# THE STIGMA OF SEVERE MENTAL ILLNESS: SOME POTENTIAL SOLUTIONS FOR A RECALCITRANT PROBLEM

David L. Penn, Ph.D., and James Martin, B.A.

Despite recent advances in the treatment of individuals with severe mental illness (SMI), their full integration into society is hindered by lingering negative attitudes towards them. In this paper, a brief overview is provided on stigmatization towards individuals with SMI, including its' impact on quality of life and self-esteem, as well as the factors which likely underlie it. Research is reviewed showing that lowered negative perceptions towards persons with SMI are associated with previous contact with this population and with presentation of empirically-based information on the association between violence and SMI. Limitations of these findings are discussed with an eye towards developing improved techniques for reducing stigma.

It is clear that persons with severe mental illnesses (SMI) such as schizophrenia are stigmatized by the general population. Reviews of the literature and recent empirical findings indicate that persons with SMI are viewed negatively by the public (1-6). These negative feelings are generally in excess of those toward people with a physical illness (7), although they may not be greater than those toward people with substance use disorders (see 1,8, for somewhat conflictual findings with different methodologies). In-

The authors are affiliated with the Department of Psychology, Louisiana State University.

Address correspondence to David Penn, Ph.D., Department of Psychology, Louisiana State University, 236 Audubon Hall, Baton Rouge, LA 70803-5501.

PSYCHIATRIC QUARTERLY, Vol. 69, No. 3, Fall 1998
0033-2720/98/0900-0235$15.00/0 

terestingly, the negativity toward persons with SMI is not limited to members of the community but can also be found among mental health professionals (reviewed in 9). The nature of these negative feelings tends to be primarily fear, rather than dislike, neglect, or anger, as evidenced by surveys indicating that many individuals view people with SMI as dangerous and unpredictable (for discussions, see 5, 10-11).

The stigma of SMI has a number of adverse consequences. Specifically, stigmatization is generally associated with decreased employment and housing opportunities (12-14), increased family stress (15), and conflictual feelings (from the public) regarding acceptance into the community (16). Furthermore, the person with SMI may internalize stigma reactions resulting in depression (17), increased anxiety and decrements in social performance (18), lower self-esteem (19), and the adoption of secrecy and withdrawal as coping strategies (20). Although the internalization of stigma is not unique to persons with SMI (see 21), it may be as potentially damaging as the direct effects of stigma on employment and social relations. Therefore, the stigma of SMI likely interferes with the ability of persons with SMI to re-integrate into the community and may, by increasing ambient psychosocial stress, increase the likelihood of future relapse.

Given the pernicious effects of stigma on the lives of persons with SMI, it is imperative that mental health researchers and clinicians discover ways to reduce and ultimately, eliminate, stigmatizing attitudes and behaviors. A likely first step is to identify factors which contribute to stigma. In the ensuing section, factors associated with stigma (either in a causal or correlational manner) are briefly reviewed.

## FACTORS UNDERLYING STIGMA TOWARDS PERSONS WITH SMI

Stigma is a multifaceted construct which involves attitudes, feelings, and behaviors. As such, numerous factors likely contribute to its manifestation. These factors include having a label of mental illness, the social skill deficits and appearance of persons with SMI, lack of contact with individuals who have a mental illness,

and the perception of individuals with SMI as being extremely dangerous.

Labeling theory has its roots in the early work of Scheff (22,23), who originally posited that societal reactions have a strong etiological role in mental illness (24). Such a formulation has been disputed, with critics arguing that societal attitudes are not overly negative, that behaviors rather than labels cause rejection, and that persons with mental illness experience only temporary stigmatization from others (e.g., 25-27; for reviews and discussion, see 8, 24). Many of these criticisms have been refuted, as revealed by findings indicating that labels, even in the absence of aberrant behavior, can contribute to stigma (e.g., 28; reviewed by 24), and that public attitudes toward persons with mental illness are indeed not positive (5). Link and colleagues have provided evidence for a "modified labeling theory," which emphasizes the *consequences* of having a psychiatric label rather than its potential causal role in mental illness (20, 24). Thus, although a psychiatric label doesn't cause mental illness, it is certainly associated with a myriad of negative outcomes, which in turn may exacerbate and/or prolong the individual's psychiatric condition.

In addition to the deleterious effects of possessing a psychiatric label, individuals with SMI may be stigmatized because of illness-related behaviors and social skill deficits. Many of the symptoms associated with SMI, such as affect dysregulation, bizarre behavior, responding to internal stimuli, and language irregularities, likely scare or intimidate members of the non-psychiatric community. Support for this assertion is found in research showing that behaviors associated with mental illness in general (e.g., anxiety; tension), tend to produce negative reactions in excess of those associated with labeling effects (24, 29). In a recent study relevant to SMI, subjects read a description of a hypothetical individual whose schizophrenia was described either in terms of a label, symptoms, or a combination of both (30). The findings revealed that subjects who received the "symptom condition," either alone or in combination with the label of schizophrenia, rated the target person as less skilled (e.g., "is unable to maintain a job") relative to subjects in the "label-only" condition. Thus, the presence of psychiatric symptoms likely activated negative stereo-

types which influenced subjects' perceptions of a person with SMI.

The behaviors which contribute to stigma are not limited to those typically associated with active symptomatology. Specifically, individuals with SMI, relative to both clinical and non-clinical control subjects, show persistent and prominent deficits in social skills (31-33). These deficits (e.g., speech dysfluencies, poor eye contact, difficulty staying on topic) potentially contribute to negative interpersonal encounters, which may be aversive to members of the non-psychiatric public. Interestingly, social skills are also associated with perceptions of physical attractiveness among persons with SMI (34). Since physically attractive persons are perceived more favorably (i.e., in terms of abilities, competencies, personality, etc) and receive greater preferential treatment from others relative to physically unattractive persons, (35-37), it stands to reason that social skill deficits may *increase* stigma by contributing to perceptions of persons with SMI as being unattractive and undesirable.

There is growing evidence that contact with persons with mental illness may impact negative perceptions. In particular, self-reported previous contact with persons with mental illness is associated with more favorable attitudes (38,39) and lower ratings of perceived dangerousness toward persons with SMI (30,40). The effect of contact may be strongest for perceptions of males rather than females with SMI (41), a finding likely a result of the generally positive attitudes the public hold toward women with mental illness (18). The precise mechanisms underlying the contact effect are unclear, although it may increase individuals' knowledge base concerning SMI, a factor also associated with reduced stigma (2,42,43). Additional factors may also mediate the relationship between contact and stigma. As reviewed by Corrigan and Penn (9), these include frequent contact with persons who only moderately disconfirm the stereotype and/or are typical to the majority group in all dimensions other than the one associated with stigma, institutional support for contact, and cooperative interaction and equal status between the stigmatized individuals and members of the community. One of the challenges to future research is to determine how contact reduces stigma; in other words, the conditions under which contact may

or may not impact stigma. In this regard, mental health professionals may look toward their colleagues in social psychology for insights into these issues (9).

A final factor which contributes to stigma is perceived dangerousness. Empirical findings and reviews of the literature indicate that, in general, the public view persons with SMI as extremely dangerous (44). These perceptions appear to play a prominent role in the community's reactions toward persons with SMI. For example, Angermeyer and Matschinger (45) reported that attitudes toward mental illness became more negative following two assassination attempts against prominent politicians in Germany by persons with schizophrenia. In a more direct test of the role of perceived dangerousness on stigma, Link et al. (24) found that subjects scoring high on a perceptions of dangerousness scale, relative to those scoring low on the scale, were more likely to reject a hypothetical individual described as having been previously hospitalized in a "mental hospital." These findings led Link et al. to conclude: ". . . these results suggest that characteristics of respondents, in this case, their beliefs about the dangerousness of the mentally ill, affect how they react to a labeled person above and beyond that person's described behavior" (p. 1486). Thus, perceptions of dangerousness appear to be a critical factor in contributing to psychiatric stigma.

One could certainly argue that the public's perceptions are reasonable given evidence that, in general, persons with SMI are more prone to violence compared to members of the general population (for reviews and discussion, see 46-53). However, as discussed previously (41), reviews of the literature indicate that the risk of violent behavior among persons with SMI is modest relative to the risk associated with age, gender, violence history, socioeconomic status, and educational level (5,54). It should also be noted that the violence rates of persons with SMI are generally lower than for individuals with substance use disorders (49,55), a group which makes up a larger percentage of the population than those with SMI. Furthermore, the risk of violence among persons with SMI is not a fixed figure. Rather, it depends on factors such as dual-diagnosis (56,57), the presence of acute symptomatology (i.e., delusions involving loss of control, perceived threat, and paranoia) (10,58-60), and social context (e.g.,

46). Therefore, the picture that emerges is one of a public whose fears of persons with SMI are excessive and not in line with empirically-based evidence on the association between mental illness and violent behavior.

Since public perceptions of violence in SMI are excessive and perceived dangerousness contributes to stigma, one would expect that addressing public fears should reduce stigma. Based on this logic, a study was designed to directly address concerns regarding violence and mental illness. This study is described in the following section.

## DISPELLING THE STIGMA OF SEVERE MENTAL ILLNESS: AN EMPIRICAL STUDY

Changing public attitudes toward persons with SMI dates to work by Cumming and Cumming (61), and has been met with mixed success (62-66). However, only two studies, to our knowledge, directly addressed the issue of violence and severe mental illness (67,68). In the first study (67), a brief message stating that the majority of persons with mental illness are not violent, was presented prior to and following a made-for-TV film. The film portrayed a psychiatric patient who, while out on a day pass, murdered his wife. The findings revealed that the brief message did not impact subjects' attitudes toward mental illness. Although Wahl and Lefkowits (67) concluded that providing "compensatory information" may be limited in reducing stigma, they also noted that the film may have been too emotionally arousing to be overcome by a brief message. In a second study (68), the negative effects (on attitudes) of a newspaper article which described a violent crime committed by a person with mental illness was effectively offset by two types of factual information; one addressed misconceptions about mental illness, including the infrequency of violent behavior among persons with mental illness, and the other underscored the role of media distortion on impacting community attitudes toward persons with mental illness. These findings suggest that factual information may be effective in nullifying the influence of negative news coverage of persons with mental illness, at least as promulgated by the print-media.

A recent study by Penn et al. (41) extended upon Thornton and Wahl's findings by investigating the effects of factual information (i.e., empirically-based), previous contact with persons with SMI, and target gender, on perceptions of dangerousness toward both a specific target person with SMI and persons with SMI in general. The subjects in Penn et al., were 182 undergraduate students from a midwestern university. To address the role of information on perceptions of dangerousness, subjects were randomly assigned to one of four information conditions. These were entitled "no information," "general information," "acute information," and "comparative information" conditions. The no information condition merely instructed subjects that they were about to read a description of a man(woman) with schizophrenia (described below). The general information condition comprised a general description of the symptoms and course of schizophrenia (based on the DSM-IV). The acute and comparative information conditions both began with information contained in the general information condition. The acute information condition then summarized the association between the presence of psychotic symptoms and violent behavior in psychiatric patients. Finally, the comparative information condition compared the prevalence rates of violent behavior across psychiatric disorders. Prevalence rate data were based on the Epidemiologic Catchment Area Surveys which showed that persons with SMI had lower violence rates than individuals with substance use disorders (49).

All information conditions were administered prior to a vignette describing either a male or female target with schizophrenia. A variation of this vignette has been used in previous research (24,30). Following presentation of the vignette, subjects completed two measures of perceived dangerousness: One measure evaluated subject perceptions regarding the dangerousness of persons with SMI in general ("Danger-G"), while the other measure evaluated subject perceptions regarding the dangerousness of the target individual ("Danger-I"). Subjects were also classified into those with and without previous contact with persons with mental illness. However, since the findings regarding previous contact and target gender were reported earlier in this ar-

ticle, and these variables didn't interact with the Information variable, they won't be repeated here.

Analyses revealed a main effect of Information condition only for dangerousness perceptions of persons with mental illness in general (i.e., Danger-G). Post-hoc tests showed that the "comparative information" condition was associated with lower ratings of dangerousness relative to the other groups. When a more stringent post-hoc test was used (i.e., one that controlled for conducting multiple statistical tests), only the "acute" and "comparative" information conditions significantly differed from one another. For perceptions of the target individual, the effect of the Information condition was not significant, although the group means were in the hypothesized direction.

These findings suggest that providing specific information on the relationship between violence and mental illness may impact individuals' fears about persons with schizophrenia in general. However, there were clearly limits to this effect, as perceptions of the target individual were not affected. Furthermore, the data indicate that some information may have a deleterious effect on perceptions of dangerousness; providing information on the role of acute symptoms in initiating violent behavior appeared to *increase* subject fears (i.e., as presented in the "acute information" condition). Thus, we concluded that efforts to reduce stigmatization via information packages may not benefit from focusing on psychotic symptoms.

Although the findings from Penn et al. are promising, a number of limitations should be considered so as to place the results in a proper context. First, the study was conducted with undergraduate students, a group with less crystallized attitudes than older adults (69). However, affecting the attitudes of college-age persons may be an important step in changing their behaviors toward persons with SMI after they leave school. Second, the study conclusions are limited to impacting perceptions of dangerousness; generalization of the findings to affecting discriminatory behaviors was not evaluated. Finally, the "comparative information" condition did not address the issue of dual-diagnosis. As individuals with schizophrenia are at high risk for substance use disorders (70), it is possible that including information on risk for dual-diagnosis may have eliminated or reduced the observed

Information effect. Although this is an empirical question, it should be noted that if substance use comorbidity is included in information packages, then, as noted by Penn et al., (41), such information should also state that: Substance use disorders co-occur at a high rate with other psychiatric disorders; substance use raises the risk of violent behavior for *all* psychiatric conditions; and over 50% of persons with SMI have never met criteria for a substance use disorder. Thus, any comprehensive information package attempting to reduce stigma should present a complete picture regarding comorbidity issues, not just those relevant to SMI.

## CONCLUSIONS

In this article, we have reviewed research indicating that negative attitudes toward persons with SMI can be reduced. The most promising methods for impacting psychiatric stigma are promoting contact between the community and persons with SMI, and information which directly addresses issues of violence and other misconceptions concerning mental illness. However, as noted in the foregoing, there are still unanswered questions regarding not only *how* these factors impact stigma, but also the extent to which changes in the laboratory translate into real changes in the lives of persons with SMI. Until that issue can be addressed, the findings summarized here provide hope, but clearly not an answer, for reducing psychiatric stigma.

As mental health professionals, we must not only redouble our efforts to reduce psychiatric stigma for our clients, but we must do so in a responsible and ethical manner. Clearly, blanket statements such as "persons with SMI are no more likely to be violent than members of the general community," and "labels alone cause stigma," are unethical, misleading, and not supported by empirical findings. In this regard, one has to question the use of "politically-correct" labels, such as "consumer," "client," "customer" and even "severe mental illness" in identifying individuals whose psychiatric symptoms are often characterized by psychosis and who may be dependent on the mental health system. This type of reality is likely not well represented by vague, innocuous la-

bels, some of which are not even preferred by persons with a psychiatric disorder (71). Of course, this is an empirical question which we are currently addressing in our laboratory. Until answers to these questions are obtained, however, the process of stigma reduction should not be one of "they are no different than we are," but rather, that of acceptance into the community, differences and all.

## REFERENCES

1. Angermeyer MC, Matschinger H: Social distance towards the mentally ill: Results of representative surveys in the Federal Republic of Germany. Psychological Medicine 27:131-141, 1997.
2. Brockington I, Hall P, Levings J, et al: The community's tolerance of the mentally ill. British Journal of Psychiatry 162: 93-99, 1993.
3. Greenley J: Social factors, mental illness, and psychiatric care: Recent advances from a sociological perspective. Hospital and Community Psychiatry 35:813-820, 1984.
4. Hamre P, Dahl A, Malt U: Public attitudes to the quality of psychiatric treatment, psychiatric patients, and prevalence of mental disorders. Norwegian Journal of Psychiatry 4:275-281, 1994.
5. Monahan J:Mental disorder and violent behavior: Perceptions and evidence. American Psychologist 47:511-521, 1992.
6. Wolff G, Pathare S, Craig T, et al: Community attitudes to mental illness. British Journal of Psychiatry 168:183-190, 1996.
7. Weiner B, Perry RP, Magnusson, J:An attributional analysis of reactions to stigmas. Journal of Personality and Social Psychology 55:738-748, 1988.
8. Skinner LJ, Berry KK, Griffith SE, et al: 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, 1995.
9. Corrigan PW, Penn DL: Stigma busting and stereotypes: Lessons from social psychology on discrediting psychiatric stigma. Manuscript under review, 1998.
10. Link BG, Stueve A: Psychotic symptoms and the violent/illegal behavior of mental patients compared to community controls, in Violence and Mental Disorders: Developments in Risk Assessment. Edited by Monahan J, Steadman, Chicago, Illinois: University of Chicago Press, 1994.
11. Wahl OF: Media madness: Public images of mental illness. New Brunswick, NJ: Rutgers University Press, 1995.
12. Farina A, Felner RD: Employment interviewer reactions to former mental patients. Journal of Abnormal Psychology 82:268- 272, 1973.
13. Link BG: Mental patient status, work, and income: An examination of the effects of a psychiatric label. American Sociological Review 47:202-215, 1982.
14. Page S:Effects of the mental illness label in attempts to obtain accommodation. Canadian Journal of Behavioral Science 9: 84-90, 1977.
15. Wahl OF, Harman CR: Family views of stigma. Schizophrenia Bulletin 15:131-139, 1989.

16. Farina A, Thaw J, Loevern JD, et al: People's reactions to a former mental patient moving to their neighborhood. Journal of Community Psychology 2:108-112, 1974.
17. Link BG, Struening E, Rahav M, et al: On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. Journal of Health and Social Behavior, in press.
18. Farina A: Are women nicer people than men? Sex and the stigma of mental disorders. Clinical Psychology Review 1:223-243, 1981.
19. Link BG: Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. American Sociological Review 52:96-112, 1987.
20. Link BG, Cullen FT, Struening E, et al: A modified labeling theory approach to mental disorders: An empirical assessment. American Sociological Review 54:400-423, 1989.
21. Steele CM, Aronson J:Stereotype threat and the intellectual test performance of African-Americans. Journal of Personality and Social Psychology 69:797-811, 1995.
22. Scheff T: Being mentally ill: A sociological theory. Chicago: Aldine, 1966.
23. Scheff T:The labeling theory of mental illness. American Sociological Review 39:444-452, 1974.
24. Link BG, Cullen FT, Frank J, et al: The social rejection of former mental patients: Understanding why labels matter. American Journal of Sociology 92:1461-1500, 1987.
25. Crochetti G, Spiro H, Siassi I: Are the ranks closed?: Attitudinal social distance and mental illness. American Journal of Psychiatry 127:1121-1127, 1971.
26. Gove WR: The current status of the labeling theory of mental illness. In: Deviance and mental illness, pp. 273-300, edited by Gove, WR, Beverly Hills, CA: Sage, 1982.
27. Weinstein R: Labeling theory and the attitudes of mental patients: A review. Journal of Health and Social Behavior 24:70- 84, 1983.
28. Piner KE, Kahle LR: Adapting to the stigmatizing label of mental illness: Foregone but not forgotten. Journal of Personality and Social Psychology 47:805-811, 1984.
29. Socall DW, Holtgraves T: Attitudes toward the mentally ill: The effects of label and beliefs. The Sociological Quarterly 33: 435-445, 1992.
30. Penn DL, Guynan K, Daily T, et al: Dispelling the stigma of schizophrenia: What sort of information is best? Schizophrenia Bulletin 20:567-578, 1994.
31. Bellack AS, Morrison RL, Wixted JT, et al: An analysis of social competence in schizophrenia. British Journal of Psychiatry 156:809-818, 1990.
32. Mueser KT, Bellack AS, Douglas MS, et al: Prevalence and stability of social skill deficits in schizophrenia. Schizophrenia Research 5:167-176, 1991.
33. Mueser KT, Bellack AS, Morrison RL, et al: Social competence in schizophrenia: Premorbid adjustment, social skill, and domains of functioning. Journal of Psychiatric Research 24:51-63, 1990.
34. Penn DL, Mueser KT, Doonan R: Physical attractiveness in schizophrenia: The mediating role of social skill. Behavior Modification 21:78-85. 1997.
35. Eagly AH, Ashmore R, Makhijani MG, et al: What is beautiful is good, but . . . .: A meta-analytic review of research on the physical attractiveness stereotype. Psychological Bulletin 110: 109-128, 1991.

36. Burns GL, Farina A: The role of physical attractiveness in adjustment. Genetic, Social, and General Psychology Monographs 118:157-194, 1992.
37. Feingold A: Good-looking people are not what we think. Psychological Bulletin 111: 304-341, 1992.
38. Desforges DM, Lord CG, Ramsey SL, et al: Effects of structured cooperative contact on changing negative attitudes toward stigmatized social groups. Journal of Personality and Social Psychology 60:531-544, 1991.
39. Holmes P, Corrigan PW, Williams P: The relation of knowledge and attitudes about persons with severe mental illness. Paper presented at the annual meeting of the Association for the Advancement of Behavior Therapy, Miami, Fl, November, 1997.
40. Link BG, Cullen FT: Contact with the mentally ill and perceptions of how dangerous they are. Journal of Health and Social Behavior 27:289-303, 1986.
41. Penn DL, Kommana S, Mansfield M, et al: Dispelling the stigma of schizophrenia: II. The impact of information on dangerousness. Schizophrenia Bulletin, in press.
42. Barrowclough C, Tarrier N, Watts S, et al: Assessing the functional value of relatives knowledge about schizophrenia: A preliminary report. British Journal of Psychiatry 151:1-8, 1987.
43. Roman PM, Floyd HH: Social acceptance of psychiatric illness and psychiatric treatment. Social Psychiatry 16:21-29. 1981.
44. Steadman HJ: Critically reassessing the accuracy of public perceptions of the dangerousness of the mentally ill. Journal of Health and Social Behavior 22:310-316. 1981.
45. Angermeyer MC, Matschinger H: Impact of violent attacks by psychiatric patients on social distance towards the mentally ill. Paper presented at the International Sociological Association, 1994.
46. Hiday AY: The social context of mental illness and violence. Journal of Health and Social Behavior, 36, 122-137, 1995.
47. Marzuk PM: Violence, crime, and mental illness: How strong a link? Archives of General Psychiatry 53:481-486, 1996.
48. Mulvey EP: Assessing the evidence of a link between mental illness and violence. Hospital and Community Psychiatry 45:663- 668, 1994.
49. Swanson JW, Holzer CE, Ganju VK, et al: Violence and psychiatric disorder in the community: Evidence from the Epidemiologic Catchment Area Surveys. Hospital and Community Psychiatry 41:761-770, 1990.
50. Taylor PJ: Schizophrenia and the risk of violence, pp. 163- 183, in Schizophrenia, edited by Hirsch S, Weinberger D, Oxford: Blackwell, 1995.
51. Taylor PJ, Monahan J: Commentary: Dangerous patients or dangerous diseases? British Medical Journal 312:967-969, 1996.
52. Torrey EF: Violent behavior by individuals with serious mental illness. Hospital and Community Psychiatry 45:653-662, 1994.
53. Wessely S, Taylor P:Madness and crime: Criminology versus psychiatry. Criminal Behaviour and Mental Health 1:193-228, 1991.
54. Link BG, Andrews H, Cullen FT: The violent and illegal behavior of mental patients reconsidered. American Sociological Review 57:275-292, 1992.
55. Swanson JW, Holzer CE: Violence and the ECA data. Hospital and Community Psychiatry 42:79-80, 1991.
56. Swanson JW: Alcohol abuse, mental disorder, and violent behavior. Alcohol Health and Research World 17:123-132, 1993.

57. Swanson JW, Borum R, Swartz MS, et al: Psychotic symptoms and disorders and the risk of violent behavior in the community. Criminal Behaviour and Mental Health 6:309-326, 1996.
58. Link BG, Monahan J, Stueve A, et al: Real in their consequences: A sociological approach to understanding the association between psychotic symptoms and violence. Manuscript under review, 1997.
59. Swanson JW, Estroff S, Swartz M, et al: Violence and severe mental disorder in clinical and community populations: The effects of psychotic symptoms, comorbidity, and lack of treatment. Psychiatry 60:1-22, 1997.
60. Wessely, S., Buchanan, A., Reed, A, et al: Acting on delusions, I: Prevalence. British Journal of Psychiatry 163:69- 76, 1993.
61. Cumming E, Cumming J: Closed ranks: An experiment in mental health. Cambridge, MA: Harvard University Press, 1957.
62. Domino G: Impact of the film "One Flew Over the Cuckoo's Nest" on attitudes toward mental illness. Psychological Reports 53:179-182, 1983.
63. Farina A, Fisher JD, Getter H, et al: Some consequences of changing people's views regarding the nature of mental illness. Journal of Abnormal Psychology 87:272-279, 1978.
64. Fisher JD, Farina A: Consequences of beliefs about the nature of mental disorders. Journal of Abnormal Psychology 88: 320-327, 1979.
65. Keane M: Contemporary beliefs about mental illness among medical students: Implications for education and practice. Academic Psychiatry 14:172-177, 1990.
66. Keane M: Acceptance vs. rejection: Nursing students' attitudes about mental illness. Perspectives in Psychiatric Care 27:13-16, 1991.
67. Wahl OF, Lefkowits JY: Impact of a television film on attitudes toward mental illness. American Journal of Community Psychology 17:521-528, 1989.
68. Thornton JA, Wahl OF: Impact of a newspaper article on attitudes toward mental illness. Journal of Community Psychology 24:17-25, 1996.
69. Sears DO: College sophomores in the laboratory: Influences of a narrow data base on social psychology's view of human nature. Journal of Personality and Social Psychology 51:515-530, 1986.
70. Mueser KT, Bennett M, Kushner MG: Epidemiology of substance use disorders among persons with chronic mental illness, in Double Jeopardy: Chronic Mental Illness and Substance Use Disorders, edited by Lehman AF, Dixon LB, Chur, Switzerland: Harwood Academic Publishers, 1995.
71. Mueser KT, Glynn SM, Corrigan PW, et al: What's in a name? The preferences of participants in mental health services. Psychiatric Services 47:760-761, 1996.