworker" to talk with the audience briefly; the caseworker states that the audience would like to ask Joan some questions. Joan nervously agrees, replying, "Yes, but I'd like to go soon. I'm not sure if I took my medicine." An audience member quickly asks her how she feels about being back in the community, to which she replies, "The social worker made me think it would be better, but I'm not sure. I'm a little scared of the city and things have changed so much. . . . I really don't know anyone anymore. I'm afraid I won't make it again."

NAMI has recently created a multimedia presentation designed to inform the public about issues related to, and treatments for, severe mental illness (National Alliance for the Mentally Ill, 1998). This presentation (entitled the "Science and Treatment Kit") was created to communicate to audiences that severe mental illnesses are biologically based brain disorders that can be successfully diagnosed and treated. It was specifically designed to educate the media, legis-

lators, and business leaders, and has materials relevant to each of these three groups as well as suggestions on how to best present the kit material. For example, it is suggested that legislators be provided with the latest cost and treatment information (e.g., brain disorders can be treated more cost-effectively than many other physical illnesses); this information is available in the kit.

While many promising techniques for reducing stigma toward persons with disabilities (both psychiatric and medical) have been described, few have been empirically analyzed regarding their effectiveness in changing attitudes and behavior; those that have been have met with mixed results. Cumming and Cumming (1957) studied the effects of a 6-month educational campaign consisting of educational films and lectures. They found that subjects were so uncomfortable with the main idea of the campaign (i.e., that normal and abnormal behavior fall along the same continuum) that the participants eventually rejected most of the information presented. Susser and Watson (as cited in Rabkin, 1974) interpreted these results as suggesting that the subjects feared mental illness and tried to ignore its manifestations as far as possible. More recently, Wahl and Lefkowitz (1989) found that placement of disclaiming information (i.e., that the majority of persons with severe mental illness are nonviolent) before and after a film about a man with severe mental illness who kills his wife did not improve subjects' attitudes toward mental illness. This finding is consistent with that reported by Domino (1983), who, prior to the release of *One Flew Over the Cuckoo's Nest*, administered a 108-item questionnaire measuring several categories of attitudes toward mental illness, including attitudes toward mentally ill patients, to 146 undergraduate students. Three months following the release of the film, the same questionnaire was readministered to 124 of the subjects, 85 of whom had seen the film and 39 who had not. A documentary film was then shown to the subjects, the content of which compared scenes of *Cuckoo's Nest* to real-life scenes at the hospital where *Cuckoo's Nest* was filmed. The purpose of this documentary was to provide a more real-life account of life inside a mental institution. Results indicated that the documentary had no effect on the attitudes of subjects who had negative attitudes about mental illness after seeing *Cuckoo's Nest*.

Not all stigma-reducing interventions based on education have met with failure, however. Several recent studies, while producing mixed results, have provided insightful and promising information regarding how education may be used. Thornton and Wahl (1996) investigated whether corrective information could offset the negative effects of a newspaper article that reported a violent crime committed by someone with a mental illness. In this study, the newspaper article was presented to a group of undergraduate students, some of whom also received two types of corrective information: The first provided information regarding misconceptions about mental illness, including facts concerning the rarity of violent and criminal acts committed by persons with mental illness. The second focused on media distortions of mental illness; specifically,

how newspapers give biased or misleading presentations. The results indicated that students who read these articles prior to reading the stigmatizing article reported having less fear and more acceptance of persons with mental illness than did students not presented with the prophylactic articles.

In an extension of the aforementioned Wahl and Lefkowitz study (1989), Penn, Kommana, Mansfield, and Link (in press) found that providing specific information regarding the relationship between violence and mental illness may reduce fears toward persons with schizophrenia in general. Specifically, Penn et al. (in press) presented subjects with a brief "information sheet," which, based on findings from the Epidemiological Catchment Area database, stated the following:

. . . there is only a weak association between major psychiatric disorders and violence in the community. Further, recent studies suggest that individuals who abuse drugs or alcohol are actually more prone to violence than individuals with schizophrenia. Specifically, the prevalence of violence is highest among individuals who abuse drugs (34.7% of patients hospitalized for drug abuse committed at least one violent act in the past year), followed by those who abuse alcohol (24.6%), with schizophrenia and depression being remarkably similar (12.7% and 11.7% respectively).

Subjects who received this information rated individuals with schizophrenia as less dangerous than subjects who did not receive this information.

Interestingly, Penn et al. (in press) found that providing information regarding the relationship between acute symptoms and violent behavior appeared to actually *increase* subjects' fears. For this information condition, subjects were informed that

recent studies suggest that a key factor in determining violence in psychiatric patients is the presence of psychotic symptoms. If a psychiatric person is in a psychotic phase (i.e., in the active phase), then the risk of violence is higher than in the "normal" population. However, if the individual is not in the active phase (i.e., the symptoms are in remission), then his/her likelihood of violence is comparable to that of the average individual without a history of mental illness.

Penn et al. (1994) found similarly mixed results in an experiment that controlled the kinds of information presented to subjects. While they found that information regarding stable posttreatment living arrangements (i.e., that the person with schizophrenia lived in a supervised group home with a 24-hour

staff) reduced negative attitudes toward persons with severe mental illness, they also found that information regarding prior acute symptomatology tended to augment fears. Thus, the foregoing suggests that some efforts to correct misconceptions regarding schizophrenia and violent behavior may actually *increase* rather than decrease stigma.

The literature regarding the use of education in the reduction of negative attitudes and stigma indicates that this method should be used carefully and strategically. Specifically, future endeavors should emphasize misconceptions regarding persons with severe mental illness, in particular, the view promulgated by the media that most of them are dangerous and prone to homicidal tendencies. Such information may highlight the fact that violence in severe mental illness is relatively rare, and is less frequent than that observed in other psychiatric conditions (e.g., drug abuse). It is also clear that information concerning acute symptomatology needs to be approached very carefully, if not avoided altogether. Finally, Flowerman (1947; as cited in Devine, 1995) has indicated that in order for education, or other means of informing or persuading the public, to exert an influence, several conditions must be present: (a) the educational message (termed "propaganda" by Flowerman) must be received under favorable conditions so it will be processed; (b) it must attract attention; (c) it must be enjoyable and not cause psychological discomfort; and (d) it must be understood and not evaded by misunderstanding. The violation of one or more of these conditions has been shown to adversely impact the effectiveness of educational information (see Cumming & Cumming, 1957).

Contact With Persons With Severe Mental Illness

A substantial literature suggests that prejudice toward ethnic minorities and other "outgroup members" can be reduced via promotion of personal contact (Gaertner, Rust, Dovidio, Bachman, & Anastasio, 1996; Hamburger, 1994; Rothbart & John, 1985; Stephan, 1987). Devine (1995) has outlined several conditions under which changing prejudiced attitudes through intergroup contact is optimal, the most basic of which are: (a) participants of both groups must be of equal status; (b) interaction should be cooperative rather than competitive; (c) there should be institutional support for contact; and (d) contact should involve high levels of intimacy (one-on-one interaction between members of each group).

These conditions likely represent "necessary" but not always "sufficient" factors in reducing inter-group conflict. In demonstrating this, consider the following scenario. John Doe is a person with severe mental illness who works for a company that strongly supports the Americans with Disabilities Act. John is assigned a task that involves interdependence and close personal contact with another employee who does not have a mental illness (John reads information aloud that the other employee has to enter into the computer). All four of the

aforementioned conditions are present in this scenario, increasing the chances that prejudiced attitudes toward persons with mental illness will be reduced. Several things could happen, however, to undermine the process of destigmatization. For example, if either John or his partner continually makes mistakes, the outcome of their interaction may be negative and John's partner could blame the mistakes on his "mentally ill" partner. Second, John's partner could attribute John's employment status to institutional rather than personal factors (i.e., being hired because of the Americans with Disabilities Act rather than specific competencies). Thus, both of these situations could lead to the perpetuation of negative stereotypes of persons with mental illness.

There is empirical support for the effect of contact on reducing stigma toward persons with severe mental illness. Desforges et al. (1991) assigned 95 undergraduate subjects to one of three contact conditions: scripted cooperative contact, jigsaw cooperative contact, and a control condition. In the jigsaw cooperative contact condition, each subject was told that they were to work in pairs with a former mental patient (actually a confederate blind to the purpose of the study). The pairs then completed a cooperative task in which each member of the pair would assist each other in learning a passage about intravenous therapy (i.e., after both individuals read a passage, one summarized it while the other checked the summary for errors and omissions). The scripted cooperative contact required the members of the pairs to alternate reading and summarizing a given passage, but feedback concerning errors in the summary was not provided. In the control condition, the pairs of subjects were instructed to sit at opposite ends of a table and quietly study the passages without speaking to one another. The results indicated that students in both cooperative conditions, who were initially prejudiced toward persons with severe mental illness, were more accepting of the confederate at the conclusion of the study than were students in the other two conditions.

Of course, the contact condition implemented by Desforges et al. (1991) may not be applicable at a broader, societal level. The question, then, is whether more informal contact with persons with severe mental illness results in a reduction of negative attitudes toward mental illness. In fact, several studies have shown that greater contact with persons with severe mental illness is associated with more benign attitudes regarding mental illness. That is, self-reported previous personal contact with persons with severe mental illness is related to lower ratings of perceived dangerousness (Link & Cullen, 1986; Penn et al., 1994) as well as more favorable attitudes (Holmes, Corrigan, & Williams, 1997). The precise mechanisms underlying the efficacy of contact is still unknown, although it may change the underlying stereotype (discussed in Corrigan & Penn, 1998) or result in a recategorization process by which persons from the stigmatized group are now placed within one's own group (Gaertner, Mann, Dovidio, Murrell, & Pomare, 1990), a process that may result in reconceptualizing out-group members from "they" to "we" (summarized in Devine, 1995).

Since contact appears to be a potent factor in reducing stigma, the focus of future work may be in how to provide opportunities for members of the majority to interact with out-group members (Sigelman & Welch, 1993). This issue is currently being addressed by many state departments of mental health, whose offices of consumer affairs are, among other things, attempting to foster contact. For example, several states have arranged for formal dialogues between mental health care professionals and persons with mental illness, providing an opportunity for these two groups to discuss perspectives about mental illness and stigma (discussed in Corrigan & Penn, 1998). Additionally, the state of Connecticut Department of Mental Health and Addiction Services is promoting a program called "Disclosure" in which consumer advocates discuss prevalence rates of psychiatric disability in Connecticut and local recovery stories with the general public. Such contact may both disabuse community members of myths concerning severe mental illness in addition to providing them with a more meaningful experience with persons with severe mental illness.

Changing Negative Attitudes Through "Value Self-Confrontation"

Rokeach (1973) postulated that central to people's self-concept are attitudes and beliefs, and that when individuals are presented with information about themselves that contradicts their self-concepts, a state of dissatisfaction occurs. For example, someone who views her- or himself as a person who embraces the American ideal of equality will become dissatisfied when she or he learns that she or he holds values contradictory to this idea (e.g., that personal happiness is more important than equality). The self-confrontation model predicts that that particular individual will then be motivated to change her or his attitudes, beliefs, and/or behavior in an attempt to offset this uncomfortable state.

In Rokeach's original study (1973), 366 undergraduate participants were instructed to rank-order a list of 18 terminal values, defined by Rokeach as values reflecting "end states of existence" (e.g., freedom, equality, a world at peace, and national security). The participants were then instructed to compare their rankings with those of a previously surveyed peer group (with whom they should have highly identified). The experimenters then told subjects that, based on the peer group's value rankings, the peer group valued their own welfare more than the welfare of others, as they ranked the value "freedom" higher than "equality." He further stated that this same peer group had indicated on a separate measure that they were less sympathetic with the aims of civil rights demonstrators. The participants were then asked to compare the ranking of their own values to those of the peer group. Rokeach indicated that when participants discovered that their rankings were similar to those of the peer group, an uncomfortable state was induced, as they were confronted with the fact that they held attitudes contrary to their own ideals of morality and fairness.

Surveys of values conducted several weeks later revealed that the subjects as-

cribed more importance to the values of freedom and equality after the “confrontation.” It was also discovered that these shifts in rankings were associated with high levels of dissatisfaction with their original rankings. More impressively, Rokeach (1973) found that subjects in the treatment condition (i.e., self-confrontation), who had realigned their values, were more likely than controls to join the National Association for the Advancement of Colored People when solicited; solicitations sent to subjects over 1 year after completion of the study produced several more memberships.

In summary, Rokeach (1973) found that if people were induced to evaluate and reorder their priorities in accordance with values they believe are important (e.g., freedom and equality), behavior related to these priorities can be changed. This method is relevant to changing stigma-related behavior in that stigmatization falls on the same unpleasant and irrational continuum as does racism, the problem successfully attacked by Rokeach. Thus, research similar to Rokeach’s original study could be conducted in which research participants are prompted to look at how their stigma-related attitudes might conflict with values that should be important to them (e.g., equality). A measure of behavior change, indicative of reduced stigmatization toward persons with severe mental illness, could then be assessed (e.g., volunteering to work with persons with mental illness, joining NAMI, etc.). Such a study is described below.

Mayville (1997) used this paradigm in an attempt to create employment opportunities for persons with severe mental illness in a California community. Local businesspeople belonging to a philanthropic business organization were asked to complete the Rokeach Value Survey (1973) as well as a brief measure of their likelihood of hiring someone with severe mental illness. One week later, they were presented with feedback about their rankings relative to rankings of the same values made by a sample of businesspeople in the community. The subjects were told that these rankings were made by their peers according to traditional American ideals of helpfulness and equality. During this meeting, it was explicitly pointed out to them that on average, they ranked the values “helpful” and “equality” as being *less* important than did the peer group. The businesspeople were instructed to think about this disparity, and to consider the implications of lower rankings of helpfulness and equality on their willingness to hire persons with severe mental illness. Two weeks later, participants were asked to complete new value surveys, as well as a questionnaire regarding their willingness to hire persons with severe mental illness. While mean rankings of the two target values (i.e., helpfulness and equality) significantly increased in importance from pretest to posttest, reported willingness to hire persons with severe mental illness did not.

Several factors should be considered in evaluating the study findings and in considering the potential utility of this method in reducing the stigma associated with severe mental illness. First, the level of induced self-confrontation was relatively weak in comparison to other studies of this sort. Mayville (1997) ex-

plained that this was intentional, as it was feared that the research participants might be offended by a harsher interpretation of the value rankings, which could have resulted in a potential loss of interest in the study altogether. Such a concern has not been an issue in studies using more impressionable and invested samples such as college students. Second, the target behavior in this study, hiring persons with severe mental illness, may have been a bit too ambitious with respect to personal value investment. However, given the positive results of this study regarding value rankings, future studies may be successful in inducing behavior change involving a lesser commitment (e.g., joining NAMI).

Based on the success of past studies using value self-confrontation, this methodology could prove viable in future attempts to reduce stigma toward persons with severe mental illness. Interestingly, self-confrontation bears a family resemblance to cognitive dissonance theory, especially Aronson's (1992) reconceptualization of cognitive dissonance in terms of the role of the self-concept in producing attitude change. Unlike self-confrontation, which relies on creating a state of discomfort based on a comparison of one's personal values with those of a peer group, the discomfort produced by cognitive dissonance is based on a discrepancy between one's attitudes and behaviors. Aronson argued that the dissonance state caused by attitude-behavior discrepancies will be strongest when the self-concept is involved. For example, an individual who is prejudiced against persons with severe mental illness would experience the greatest amount of cognitive dissonance if she or he is induced to write a position paper advocating the hiring of persons with severe mental illness in the workplace, and notions of "fairness" and "equality" are important to her or him. Like self-confrontation, cognitive dissonance can lead to behavioral changes. Specifically, recent studies have shown that inducing cognitive dissonance was effective in promoting a number of positive behaviors, including water conservation and condom use (reviewed in Aronson). Therefore, confronting individuals with information that is discrepant with their own self-concepts may be a valuable tool in the fight against stigma.

Conclusion

Research focusing on how to reduce the stigma associated with severe mental illness has provided several promising models for combating this debilitating and pervasive problem. The promotion of personal contact with persons with severe mental illness, and education directed at the issue of violence, appear especially exciting in this regard. Additional work is needed to determine how education and contact can efficiently and effectively be employed with the general public. The method of value self-confrontation has proven to be an effective way of inducing attitude and behavior change toward persons in minority groups, but more work is needed to determine the efficacy of this method for changing negative attitudes and behaviors toward persons with severe mental illness.

In trying to reduce the stigmatization of persons with severe mental illness, we must be cognizant that attitude change alone is unlikely sufficient to achieve this goal. Rather, we must equally emphasize behavioral changes. In this regard, we should refer to our colleagues in social psychology for insights into the relationship between attitudes and behaviors. Research suggests that attitude-behavior consistency is strengthened if attitudes are accessible, stable, formed as a result of direct experience, and are certain (Krauss, 1995; Petty, 1995). Thus, individuals with positive attitudes toward persons with severe mental illness will be more likely to act on those attitudes if they easily come to mind and if they were formed following direct contact with persons with severe mental illness. Furthermore, attitudes and behaviors should be measured at the same level of specificity; for example, the specific behavior of hiring persons with severe mental illness will be better predicted by a specific attitude (e.g., how one feels about hiring persons with severe mental illness) rather than a general attitude (e.g., attitudes toward persons with severe mental illness in general). Thus, efforts should be made to assess specific attitudes regarding specific beneficial behaviors toward persons with severe mental illness, and to create methods to increase these specific behaviors. Finally, as shown by cognitive dissonance research, the association between attitudes and behaviors is not unidirectional; behavioral change may impact attitudes, not just vice versa.

As mental health professionals, it is incumbent upon us to augment larger organized efforts to fight stigma on smaller levels through relations with our clients and colleagues. However, as warned by Penn and Martin (in press), these efforts must be undertaken in an ethical and responsible manner. Specifically, general statements implying that all persons with severe mental illness are no more likely to be dangerous than anybody else or that labels alone cause stigma are misleading and unethical. While the fight against stigma should be undertaken with fervor, convicted and passionate efforts should be tempered with balanced and accurate information.

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