# Lessons From Social Psychology on Discrediting Psychiatric Stigma

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*Advocacy, government, and public-service groups rely on a variety of strategies to diminish the impact of stigma on persons with severe mental illness. These strategies include protest, education, and promoting contact between the general public and persons with these disorders. The authors argue that social psychological research on ethnic minority and other group stereotypes should be considered when implementing these strategies. Such research indicates that (a) attempts to suppress stereotypes through protest can result in a rebound effect; (b) education programs may be limited because many stereotypes are resilient to change; and (c) contact is enhanced by a variety of factors, including equal status, cooperative interaction, and institutional support. Future directions for research and practice to reduce stigma toward persons with severe mental illness are discussed.*

Severe mental illnesses like schizophrenia strike with a two-edged sword (Corrigan & Penn, 1997). On one side, the biological and psychosocial factors that affect the course of schizophrenia lead to psychotic symptoms, diminished social functioning, and depleted support networks. On the other, the stigma of severe mental illness leads to prejudice and discrimination. Stigmas are negative and erroneous attitudes about these persons. Unfortunately, stigma's impact on a person's life may be as harmful as the direct effects of the disease. As a result, various advocacy, government, and community-service groups believe that expunging stigma from societal discourse—replacing these negative stereotypes with accurate and more hopeful views of mental illness—will significantly enhance the quality of life of people with these disorders. These advocates promote a variety of strategies, including *protest,* which seeks to suppress stigmatizing attitudes of mental illness and behaviors that promote these attitudes; *education,* which replaces stigma with accurate conceptions about the disorders; and *contact,* which challenges public attitudes about mental illness through direct interactions with persons who have these disorders.

Although these stigma-reduction strategies may hold promise in improving the lives of persons with severe mental illness, such interventions should not be accepted on faith. Rather, the theoretical assumptions and empirical support for these strategies should be closely examined. Social psychology and the study of social cognition, in particular, have generated useful models for understanding the functions of stereotypes and discrimination in ethnic and other minority groups. These models may help explain the stigma experienced by persons with severe mental illness as well as further the effectiveness of strategies that attempt to reduce it.

In this article, we argue that efforts to reduce stigmatization of persons with severe mental illness will be strengthened by the use of theory and findings from the social psychology literature on stigma reduction for persons of ethnic minorities and other "out-groups." This argument is reminiscent of an earlier appeal in this journal to better integrate the fields of social and clinical psychology (Leary & Maddux, 1987). We begin by providing an overview of the stigma associated with severe mental illness, followed by a review of public efforts to reduce stigma toward persons with these disorders. Then, we describe three strategies used to reduce stigma toward persons with severe mental illness: protest, education, and contact. For each strategy, we summarize existing research conducted on changing stigma toward persons with severe mental illness and follow each summary with a discussion of the social psychological literature in this area. The article concludes with a discussion of future directions for both the practice of, and the research in, stigma reduction for those with severe mental illness.

## Stigma and Stereotype Defined

Stereotypes per se are not necessarily pernicious. Social psychologists view stereotypes as knowledge structures that are learned by most members of a social group (Augoustinos & Ahrens, 1994; Esses, Haddock, & Zanna, 1994; Hilton & von Hippel, 1996; Judd & Park, 1993; Krueger, 1996; Mullen, Rozell, & Johnson, 1996). Stereo-

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types are especially efficient means of categorizing information about social groups. Stereotypes are considered social because they represent collectively agreed-on notions of groups of persons. They are efficient because people can quickly generate impressions and expectations of individuals who belong to a stereotyped group (Hamilton & Sherman, 1994).

Just because most people have knowledge of a set of stereotypes does not imply that they will endorse these stereotypes, use them to generate negative judgments, or act on them in a discriminatory manner (Jussim, Nelson, Manis, & Soffin, 1995). People who are prejudiced endorse these negative stereotypes and act against minority groups accordingly (Devine, 1988, 1989, 1995; Hilton & von Hippel, 1996; Krueger, 1996). *Stigma* is another term for prejudice or negative stereotyping. In terms of mental illness, stigmas represent invalidating and poorly justified knowledge structures that lead to discrimination.

## The Stigma of Severe Mental Illness

Stigmas about mental illness seem to be widely endorsed by the general public.[1] Citizens have negative stereotypes that are not warranted and are overgeneralized. Studies have shown that many citizens in the United States (Link, 1987; Rabkin, 1974; Roman & Floyd, 1981) and in most Western nations (Bhugra, 1989; Brockington, Hall, Levings, & Murphy, 1993; Greenley, 1984; Hamre, Dahl, & Malt, 1994; Madianos, Madianou, Vlachonikolis, & Stefanis, 1987) endorse stigmatizing attitudes about mental illness. Stigmatizing views about mental illness are not limited to uninformed members of the general public. Research has also shown that well-trained professionals from most mental health disciplines subscribe to stereotypes about mental illness (Keane, 1990; Lyons & Ziviani, 1995; Mirabi, Weinman, Magnetti, & Keppler, 1985; Page, 1980; Scott & Philip, 1985).

Several themes recur in stigmatizing attitudes. Media analyses of film and print representations of mental illness have identified three common misconceptions: People with mental illness are homicidal maniacs who need to be feared, they have childlike perceptions of the world that should be marvelled, or they are rebellious, free spirits (Farina, 1998; Gabbard & Gabbard, 1992; Hyler, Gabbard, & Schneider, 1991; Mayer & Barry, 1992; Monahan, 1992; Wahl, 1995). Similarly, results of two independent factor analyses of the survey responses of more than 2,000 English and American citizens yielded three factors (Brockington et al., 1993; Taylor & Dear, 1980). The first factor is *fear and exclusion:* Persons with severe mental illness should be feared and, therefore, should be kept out of most communities. The second factor is *authoritarianism:* Persons with severe mental illness are irresponsible, and their life decisions should be made by others. The third factor is *benevolence:* Persons with severe mental illness are childlike and need to be cared for.

Stigmatizing attitudes are not limited to mental illness. Persons with physical illness and disabilities are also the object of disparaging opinions. However, the general public seems to disapprove of persons with severe mental illness significantly more than of persons with physical disabilities like Alzheimer's disease, blindness, or paraplegia (Corrigan, River, Lundin, Wasowski, et al., 1998; Piner & Kahle, 1984; Socall & Holtgraves, 1992; Weiner, Perry, & Magnusson, 1988). Severe mental illness has been viewed as similar to drug addiction, prostitution, and criminality (Albrecht, Walker, & Levy, 1982; Skinner, Berry, Griffith, & Byers, 1995). Unlike physical disabilities, persons with mental illness are perceived to be in control of their illness and responsible for causing it (Weiner et al., 1988). Furthermore, research respondents were less likely to pity persons with mental illness, instead reacting to psychiatric disability with anger and believing that help is not deserved (Socall & Holtgraves, 1992; Weiner et al., 1988).

Negative attitudes like these have a significant impact on the disabilities associated with mental illness. First-person accounts in *Schizophrenia Bulletin* repeatedly describe the pain of stigma and discrimination. The results from more carefully sampled survey research support these accounts; one study found that 75% of family members believed stigma decreased their children's self-esteem, hindered their ability to make friends, and undermined their success in obtaining employment (Wahl & Harman, 1989).

[1] We define mental illness as the categories of schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, and personality disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM–IV;* American Psychiatric Association, 1994). Stigma researchers typically distinguish the stigma of mental illnesses like these from other *DSM–IV* groups such as developmental disabilities and substance abuse disorders.

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Persons with severe mental illness living in New York City viewed stigma with similar concern (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). They believed the public would be likely to exclude them from close friendships or competitive jobs because of their mental illness. The impact of stigma is not limited to the individual diagnosed with mental illness. Families also report lowered self-esteem and strained relationships with other family members because of stigma (Lefley, 1992; Wahl & Harman, 1989) and may be the victims of a "courtesy-stigma" (i.e., being stigmatized because of their association with someone with a severe mental illness; Goffman, 1963).

Despite these findings, some researchers have argued that stigma is a societal illusion. They cite data that suggest the public does not endorse negative attitudes about mental illness (Crocetti, Spiro, & Siassi, 1971; Lindsay, 1982) or that the public does not always act on these attitudes with rejecting behaviors (Farina, 1981; Huffine & Clausen, 1979; Weinstein, 1983). Link and colleagues (Link & Cullen, 1983; Link, Cullen, Mirotznik, & Struening, 1992) responded to these assertions by noting that just because people publicly renounce stigma does not mean stigma is absent from Western culture or that it does not lead to discrimination. There are cultural benefits for citizens who deny endorsement of stereotypes in public, yet still are likely to prejudge in private. Hence, persons may say they do not agree with stigma but, in fact, discriminate when private opportunities present themselves (Gaertner & Dovidio, 1986).

Several studies have documented the behavior (i.e., discrimination) that results from stigma. Citizens are less likely to hire persons who are labeled mentally ill (Bordieri & Drehmer, 1986; Farina & Felner, 1973; Link, 1987; Olshansky, Grob, & Ekdahl, 1960), are less likely to lease them apartments (Page, 1977, 1983, 1995), and are more likely to falsely press charges against them for violent crimes (Sosowsky, 1980; Steadman, 1981). The detrimental impact of stigma is not limited to discrimination by others. Some persons with severe mental illness also endorse stigmatizing attitudes about psychiatric disability and hence about themselves. These persons may experience diminished self-esteem, which correlates with a lower quality of life (Mechanic, McAlpine, Rosenfield, & Davis, 1994). Moreover, persons who self-stigmatize are less likely to be successful in work, housing, and relationships (Link et al., 1989). These individuals seem to convince themselves that socially endorsed stigmas are correct and that they are incapable of independent living.

## Public Efforts to Reduce Stigma Toward Severe Mental Illness

Advocacy and other groups have targeted stigma in a deliberate attempt to improve the lot of persons with severe mental illness. For example, the National Alliance for the Mentally Ill (NAMI), a grass-roots group of family members and persons with severe mental illness, has made combating stigma a top priority for its 172,000 members (Flynn, 1987; NAMI E-news, 1998). They launched the "Campaign to End Discrimination" in 1995 as a concerted effort to diminish stigma. The National Mental Health Association, a mental health advocacy group, has been educating the public about mental illness for more than 90 years. Furthermore, nationwide consumer groups have examined the loss of personal power that results from stigma and have developed corresponding education and advocacy programs. The National Stigma Clearinghouse, for example, aggressively responds to negative images of mental illness, raises public consciousness about psychiatric disabilities, and communicates with the media about positive images of mental illness (Arnold, 1993).

Government agencies have also joined the fray. The Center for Mental Health Services has an intramural office on consumer empowerment and funds extramural projects that attempt to discount stigma. Many state departments of mental health hire consumer advocates whose job, in part, requires vigilance to misrepresentations of mental health issues. Service groups made up of private citizens have also shown their concern about stigma. In 1996, Rotary International inaugurated "Erase the Stigma," a campaign to educate American business leaders about the truths and misconceptions of severe mental illness.

Three types of strategies—protest, education, and contact—make up the stigma-reduction armamentarium. Advocacy groups protest inaccurate and hostile representations of mental illness as a way to challenge the stigmas they represent. These efforts send two messages: To the media, they say stop reporting inaccurate representations of mental illness; to the public, they say stop believing negative views about mental illness. Protest is a reactive strategy; it diminishes negative attitudes about mental illness but fails to promote more positive attitudes that are sup-

ported by facts. Education provides information so that the public can make more informed decisions about mental illness. Education strategies are augmented by face-to-face contact. Stigma is diminished when members of the general public meet persons with schizophrenia who are able to hold down jobs or live as good neighbors in the community.

It should be noted that these stigma-reduction strategies are not always conducted in isolation from one another (Holmes, Corrigan, Williams, Canar, & Kubiak, in press). For example, an advocate might educate media groups while protesting a stigmatizing image of mental illness. A consumer group might recruit a person with mental illness (contact) to present an education program. Hence, we must also consider the combined impact of two or three of these stigma-reduction strategies.

## Protesting Prejudice About Mental Illness

One way to diminish the impact of stereotypes and stigma is to protest situations where these experiences occur. The news media is replete with examples of minority groups protesting messages of the Ku Klux Klan or the American Nazi Party. In a like manner, advocacy and service groups have embraced protest as a means of diminishing mental illness stigma. NAMI, for example, has passed out "media watch kits" to local affiliates for monitoring newspapers, television, and periodicals in their area (Flynn, 1987). These kinds of efforts seek to change representations of mental illness. For example, newspaper and poster ads for a film titled *Crazy People* were patently offensive; they included a picture of a cracked egg with hands and arms and the caption, "Warning: Crazy people are coming" (Wahl, 1995). Paramount Pictures changed marketing strategies after a discussion with representatives from several advocacy groups. The new ad had pictures of the film's stars, Dudley Moore and Daryl Hannah, with the revised header, "You wanna laugh tonight?" A Philadelphia newspaper was promoting the Paramount picture by offering free admission to persons who could prove they were "crazy." Members of local advocacy groups wrote letters, marched outside newspaper offices, and met with the paper's publisher until this marketing scheme stopped.

Examples like these suggest that protest reduces the frequency of publicly endorsed stereotypes. Citizens may be encountering far fewer sanctioned examples of stigma and stereotypes because of protest efforts (Wahl, 1995). There is, however, little empirical research on the psychological impact of protest campaigns on people's prejudice about mental illness. Researchers do not know, for example, whether a "just say no to negative stereotypes" effort actually leads to more enlightened views of mental illness. Social psychological research on suppression of prejudice against minority groups has yielded some interesting findings that may answer questions about the short-term impact of protest. Suppression occurs with the controlled inhibition of unwanted stereotypic thoughts and is evinced when persons either no longer endorse prejudice or fail to recall specific stereotypes (Devine, 1989; Macrae, Bodenhausen, Milne, & Wheeler, 1996). Suppression is frequently brought about by public protest (e.g., one product of the 1960s civil rights crusade was the message that it was not socially permissible to endorse stereotypes about racial minorities).

Unfortunately, there are limits to suppression. Wegner and Erber (1992) expressed these limits when noting the irony of attitude suppression: "It seems that the very attempt to keep unwanted thoughts out of mind makes them all the more insistent" (p. 903). Wegner, Schneider, Carter, and White (1987) demonstrated this effect in their white bear experiment. Research participants who were instructed to *not* think about a white bear were initially successful by distracting themselves. However, white bear thoughts eventually returned, demonstrating the difficulty of effective thought suppression. Subsequent research showed that the suppression of targeted ideas leads to the same psychophysiological reactions as active thought about these ideas (Wegner, Shortt, Blake, & Page, 1990). Research participants instructed not to think about sex showed the same elevations in sympathetic arousal as participants who concentrated on the topic.

Macrae, Bodenhausen, Milne, and Jetten (1994) demonstrated the relevance of this rebound effect to suppressing minority group stereotypes in three studies. Participants who were instructed to avoid thinking about a white male skinhead in a stereotypic fashion were more likely to write a negatively stereotypic life story about the person, more quickly identified stigmatizing descriptors from an adjective checklist, and physically distanced themselves from skinheads, relative to participants who were not asked to suppress stereotypic beliefs. Extrapolating these findings to mental illness stigma, this research suggests that members of the general public who attempt to suppress negative stereotypes about psychiatric disability may actually be priming these stereotypes.

Rebound occurs because suppression is fundamentally an effortful cognitive process (Macrae, Bodenhausen, et al., 1994; Macrae et al., 1996). Persons must actively keep stereotypes out of consciousness by attending to other social events or recalling irrelevant information. Unfortunately, the cognitive capacity needed to keep a stereotype out of consciousness depletes limited capacity reserves that might be used for other purposes. Persons have difficulty processing other social information, including information that might disconfirm the stereotype, when suppressing these attitudes (Bargh, 1989; Hasher & Zacks, 1979; Macrae et al., 1996). Thus, persons are not able to learn information that might contradict the stereotypes (Hewstone, Macrae, Griffiths, & Milne, 1994; Macrae, Bodenhausen, & Milne, 1995). For example, citizens trying to suppress dangerousness stereotypes about a patient from a nearby psychiatric hospital may fail to notice that the patient is actually friendly and engaging, information that would disconfirm the dangerousness stigma.

Research on stereotype suppression and rebound suggests some compelling limitations to protest efforts. How-

ever, most of this research examined short-term effects on attitude change. Research needs to examine how extended protest affects attitudes over the long term. Perhaps stereotype rebound does not occur when citizens encounter repeated instructions to suppress a stereotype. Research should also examine protest effects on behavior, because the ultimate goal of suppression is on behavioral, not attitude, changes. Wahl (1995) has suggested that efforts to suppress the behavior of media groups (i.e., in their portrayal of persons with severe mental illness) may lead to fewer negative portrayals of persons with mental illness on television and in the movies. Thus, changes in media behavior may lead to improved attitudes and behaviors of the average citizen over time.

## Public Education About Mental Illness

A second way to impact stereotypes and prejudice is by providing information that contradicts them. Education and information programs that address minority-group stereotypes have used books, videos, slides, and other audiovisual aids to highlight false assumptions about groups (e.g., that all persons with severe mental illness are extremely violent) and to provide facts that counter these assumptions (Bookbinder, 1978; Pate, 1988; Shapiro & Margolis, 1988; Smith, 1990). Such didactic formats are frequently augmented by discussions (Lynch, 1987; Quicke, Beasley, & Morrison, 1990); participants are more likely to reject false assumptions and remember accurate information when they discuss the material with teachers and peers. Participants may also obtain information through simulations (e.g., negotiating a wheelchair through an obstacle course to understand ambulatory disabilities or participating in "Simon says" games where up–down and left–right are reversed to experience spatial disorientation). Simulations were developed by members of the disability community to help persons who are not disabled understand their trials (Kiger, 1992). Patricia Deegan and the National Empowerment Center have devised a simulation for mental illness. In this exercise, participants experience the intrusive nature of auditory hallucinations by trying to complete simple work tasks while listening to an audiotape of irrelevant and mixed-up voices.

Several groups have developed and implemented education programs. NAMI developed and distributed their "science and treatment kit" for informing the public about mental illness and corresponding treatment. The National Mental Health Association has developed education programs for children. The popular media has produced films and television shows that disseminate stigma-countering information. For example, NAMI worked with CBS to produce the *Marie Balter Story,* a movie about the struggle and successes of a woman who had been institutionalized for more than a decade. CBS and Hallmark Cards aired a 1986 film, *Promise,* in which James Woods and James Garner depicted the real-life interactions of a man with schizophrenia and his brother. Media efforts are promising because they can reach a large audience.

Several studies have examined the effects of education on mental illness stigma. Research indicates that persons who have a better understanding of mental illness are less likely to endorse stigma and discrimination (Brockington et al., 1993; Link & Cullen, 1986; Link, Cullen, Frank, & Wozniak, 1987; Roman & Floyd, 1981). Several studies have also shown that participation in brief courses on mental illness and treatment lead to improved attitudes about persons with mental illness (Keane, 1990, 1991; Morrison, 1976, 1977, 1980; Morrison, Becker, & Bourgeois, 1979; Morrison, Cocozza, & Vanderwyst, 1980; Morrison & Teta, 1977, 1978, 1979, 1980). These programs are effective for a wide variety of participants, including psychology graduate students, adolescents, nursing students, community residents, persons with mental illness, and medical students.

Penn et al. (1994) examined the effect of education in a study that controlled the kinds of information presented to participants. Some participants received information about the target individual's acute symptoms, whereas others were informed about his after-care plan. Although the investigators believed this information would allay negative responses toward the target, results were mixed. Information about posttreatment living arrangements reduced negative judgments about the target person. However, participants who were given information about psychotic symptoms showed a significant increase in negative attitudes about schizophrenia. In a subsequent study, Penn, Kommana, Mansfield, and Link (in press) assumed that stigmatizing views about schizophrenia stem from concerns about dangerousness and targeted these beliefs in various information segments. Results showed that participants who learned the base rates of violence in persons with mental illness (relative to other disorders) were less likely to stigmatize than a no-information control group.

A brief education effort by Thornton and Wahl (1996) seemed to diminish stigmatizing attitudes about mental illness. They appended an article that discussed misconceptions about mental illness to a popular press item about the tragic death of an innocent victim at the hands of a mentally ill patient. Persons who read the appended article endorsed fewer stigmatizing attitudes. Sometimes, however, brief programs like these fail; other studies have shown that brief informational segments attached to media presentations about mental illness seem to have no effect on viewer attitudes (Domino, 1983; Wahl & Lefkowits, 1989).

Providing sufficient information to counter stigma regarding symptoms is difficult in brief programs like these. Holmes et al. (in press) examined the effects of a semester-long education program on the stigmatizing attitudes of community college students. Participants improved their attitudes about benevolence and fear, although the size of these effects was limited, and attitude change affected by education interacted with the research participants' preeducation knowledge. Students with more knowledge about severe mental illness prior to participating in an education program were less likely to endorse stigmatizing attitudes

after completing the program. This finding is generally consistent with what's known about propaganda-related efforts to change attitudes and beliefs toward minority groups: They tend to reach those who already agree with the message (Devine, 1995).

### Stereotypes' Resilience to Disconfirmation

These general findings parallel the mixed results of education programs that target race and other minority group stereotypes (Devine, 1995; Pruegger & Rogers, 1994). On the one hand, attitudes (and hence stereotypes) seem to be relatively plastic phenomena, which can be modified through planned change techniques (Rothbart & Lewis, 1988). Fields like advertising and marketing are dedicated to the belief that personal opinion can be influenced by appropriately formatted information. On the other hand, social psychological researchers have documented several resilient characteristics of stereotypes, suggesting that these knowledge structures are extremely difficult to disconfirm once developed (Fyock & Stangor, 1994; Rothbart & John, 1993). These characteristics explain why the effects of education on psychiatric stigma may be limited.

Researchers have suggested that activation of well-learned and often-used stereotypes, as opposed to newly acquired attitudes, is an automatic cognitive process (Devine, 1989; Hilton & von Hippel, 1996; Macrae, Milne, & Bodenhausen, 1994). For example, people spontaneously become aware of stereotypes after encountering a minority group member to which the stereotypes correspond. Well-learned and preexisting stereotypes serve as templates that encode subsequent information that might counter these stereotypes. As a result, stereotypes produce a consistency effect that undermines disconfirmation (i.e., social information is recalled in a manner that is consistent with the preexisting stereotypes). This phenomenon has been supported in two independent meta-analyses of 80 studies (Fyock & Stangor, 1994; Stangor & McMillan, 1992).

The consistency effect is evident even in situations where research participants are explicitly directed to suppress a stereotype (Fyock & Stangor, 1994). This effect tends to be most pronounced in situations that demand high cognitive load (Macrae, Hewstone, & Griffiths, 1993; Stangor & Duan, 1991). Persons are likely to be most sensitive to stereotype-confirming information when they are distracted by other cognitive tasks or when cognitive capacity is diminished by psychophysiological arousal.

The consistency–confirmation effect is not limited to passive influences on the recollection of information; it also affects active processes related to information seeking. There is a tendency to seek out information about minority group members that confirms stereotypes about those groups (Bodenhausen & Wyer, 1985; Pendry & Macrae, 1994; Skov & Sherman, 1986). Moreover, stereotypes have been perceived to be confirmed even when confirming evidence is absent (Bodenhausen & Wyer, 1985). Finally, stereotypes seem to override information that would discount a prejudicial judgment (Krueger & Rothbart, 1988; Macrae et al., 1995). For example, criminal justice research has shown that minority group stereotypes may outweigh factual case evidence in a jury's decision about guilt (Bodenhausen & Lichtenstein, 1987). These findings suggest that participants in an education program may easily recall information that confirms mental illness stigma about dangerousness and may ignore information that challenges these stigmas, such as information that the acute symptoms associated with violent behavior may remit.

### Limits to Resilience

Despite these findings, there are limits to the resilience of stereotypes. First, just because most people have knowledge of a set of stereotypes does not imply that they will endorse these stereotypes, use them to generate stigmatizing judgments, or act on them in a discriminatory manner (Jussim et al., 1995). For example, persons can recall stereotypes about a racial group in America but do not necessarily agree that the stereotypes are valid. According to Devine (1995), negative stereotypes may be automatically activated by environmental factors, but individuals low in prejudice may inhibit these stereotypes by using more cognitively controlled personal beliefs (e.g., that it is unfair to stereotype on the basis of ethnic group or gender). People who are prejudiced endorse these negative stereotypes and act against minority groups accordingly (Devine, 1989, 1995; Hilton & von Hippel, 1996; Krueger, 1996).

Second, the stereotype-consistency effect does not alter the processing of all information. It is most pronounced when persons are asked to consider whether minority group members' traits, rather than their behaviors, are consistent with a stereotype (Fyock & Stangor, 1994). Research has shown that persons are more likely to relate traits (e.g., members of that group are aloof and unfriendly) to stereotype labels rather than behaviors (e.g., those group members will not be helpful in a time of need). Therefore, behavioral expectations about minority groups may be more amenable to education than trait characteristics. Thus, if we intend to improve housing opportunities for persons with severe mental illness, then the target of education should be prospective landlords' beliefs about the likelihood of physical violence (behavior) among persons with severe mental illness rather than on whether persons are irritable or unpredictable (traits).

This finding suggests that education programs might lead to diminished discrimination even if dramatic changes in stereotypes and stigma are not observed. Unfortunately, researchers have not examined the impact of education programs on behavior change. Moreover, researchers have examined the immediate impact of education on attitudes (Corrigan, River, Lundin, Penn, et al., 1998; Holmes et al., in press; Keane, 1990, 1991; Penn et al., 1994, in press) but generally have not followed up on its long-term impact. Researchers need to examine how education facilitates attitude and behavior change over the long term.

## Contact With Persons With Severe Mental Illness

Contact with minority group members may augment the effects of education on reducing stigma. Researchers have shown that members of the majority who have met persons representing a minority or other group are more likely to disconfirm stereotypes describing that group (Gaertner, Rust, Dovidio, Bachman, & Anastasio, 1996). Hence, contact may be an important strategy for decreasing stereotypes and mental health stigma.

One important variable that mediates contact is opportunity; members of the majority must have opportunities to interact with minority group members if stigma is to change (Sigelman & Welch, 1993). Hence, persons with severe mental illness must have formal opportunities to contact and interact with the general public. Many state departments of mental health have developed offices of consumer affairs to, in part, foster contact. For example, the State of Connecticut Department of Mental Health and Addiction Services is promoting a program called "Disclosure" to further this cause. They believe disclosing the breadth of psychiatric disability in Connecticut and revealing recovery stories will significantly reduce stigma and discrimination. The states of New York (Blanch, Fisher, Tucker, Walsh, & Chassman, 1993; Knight & Blanch, 1993a, 1993b), Florida (Loder & Glover, 1992), and Illinois (Corrigan, Lickey, Schmook, Virgil, & Juricek, in press) have expanded on this effort by arranging formal dialogues between persons with mental illness and mental health care professionals. These dialogues provided a forum for consumers and health care professionals to exchange perspectives about mental illness and challenge latent stigmatizing attitudes.

Researchers have examined the effect of contact on psychiatric stigma. A recent meta-analysis revealed that providing contact with persons with mental illness is associated with improved attitudes, with the findings strongest when contact was provided in the context of general undergraduate training (Kolodziej & Johnson, 1996). The positive effects of contact on attitudes toward persons with mental illness has also been demonstrated outside of student and employee training. Specifically, there is an inverse relationship between self-reported previous contact with persons with mental illness and psychiatric stigma (Holmes et al., in press; Link & Cullen, 1986; Penn et al., 1994, in press). In a laboratory study, Desforges et al. (1991) carefully examined the effects of strategic contact in a study with 95 undergraduates in a randomized controlled trial. After students who were initially predjudiced participated in a cooperative task with a person described as recently released from a mental institution, these students endorsed more positive attitudes about the mentally ill person and showed greater acceptance toward mental illness in general.

This study by Desforges et al. (1991) echoes the results of numerous studies that have shown that contact improves attitudes about minority and other groups (for reviews, see Gaertner et al., 1996; Hamburger, 1994; Rothbart & John, 1985; Stephan, 1987). Additional research has identified factors that augment the effects of interpersonal contact, including equal status among participants (Cook, 1985; Riordan, 1978), cooperative interaction (Johnson, Johnson, & Maruyama, 1984; Worchel, 1986), institutional support for contact (Adlerfer, 1982; Williams, 1977), frequent contact with individuals who mildly disconfirm the stereotype (Johnston & Hewstone, 1992; Weber & Crocker, 1983), a high level of intimacy (Amir, 1976; Brown & Turner, 1981; Ellison & Powers, 1994), and real-world opportunities to interact with minority group members outside of contrived situations (Sigelman & Welch, 1993). These factors have several implications for programs that facilitate contact between members of the general public and persons with severe mental illness.

Contact programs for mental illness will be more successful when all participants have equal status. Hence, persons with mental illness need to be presented as one of many citizens attending a program rather than as the "token mentally ill patient." Equal status is facilitated when persons with mental illness are cooperating with others on a work task. In this way, citizens with mental illness are viewed as competent and bring needed skills and energy to the chore. Status is also facilitated when contact provides opportunities for friendly and intimate interaction among participants. Rather than limiting the engagement to businesslike exchanges, stereotype and stigma are diminished when members of the public have mutual and informal conversations with persons with mental illness. Finally, the goals of contact are facilitated when the institution formally acknowledges the effort. For example, a contact program in a school will be more effective when the principal publicly approves the effort.

Contact seems to affect stigmatizing knowledge structures through cognitive individuation (i.e., a person's natural stereotype of a minority group member is superseded by another, more positive image when that person contacts a member of that group; Horwitz & Rabbie, 1989; Rothbart & John, 1985), although recategorization of the minority group member is also possible (i.e., changes in the classification from "them" to "us"; Gaertner, Mann, Dovidio, Murrell, & Pomare, 1990). For example, encountering an equal-status person with severe mental illness during a mutually cooperative task (e.g., working with a mentally ill woman on a church social) might suppress negative images about the person being dangerous or incompetent. Instead, members of the general public engaged in this interaction are likely to view the person as friendly and capable.

The strength of individuation effects varies with the level of disconfirmation engendered by the contacted group member (Kunda & Oleson, 1995). Experiences with persons who grossly vary with stereotypes about a minority group are likely to have little effect on those stereotypes. For example, members of the general public who viewed the "church social" woman with severe mental illness as friendly, capable, and hardworking may show little change in stigma about mental illness and continue to view persons

with mental illness as dangerous and incompetent. Experiences with markedly "atypical" group members may not only fail to discredit stigma (Hamburger, 1994; Rothbart & Lewis, 1988; Weber & Crocker, 1983) but may actually lead to a boomerang effect where stereotypes become more extreme (Kunda & Oleson, 1997). The woman with mental illness in our church social example is atypical because she is not disheveled or dangerous. Rather than using information about her to discount mental illness stigmas, she may be subtyped as unusual and not representative of mental illness as a whole. Subtyping in essence insulates the broader stereotype (Kunda & Oleson, 1995).

Inhibitions to stigma change caused by atypical persons are limited to individuals who are extremely dissimilar to stereotypes. Experience with contacted group members who mildly or moderately disconfirm a stereotype seems to change stigma (Kunda & Oleson, 1995, 1997). Individuals who are similar to stereotypes in most ways but vary on one or two key dimensions can also change attitudes about those perspectives. Hence, a good contact might be a person who is struggling with residual symptoms and seems socially anxious but who is earning a living wage through a job as a bagger at a local market. Citizens who meet this person may change their attitudes about mental illness hindering people from working and living independently.

## Conclusions

Reducing stigma is essential for improving the quality of life of people with severe mental illness. Decreasing stereotypes and prejudices about severe mental illness could potentially diminish the discrimination experienced by persons with these disorders. Advocacy groups, governmental organizations, and public service agencies have embraced stigma-reduction strategies like protest, education, and contact as essential ways to challenge negative stereotypes and stop discrimination. Researchers who have examined the social psychology of minority group stereotypes have highlighted some of the cognitive mechanisms that reduce stigma, the limitations of these strategies, and some factors that moderate their effects.

Extrapolating research based on minority and other group stereotypes to the injustice of psychiatric disability has its problems. For example, persons who are subjected to racial stereotypes exemplify a "discredited" stigma because the characteristics identifying the minority group (e.g., skin color) are readily apparent to others (Goffman, 1963). Persons with severe mental illness may represent individuals who are both discredited (i.e., they may manifest psychotic symptoms in public) and "discreditable" (i.e., if in remission, they may be able to hide their mental illness from others). For persons with discredited stigma (i.e., acute symptoms), stigma-reduction efforts might need to focus on making accomodations for them and building community tolerance and compassion for their disorder. For persons with a discreditable stigma (i.e., their symptoms are in remission), efforts should be focused on dispelling myths about severe mental illness and trying to change negative stereotypes (e.g., once a person has had a mental illness, they'll always be unpredictable). Therefore, researchers need to consider the discredited–discreditable dimension when developing specific interventions to reduce stigmatization toward persons with severe mental illness.

The research reviewed in this article points to a number of future directions in the practice and research of eliminating psychiatric stigma. For example, the integration of research in social and clinical psychology leads to the following hypotheses:

1. Protest and suppression of mental illness stigma may lead to short-term rebound effects. Namely, members of the general public will more likely recall negative information about individuals with severe mental illness when they are instructed to suppress stereotypes about them. Moreover, members of the general public who are instructed to suppress stigma will learn less factual information about mental illness during educational programs than will peers who do not receive those instructions.

2. Active forms of education that combine formal instruction with discussion and simulations will lead to greater reduction in stigma than formal lectures alone. Program success will depend, however, on providing information that presents the symptoms and deficits of mental illness in a hopeful light. Education programs should have more positive effects on expectations about the behavior of a person with mental illness, whereas views about the person's traits should remain static.

3. Contact with persons with mental illness should diminish psychiatric stigma. Contact effects should improve when there is equal status among participants, cooperative tasks define the interaction, there is institutional support for contact, there are high levels of intimacy, and the person with severe mental illness does not greatly differ from the stereotype.

Stigma-changing efforts should not be limited to changing attitudes only. For example, in a recent meta-analysis, Krauss (1995) found that the mean association between attitudes and future behavior is approximately .39, suggesting that changing attitudes does not assure change in behavior. This association is strengthened if attitudes are accessible, stable, formed as a result of direct experience, and personally relevant (Krauss, 1995; Petty, 1995). Moreover, individual differences in responding to stigma-reduction strategies should be explored. This may be especially appropriate for factors such as gender; although men and women have similar attitudes toward persons with mental illness, women's behavior tends to be kinder (Farina, 1981). Such individual difference variables may represent rate-limiting factors in the effectiveness of various stigma-reduction strategies.

Research reviewed in this article has focused on strategies for changing public attitudes about and behavior toward persons with severe mental illness. Persons with mental illness need not, however, be passive agents in this process, awaiting society to become more accepting of them and their mental illness. There are a variety of strategies that persons with severe mental illness might select to

cope with the impact of stigma (Corrigan, 1998; Farina, 1998). Specific strategies include selective disclosure of one's mental health history (River & Holmes, in press); those that foster empowerment like mutual help groups (Kurtz & Chambon, 1987), psychosocial clubhouses (Beard, Propst, & Malamud, 1994), and Fairweather lodges (Fairweather, 1969); and hiring consumers of mental health services to provide these services (Mowbray, Moxley, Jasper, & Howell, 1997). These strategies may counteract the loss of self-esteem and self-efficacy experienced by persons with severe mental illness because of societal stigma. Future research needs to examine the impact of stigma on self-coping and empowerment.

These investigations only begin to define a research program that will significantly enhance stigma-reduction efforts. Information from this program will sharpen activist efforts to diminish negative stereotypes and discrimination aimed at persons with severe mental illness. With diminished stigma, these persons will have greater opportunities to live independent lives and successfully address their personal goals.

## REFERENCES


Adlerfer, C. P. (1982). Problems of changing white males' behavior and beliefs concerning race relations. In P. Goodman (Ed.), *Change in organizations* (pp. 122–165). San Francisco, CA: Jossey-Bass.

Albrecht, G. L., Walker, V. G., & Levy, J. A. (1982). Social distance from the stigmatized: A test of two theories. *Social Science & Medicine, 16,* 1319–1327.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Amir, Y. (1976). Contact hypothesis in ethnic relations. *Psychological Bulletin, 71,* 319–342.

Arnold, J. (1993). A clearinghouse mobilizes against stigma. *Journal of the California Alliance for the Mentally Ill, 4,* 50–51.

Augoustinos, M., & Ahrens, C. (1994). Stereotypes and prejudice: The Australian experience. *British Journal of Social Psychology, 33,* 125–141.

Bargh, J. A. (1989). Conditional automaticity: Varieties of automatic influence in social perception and cognition. In J. S. Uleman & J. A. Bargh (Eds.), *Unintended thought* (pp. 3–51). New York: Guilford Press.

Beard, J. H., Propst, R. N., & Malamud, T. J. (1994). The Fountain House model of psychiatric rehabilitation. In *An introduction to psychiatric rehabilitation* (pp. 42–52). Columbia, MD: International Association of Psychosocial Rehabilitation Services.

Bhugra, D. (1989). Attitudes toward mental illness: A review of the literature. *Acta Psychiatrica Scandinavica, 80,* 1–12.

Blanch, A., Fisher, D., Tucker, W., Walsh, D., & Chassman, J. (1993). Consumer–practitioners and psychiatrists share insights about recovery and coping. *Disability Studies Quarterly, 13,* 17–20.

Bodenhausen, G. V., & Lichtenstein, M. (1987). Social stereotypes and information-processing strategies: The impact of task complexity. *Journal of Personality and Social Psychology, 52,* 871–880.

Bodenhausen, G. V., & Wyer, R. S. (1985). Effects of stereotypes on decision making and information processing. *Journal of Personality and Social Psychology, 48,* 267–282.

Bookbinder, S. R. (1978). *Mainstreaming—What every child needs to know about disabilities.* Providence, RI: Rhode Island Easter Seal Society.

Bordieri, J., & Drehmer, D. (1986). Hiring decisions for disabled workers: Looking at the cause. *Journal of Applied Social Psychology, 16,* 197–208.

Brockington, I., Hall, P., Levings, J., & Murphy, C. (1993). The community's tolerance of the mentally ill. *British Journal of Psychiatry, 162,* 93–99.

Brown, R. J., & Turner, J. C. (1981). Interpersonal and intergroup behavior. In J. Turner & H. Giles (Eds.), *Intergroup behavior* (pp. 33–65). Chicago: University of Chicago Press.

Cook, S. W. (1985). Experimenting on social issues: The case of school desegregation. *American Psychologist, 40,* 452–460.

Corrigan, P. W. (1998). The impact of stigma on severe mental illness. *Cognitive and Behavioral Practice, 5,* 201–222.

Corrigan, P. W., Lickey, S., Schmook, A., Virgil, L., & Juricek, M. (in press). Dialogue among stakeholders of severe mental illness. *Psychiatric Rehabilitation Journal.*

Corrigan, P. W., & Penn, D. L. (1997). Disease and discrimination: Two paradigms that describe severe mental illness. *Journal of Mental Health, 6,* 355–366.

Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Wasowski, K. U., Campion, J., Mathisen, J., Gagnon, C., Bergman, M., Goldstein, H., & Kubiak, M. A. (1998). *Three strategies for changing attributions about severe mental illness.* Manuscript submitted for publication.

Corrigan, P. W., River, L. P., Lundin, R. K., Wasowski, K. U., Campion, J., Mathisen, J., Goldstein, H., Bergman, M., Gagnon, C., & Kubiak, M. A. (1998). *Stigmatizing attributions about mental illness.* Manuscript submitted for publication.

Crocetti, G., Spiro, H. R., & Siassi, I. (1971). Are the ranks closed? Attitudinal social distance and mental illness. *American Journal of Psychiatry, 127,* 1121–1127.

Desforges, D. M., Lord, C. G., Ramsey, S. L., Mason, J. A., Van Leeuwen, M. D., West, S. C., & Lepper, M. R. (1991). Effects of structured cooperative contact on changing negative attitudes toward stigmatized social groups. *Journal of Personality and Social Psychology, 60,* 531–544.

Devine, P. G. (1988). *Stereotype assessment: Theoretical and methodological issues.* Unpublished manuscript, University of Wisconsin–Madison.

Devine, P. G. (1989). Stereotypes and prejudice: Their automatic and controlled components. *Journal of Personality and Social Psychology, 56,* 5–18.

Devine, P. G. (1995). Prejudice and out-group perception. In A. Tesser (Ed.), *Advanced social psychology* (pp. 467–524). New York: McGraw-Hill.

Domino, G. (1983). Impact of the film, One Flew Over the Cuckoo's Nest, on attitudes towards mental illness. *Psychological Reports, 53,* 179–182.

Ellison, C. G., & Powers, D. A. (1994). The contact hypothesis and racial attitudes among Black Americans. *Social Science Quarterly, 75,* 385–400.

Esses, V. M., Haddock, G., & Zanna, M. P. (1994). The role of mood in the expression of intergroup stereotypes. In M. P. Zanna & J. M. Olson (Eds.), *The psychology of prejudice: The Ontario experience* (Vol. 7, pp. 77–101). Hillsdale, NJ: Erlbaum.

Fairweather, G. W. (1969). *Community life for the mentally ill: An alternative to institutional care.* Chicago: Aldine.

Farina, A. (1981). Are women nicer people than men? Sex and the stigma of mental illness. *Clinical Psychology Review, 1,* 223–243.

Farina, A. (1998). Stigma. In K. T. Mueser & N. Tarrier (Eds.), *Handbook of social functioning in schizophrenia* (pp. 247–279). Boston: Allyn & Bacon.

Farina, A., & Felner, R. D. (1973). Employment interviewer reactions to former mental patients. *Journal of Abnormal Psychology, 82,* 268–272.

Flynn, L. M. (1987). The stigma of mental illness. In A. B. Hatfield (Ed.), *Families of the mentally ill: Meeting the challenges* (pp. 53–60). San Francisco: Jossey-Bass.

Fyock, J., & Stangor, C. (1994). The role of memory biases in stereotype maintenance. *British Journal of Social Psychology, 33,* 331–343.

Gabbard, G. O., & Gabbard, K. (1992). Cinematic stereotypes contributing to the stigmatization of psychiatrists. In P. J. Fink & A. Tasman (Eds.), *Stigma and mental illness* (pp. 113–126). Washington, DC: American Psychiatric Press.

Gaertner, S. L., & Dovidio, J. F. (1986). The aversive form of racism. In

J. F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination, and racism* (pp. 61–89). San Diego: Academic Press.

Gaertner, S. L., Mann, J., Dovidio, J. F., Murrell, F., & Pomare, M. (1990). How does cooperation reduce intergroup bias? *Journal of Personality and Social Psychology, 59,* 692–704.

Gaertner, S. L., Rust, M. C., Dovidio, J. F., Bachman, B. A., & Anastasio, P. A. (1996). The contact hypothesis: The role of a common ingroup identity on reducing intergroup bias among majority and minority group members. In J. L. Nye & A. M. Brower (Eds.), *What's social about social cognition?* (pp. 230–260). Thousand Oaks, CA: Sage.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* Englewood Cliffs, NJ: Prentice Hall.

Greenley, J. (1984). Social factors, mental illness, and psychiatric care: Recent advances from a sociological perspective. *Hospital and Community Psychiatry, 35,* 813–820.

Hamburger, Y. (1994). The contact hypothesis reconsidered: Effects of the atypical outgroup member on the outgroup stereotype. *Basic and Applied Social Psychology, 15,* 339–358.

Hamilton, D. L., & Sherman, J. W. (1994). Stereotypes. In R. S. Wyer & T. K. Srull (Eds.), *Handbook of social cognition* (2nd ed., Vol. 2, pp. 1–68). Hillsdale, NJ: Erlbaum.

Hamre, P., Dahl, A., & Malt, U. (1994). Public attitudes to the quality of psychiatric treatment, psychiatric patients, and prevalence of mental disorders. *Nordic Journal of Psychiatry, 4,* 275–281.

Hasher, L., & Zacks, R. T. (1979). Automatic and effortful processes in memory. *Journal of Experimental Psychology: General, 108,* 356–385.

Hewstone, M., Macrae, C. N., Griffiths, R., & Milne, A. B. (1994). Cognitive models of stereotype change: 5. Measurement, development, and consequences of subtyping. *Journal of Experimental Social Psychology, 30,* 505–526.

Hilton, J. L., & von Hippel, W. (1996). Stereotypes. *Annual Review of Psychology, 47,* 237–271.

Holmes, P., Corrigan, P. W., Williams, P., Canar, J., & Kubiak, M. (in press). The relation of knowledge and attitudes about persons with a severe mental illness. *Schizophrenia Bulletin.*

Horwitz, M., & Rabbie, J. M. (1989). Stereotypes of groups, group members, and individuals in categories: A differential analysis. In D. Bar-Tal, C. F. Graumann, A. W. Kruglanski, & W. Stroebe (Eds.), *Stereotyping and prejudice: Changing conceptions* (pp. 105–129). New York: Springer-Verlag.

Huffine, C. L., & Clausen, J. A. (1979). Madness and work: Short- and long-term effects of mental illness on occupational careers. *Social Forces, 57,* 1049–1062.

Hyler, S. E., Gabbard, G. O., & Schneider, I. (1991). Homicidal maniacs and narcissistic parasites: Stigmatization of mentally ill persons in the movies. *Hospital and Community Psychiatry, 42,* 1044–1048.

Johnson, D. W., Johnson, R., & Maruyama, G. (1984). Goal interdependence and interpersonal attraction in heterogeneous classrooms. In N. Miller & M. B. Brewer (Eds.), *Groups in contact* (pp. 187–213). New York: Academic Press.

Johnston, L., & Hewstone, M. (1992). Cognitive models of stereotype change: 3. Subtyping and the perceived typicality of disconfirming group members. *Journal of Experimental Social Psychology, 28,* 360–386.

Judd, C. M., & Park, B. (1993). Definition and assessment of accuracy in social stereotypes. *Psychological Review, 100,* 109–128.

Jussim, L., Nelson, T. E., Manis, M., & Soffin, S. (1995). Prejudice, stereotypes, and labeling effects: Sources of bias in person perception. *Journal of Personality and Social Psychology, 68,* 228–246.

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

Keane, M. (1991). Acceptance vs. rejection: Nursing students' attitudes about mental illness. *Perspectives in Psychiatric Care, 27,* 13–18.

Kiger, G. (1992). Disability simulations: Logical, methodological and ethical issues. *Disability, Handicap & Society, 7,* 71–78.

Knight, E., & Blanch, A. (1993a). *A dialogue on recovery: An experiment in progress.* Albany, NY: New York State Office of Mental Health.

Knight, E., & Blanch, A. (1993b). *A dialogue on recovery: Tips for structuring a recipient dialogue.* Albany, NY: New York State Office of Mental Health.

Kolodziej, M. E., & Johnson, B. T. (1996). Interpersonal contact and acceptance of persons with psychiatric disorders: A research synthesis. *Journal of Consulting and Clinical Psychology, 64,* 1387–1396.

Krauss, S. J. (1995). Attitudes and the prediction of behavior: A meta-analysis of the empirical literature. *Personality and Social Psychology Bulletin, 21,* 58–75.

Krueger, J. (1996). Personal beliefs and cultural stereotypes about racial characteristics. *Journal of Personality and Social Psychology, 71,* 536–548.

Krueger, J., & Rothbart, M. (1988). Use of categorical and individuating information in making inferences about personality. *Journal of Personality and Social Psychology, 55,* 187–195.

Kunda, Z., & Oleson, K. C. (1995). Maintaining stereotypes in the face of disconfirmation: Constructing grounds for subtyping deviants. *Journal of Personality and Social Psychology, 68,* 565–579.

Kunda, Z., & Oleson, K. C. (1997). When exceptions prove the rule: How extremity of deviance determines the impact of deviant examples on stereotypes. *Journal of Personality and Social Psychology, 72,* 965–979.

Kurtz, L. F., & Chambon, A. (1987). Comparison of self-help groups for mental health. *Health and Social Work, 12,* 275–283.

Leary, M. R., & Maddux, J. E. (1987). Progress towards a viable interface between social and clinical psychology. *American Psychologist, 42,* 904–911.

Lefley, H. P. (1992). The stigmatized family. In P. J. Fink & A. Tasman (Eds.), *Stigma and mental illness* (pp. 127–138). Washington, DC: American Psychiatric Press.

Lindsay, W. R. (1982). The effects of labeling: Blind and nonblind ratings of social skills in schizophrenic and nonschizophrenic control subjects. *American Journal of Psychiatry, 139,* 216–219.

Link, B. G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review, 52,* 96–112.

Link, B. G., & Cullen, F. T. (1983). Reconsidering the social rejection of ex-mental patients: Levels of attitudinal response. *American Journal of Community Psychology, 11,* 261–273.

Link, B. G., & Cullen, F. T. (1986). Contact with the mentally ill and perceptions of how dangerous they are. *Journal of Health and Social Behavior, 27,* 289–303.

Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology, 92,* 1461–1500.

Link, B. G., Cullen, F. T., Mirotznik, J., & Struening, E. (1992). The consequences of stigma for persons with mental illness: Evidence from the social sciences. In P. J. Fink & A. Tasman (Eds.), *Stigma and mental illness* (pp. 87–96). Washington, DC: American Psychiatric Press.

Link, B. G., Cullen, F. T., Struening, E. L., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review, 54,* 400–423.

Loder, A., & Glover, R. (1992). *New frontiers: Pioneer dialogue between consumers/survivors and commissioners.* Fort Lauderdale, FL: Peer Center.

Lynch, J. (1987). *Prejudice reduction and the schools.* London: Cassell.

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

Macrae, C. N., Bodenhausen, G. V., & Milne, A. B. (1995). The dissection of selection in person perception: Inhibitory processes in social stereotyping. *Journal of Personality and Social Psychology, 69,* 397–407.

Macrae, C. N., Bodenhausen, G. V., Milne, A. B., & Jetten, J. (1994). Out of mind but back in sight: Stereotypes on the rebound. *Journal of Personality and Social Psychology, 67,* 808–817.

Macrae, C. N., Bodenhausen, G. V., Milne, A. B., & Wheeler, V. (1996). On resisting the temptation for simplification: Counterintentional effects of stereotype suppression on social memory. *Social Cognition, 14,* 1–20.

Macrae, C. N., Hewstone, M., & Griffiths, R. J. (1993). Processing load

and memory for stereotype-based information. *European Journal of Social Psychology, 23,* 77–87.

Macrae, C. N., Milne, A. B., & Bodenhausen, G. V. (1994). Stereotypes as energy-saving devices: A peek inside the cognitive toolbox. *Journal of Personality and Social Psychology, 66,* 37–47.

Madianos, M. G., Madianou, D. G., Vlachonikolis, J., & Stefanis, C. N. (1987). Attitudes toward mental illness in the Athens area: Implications for community mental health intervention. *Acta Psychiatrica Scandinavica, 75,* 158–165.

Mayer, A., & Barry, D. D. (1992). Working with the media to destigmatize mental illness. *Hospital and Community Psychiatry, 43,* 77–78.

Mechanic, D., McAlpine, D., Rosenfield, S., & Davis, D. (1994). Effects of illness attribution and depression on the quality of life among persons with serious mental illness. *Social Science & Medicine, 39,* 155–164.

Mirabi, M., Weinman, M. L., Magnetti, S. M., & Keppler, K. N. (1985). Professional attitudes toward the chronic mentally ill. *Hospital and Community Psychology, 36,* 404–405.

Monahan, J. (1992). Mental disorder and violent behavior: Perceptions and evidence. *American Psychologist, 47,* 511–521.

Morrison, J. K. (1976). Demythologizing mental patients' attitudes toward mental illness: An empirical study. *Journal of Community Psychology, 4,* 181–185.

Morrison, J. K. (1977). Changing negative attributions to mental patients by means of demythologizing seminars. *Journal of Clinical Psychology, 33,* 549–551.

Morrison, J. K. (1980). The public's current beliefs about mental illness: Serious obstacle to effective community psychology. *American Journal of Community Psychology, 8,* 697–707.

Morrison, J. K., Becker, R. E., & Bourgeois, C. A. (1979). Decreasing adolescents' fear of mental patients by means of demythologizing. *Psychological Reports, 44,* 855–859.

Morrison, J. K., Cocozza, J. J., & Vanderwyst, D. (1980). An attempt to change the negative, stigmatizing image of mental patients through brief reeducation. *Psychological Reports, 47,* 334.

Morrison, J. K., & Teta, D. C. (1977). Increase of positive self-attributions by means of demythologizing seminars. *Journal of Clinical Psychology, 33,* 1128–1131.

Morrison, J. K., & Teta, D. C. (1978). Effect of demythologizing seminars on attributions to mental health professionals. *Psychological Reports, 43,* 493–494.

Morrison, J. K., & Teta, D. C. (1979). Impact of a humanistic approach on students' attitudes, attributions, and ethical conflicts. *Psychological Reports, 45,* 863–866.

Morrison, J. K., & Teta, D. C. (1980). Reducing students' fear of mental illness by means of seminar-induced belief change. *Journal of Clinical Psychology, 36,* 275–276.

Mowbray, C. T., Moxley, D. P., Jasper, C. A., & Howell, L. L. (Eds.). (1997). *Consumers as providers in psychiatric rehabilitation.* Columbia, MD: International Association of Psychosocial Rehabilitation Services.

Mullen, B., Rozell, D., & Johnson, C. (1996). The phenomenology of being in a group: Complexity approaches to operationalizing cognitive representation. In J. L. Nye & A. M. Brower (Eds.), *What's social about social cognition?* (pp. 205–229). Thousand Oaks, CA: Sage.

NAMI E-news. (1998). *State parity update* [On-line]. Retrieved August 8, 1998, from the World Wide Web: http://www.nami.org.

Olshansky, S., Grob, S., & Ekdahl, M. (1960). Survey of employment experience of patients discharged from three mental hospitals during the period 1951–1953. *Mental Hygiene, 44,* 510–521.

Page, S. (1977). Effects of the mental illness label in attempts to obtain accommodation. *Canadian Journal of Behavioral Sciences, 9,* 85–90.

Page, S. (1980). Social responsiveness toward mental patients: The general public and others. *Canadian Journal of Psychiatry, 25,* 242–246.

Page, S. (1983). Psychiatric stigma: Two studies of behavior when the chips are down. *Canadian Journal of Community Mental Health, 2,* 13–19.

Page, S. (1995). Effects of the mental illness label in 1993: Acceptance and rejection in the community. *Journal of Health and Social Policy, 7,* 61–68.

Pate, G. S. (1988). Research on reducing prejudice. *Social Education, 52,* 287–289.

Pendry, L. F., & Macrae, C. N. (1994). Stereotypes and mental life: The case of the motivated but thwarted tactician. *Journal of Experimental Social Psychology, 30,* 303–325.

Penn, D. L., Guynan, K., Daily, T., Spaulding, W. D., Garbin, C. P., & Sullivan, M. (1994). Dispelling the stigma of schizophrenia: What sort of information is best? *Schizophrenia Bulletin, 20,* 567–577.

Penn, D. L., Kommana, S., Mansfield, M., & Link, B. G. (in press). Dispelling the stigma of schizophrenia: II. The impact of information on dangerousness. *Schizophrenia Bulletin.*

Petty, R. E. (1995). Attitude change. In A. Tesser (Ed.), *Advanced social psychology* (pp. 195–249). New York: McGraw-Hill.

Piner, K., & Kahle, L. (1984). Adapting to the stigmatizing label of mental illness: Forgone but not forgotten. *Journal of Personality and Social Psychology, 47,* 805–811.

Pruegger, V. J., & Rogers, T. B. (1994). Cross-cultural sensitivity training: Methods and assessment. *Journal of Intercultural Relations, 18,* 369–387.

Quicke, J., Beasley, K., & Morrison, C. (1990). *Challenging prejudice through education: The story of a mental handicap awareness curriculum project.* Bristol, PA: Falmer Press.

Rabkin, J. G. (1974). Public attitudes toward mental illness: A review of the literature. *Psychological Bulletin, 10,* 9–33.

Riordan, C. (1978). Equal-status interracial contact: A review and revision of the concept. *International Journal of Intercultural Relations, 2,* 161–185.

River, P., & Holmes, E. P. (in press). Individual strategies for coping with stigma. *Cognitive and Behavioral Practice.*

Roman, P. M., & Floyd, H. H., Jr. (1981). Social acceptance of psychiatric illness and psychiatric treatment. *Social Psychiatry, 16,* 16–21.

Rothbart, M., & John, O. P. (1985). Social categorization and behavioral episodes: A cognitive analysis of the effect of intergroup contact. *Journal of Social Issues, 41,* 81–104.

Rothbart, M., & John, O. P. (1993). Intergroup relations and stereotype change: A social–cognitive analysis and some longitudinal findings. In P. M. Sniderman, P. E. Tetlock, & E. G. Carmines (Eds.), *Prejudice, politics, and the American dilemma* (pp. 32–59). Stanford, CA: Stanford University Press.

Rothbart, M., & Lewis, S. (1988). Inferring category attributes from exemplar attributes: Geometric shapes and social categories. *Journal of Personality and Social Psychology, 55,* 861–872.

Scott, D. J., & Philip, A. E. (1985). Attitudes of psychiatric nurses to treatment and patients. *British Journal of Medical Psychology, 58,* 169–173.

Shapiro, A., & Margolis, H. (1988). Changing negative peer attitudes toward students with learning disabilities. *Reading, Writing, and Learning Disabilities, 4,* 133–146.

Sigelman, L., & Welch, S. (1993). The contact hypothesis revisited: Black–White interaction and positive racial attitudes. *Social Forces, 71,* 781–795.

Skinner, L. J., Berry, K. K., Griffith, S. E., & Byers, B. (1995). Generalizability and specificity of the stigma associated with the mental illness label: A reconsideration twenty-five years later. *Journal of Community Psychology, 23,* 3–17.

Skov, R. B., & Sherman, S. J. (1986). Information-gathering processes: Diagnosticity, hypothesis-confirmatory strategies, and perceived hypothesis confirmation. *Journal of Experimental Social Psychology, 22,* 93–121.

Smith, A. (1990). Social influence and antiprejudice training programs. In J. Edwards, R. S. Tindale, L. Heath, & E. J. Posavac (Eds.), *Social influence processes and prevention* (pp. 183–196). New York: Plenum.

Socall, D. W., & Holtgraves, T. (1992). Attitudes toward the mentally ill: The effects of label and beliefs. *Sociological Quarterly, 33,* 435–445.

Sosowsky, L. (1980). Explaining the increased arrest rate among mental patients: A cautionary note. *American Journal of Psychiatry, 137,* 1602–1604.

Stangor, C., & Duan, C. (1991). Effects of multiple task demands upon memory for information about social groups. *Journal of Experimental Social Psychology, 27,* 357–378.

Stangor, C., & McMillan, D. (1992). Memory for expectancy-congruent and expectancy-incongruent information: A review of the social and social developmental literatures. *Psychological Bulletin, 111,* 42–61.

Steadman, H. J. (1981). Critically reassessing the accuracy of public perceptions of the dangerousness of the mentally ill. *Journal of Health and Social Behavior, 22,* 310–316.

Stephan, W. G. (1987). The contact hypothesis in intergroup relations. In C. Hendrick (Ed.), *Group processes and intergroup relations* (pp. 13–40). Beverly Hills, CA: Sage.

Taylor, S. M., & Dear, M. J. (1980). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin, 7,* 225–240.

Thornton, J. A., & Wahl, O. F. (1996). Impact of a newspaper article on attitudes toward mental illness. *Journal of Community Psychology, 24,* 17–24.

Wahl, O. F. (1995). *Media madness: Public images of mental illness.* New Brunswick, NJ: Rutgers University Press.

Wahl, O., & Harman, C. (1989). Family views of stigma. *Schizophrenia Bulletin, 15,* 131–139.

Wahl, O. F., & Lefkowits, J. Y. (1989). Impact of a television film on attitudes about mental illness. *American Journal of Community Psychology, 17,* 521–528.

Weber, R., & Crocker, J. (1983). Cognitive processes in the revision of stereotypic beliefs. *Journal of Personality and Social Psychology, 45,* 961–977.

Wegner, D. M., & Erber, R. (1992). The hyperaccessibility of suppressed thoughts. *Journal of Personality and Social Psychology, 63,* 903–912.

Wegner, D. M., Schneider, D. J., Carter, S. R., & White, T. L. (1987). Paradoxical effects of thought suppression. *Journal of Personality and Social Psychology, 53,* 5–13.

Wegner, D. M., Shortt, J. W., Blake, A. W., & Page, M. S. (1990). The suppression of exciting thoughts. *Journal of Personality and Social Psychology, 58,* 409–418.

Weiner, B., Perry, R. P., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology, 55,* 738–748.

Weinstein, R. M. (1983). Labeling theory and the attitudes of mental patients: A review. *Journal of Health and Social Behavior, 24,* 70–84.

Williams, R. M., Jr. (1977). *Mutual accommodation: Ethnic conflict and cooperation.* Minneapolis, MN: University of Minnesota Press.

Worchel, S. (1986). The role of cooperation in reducing intergroup conflict. In S. Worchel & W. G. Austin (Eds.), *Psychology of intergroup relations* (pp. 116–143). Chicago: Nelson-Hall.