Understanding the Social Norms, Attitudes, Beliefs, and Behaviors Towards Mental Illness in the United States

Bianca Manago
Indiana University

September 2015

Acknowledgements: I'd like to thank Bernice Pescosolido, Jane Sell, and Trenton Mize for their helpful feedback on earlier drafts of this paper.

In the United States, a diagnosis of mental illness carries significant amounts of stigma (Pescosolido, 2013; Martin et al., 2007). Stigma refers to the process by which individuals are simultaneously discriminated against, socially sanctioned, controlled, and isolated (Phelan, Link, & Dovidio, 2008). The overall societal opinion towards mental illness remains negative (Martin et al., 2007). Indeed, current research shows that a majority of individuals would rather not live next door to, marry, socialize, or work with an individual with mental illness (Pescosolido et al., 2010). Further, a label of mental illness also carries implications for social status, with individuals assuming less ability and competence of those with a mental illness diagnosis (Lucas & Phelan, 2012).

Stigma not only results in social consequences such as isolation and status loss, but it also has direct consequences for education, health, and life expectancy. For example, research shows that both stigma and how individuals interact with their stigmatizing environments contribute to reduced educational opportunities for children with behavioral or social problems (McLeod & Kaiser, 2004; McLeod, Uemura, & Rohrman, 2012). This not only diminishes educational success for these children while in grade school, but these negative effects extend to college (Shifrer, 2013) and beyond education, to other outcomes such as health, life chances, and even life expectancy (Fok et al., 2012; Chang et al., 2011).

In addition to being publically stigmatized by others who endorse prejudice towards people with mental illness, individuals also stigmatize themselves. That is, individuals with mental illness may internalize this public stigma towards themselves and those like them (Corrigan & Penn, 1999, Corrigan & Watson, 2002). This self-stigma has been shown to: deter individuals with mental illness from seeking help from medical professionals (Corrigan, 2004, Komiti et al., 2006, Schomerus & Angermeyer, 2008, Vogel et al., 2007), decrease adherence with prescribed treatments (Livingston & Boyd, 2010, Tsang et al., 2010), and reduce life goals, self-esteem, and self-efficacy (Corrigan, Larson, Rüsch, 2009, Fung et al., 2007).

In summary, stigma has negative social, physical, and psychological consequences (Lucas & Phelan, 2012; Martin et al., 2007; Martin et al., 2000; Pescosolido, 2013; Pescosolido et al., 2008; Shifrer, 2013). To decrease stigma and thereby improve outcomes for those with mental illness, it is important to consider the nature and effects of social norms, attitudes, beliefs, and behaviors regarding mental health and mental disorders.

MODELS OF MENTAL ILLNESS STIGMA

Stigma is complex and occurs on multiple levels. Researchers have examined many forms of stigma including: self-stigma, perceived stigma, enacted stigma, structural stigma, institutional stigma, healthcare provider stigma, etc. To explain how individual and societal-level characteristics work together to influence norms, attitudes, beliefs, and behaviors towards mental illness in the United States, three models have been offered: the social psychological model, the attribution model, and the framework integrating normative influences on stigma (FINIS) model.

Social Psychological Model

The social psychological model of stigma rests on the assumption that social norms, beliefs, and attitudes are reflected and reinforced through interpersonal interaction. It uses common social psychological concepts and themes such as self-fulfilling prophecies, stereotype threat, identity, and expectancy confirmation processes, and applies them to mental illness and stigmatization (Major & O'Brien, 2005). In short, to understand the stigma associated with

mental illness, the social psychological model argues that norms, attitudes, beliefs, and behaviors are shaped by social interactions (Goffman, 1969). Individuals apply understandings of mental illness acquired early in life to themselves or others, leading to expectations of diminished competence and a desire for social distance from individuals with mental illness. Anticipating discrimination, rejection, and shame, labeled individuals often alter their own behavior and may act defensively or avoid social interaction. The combination of enacted, felt, and anticipated discrimination results in overall diminished quality of life for labeled individuals (Link, 1982; Link et al., 1987; Link et al., 1989; Rosenfield, 1997).

Attribution Model

The attribution model of discrimination focuses attention on how the characteristics of the illness itself affect others' perceptions. Specifically, the attribution model examines how beliefs about persons' responsibility for their condition lead to stigmatizing responses towards those with mental illness. It also examines the role of fear and perceived dangerousness in stigmatizing beliefs towards those with mental illness (Corrigan et al., 2003). Research finds, for example, that if an individual is thought to have control over their illness (as is often the case with mental illness), their symptoms reflect poorly on their character, adding a layer of blame to an already heavy burden of shame, discrimination, and social isolation (Corrigan, 2000; Crocker, Major, & Steele, 1998; Goffman, 1963; Jones et al., 1984). Additionally, mental illnesses that are associated with danger and fear garner more stigma than those not associated with fear (Martin, Pescosolido, & Tuch 2000). Thus, it is not only the interactions that affect stigma, but also the attributes of the stigmatizing characteristic itself.

Framework Integrating Normative Influences on Stigma (FINIS) Model

Perhaps the most comprehensive model of stigma is the framework integrating normative influences on stigma (FINIS) model. FINIS recognizes that stigma stems from micro, meso, and macro-level systems that are inextricably linked and mutually reinforcing (Pescosolido et al., 2008b). FINIS considers the factors at each level, and how they might work together within and between levels.

Rather than examining these influences in a vacuum, it attempts to understand relationships between these levels. In doing so, FINIS incorporates a range of expertise from multiple disciplines to create a system-science approach to understanding stigma. For example, at the individual (micro) level, social interactions are necessarily colored by the characteristics of labeled individuals, their mental illness, and those with whom they interact. However, FINIS recognizes that the individuals in these interactions and their opinions towards mental illness are products of large social structures and institutions (macro-level) such as media and national contexts. Finally, it examines processes that connect the individual and structural levels (meso-level), such as the social networks, and looks for linkages between the three levels. This multilevel approach allows for a more extensive framework from which stigma researchers and practitioners can draw (see Pescosolido et al., 2008b for details). While these levels are inextricably linked, each level also has unique features.

THE MULTIPLE AND INTERACTING LEVELS OF STIGMA

The Micro Level: The Individual

Characteristics of the Mental Illness

Characteristics of the mental illness diagnosis carry straightforward consequences. Research has systematically examined the effect of type of mental illness, attribution, behavior, and perceptions of dangerousness and contagiousness on stigmatizing beliefs towards individuals with mental illness. The attribution of the illness to different causes, e.g., genetic vs. social, affects the degree and amount of stigmatization encountered by the labeled individual (McGinty et al., 2015). For example, some research, and specifically research relying on attribution theory (described above), suggests that an attribution of mental illness to biological causes may reduce the blame placed on the individual for his or her behavior (Rosenfield, 1997). However, attributing behavior to a genetic cause also has negative consequences, as it is then viewed as essential and thus, may increase perceptions of differentness, persistence, seriousness, and transmissibility of the mental illness (Phelan, 2005).

The behaviors associated with certain mental illnesses also engender varying levels of stigma. For example, research consistently shows that when a mental illness is associated with danger or violence, preferences for social distance from those who possess this characteristic increase (Martin et al., 2000, Martin et al., 2007, Phelan et al., 2000). This association with fear is particularly pernicious because research suggests that mental illness and danger are consistently linked in the public mind. However, despite this close association with fear, behaviors associated with some mental illnesses garner more stigma than others. For example, Perry (2011) found that as the extent to which one's behavior is assumed to disrupt social interaction increases, so too does the social rejection he or she receives from acquaintances and strangers.

Socio-demographic characteristics of the Stigmatizer

On the individual/interactional level, views of mental illness are thought to vary by the characteristics of those with the mental illness and those with whom they interact. Specifically, research has examined the intersection between mental illness and basic demographic characteristics such as age, race/ethnicity, gender, and class. Although socio-demographic characteristics have been found to affect a large number of social beliefs, when applied to stigma, findings are unclear (Pescosolido, 2013). Importantly, the effect of socio-demographic characteristics differs by whether they are applied to the stigmatizer or stigmatized.

For perceivers, or stigmatizers, some research suggests that race/ethnicity predicts attitudes towards people with mental illness. Research consistently finds that African American and Asian individuals stigmatize mental illness *more severely* than Whites (Anglin et al., 2006; Rao et al., 2007; Whaley, 1997). For Latinos, research on attitudes towards individuals with mental illness is inconsistent. Some research finds that Latinos perceive those with mental illness to be more dangerous than do Caucasians (Whaley, 1997), and others do not observe any significant difference between the two groups (Rao et al., 2007). While race and ethnicity appear to be important for observers' opinions towards mental illness, more research is needed to understand the origin of these differences (Abdullah & Brown, 2011; Parscepe & Cabassa, 2013).

While race and ethnicity seem to significantly predict stigmatization of people with mental illness, the effects of other sociodemographic characteristics, such as age and gender, are inconsistent. Specifically, the age of the stigmatizer is not consistently related to attitudes towards mental illness (Pescosolido, 2013). Similarly, both men and women are equally likely to hold stigmatizing beliefs after accounting for other factors (e.g., education) (Pescosolido et al., 2008a; Pescosolido, 2013; Schnittker, 2000). Finally, and somewhat surprisingly, although education and income predictably affect other social processes, their effect on stigma is inconsistent and rarely significant (Pescosolido, 2013; Corrigan & Watson, 2007).

Socio-demographic characteristics of the Stigmatized

Although some characteristics are associated with the extent to which a person stigmatizes another (e.g., race), those same characteristics do not appear to affect the extent to which someone is stigmatized. That is, although race and ethnicity may be important predictors of stigmatizing beliefs, the race/ethnicity of the person with mental illness does not appear to affect the extent to which they are stigmatized (Pescosolido et al., 2007; Martin et al., 2007). However, other socio-demographic characteristics such as age and gender do appear to affect the stigmatization of individuals with mental illness. These characteristics appear to operate through concomitant changes in perceptions of fear. For example, research suggests that the age of individuals with mental illness affects the amount of stigma they encounter. While children may be less stigmatized than adults for certain conditions (e.g., ADHD), the public perceives children with depression to be more dangerous than adults; as such, attitudes towards children with depression are more negative than attitudes towards similar adults (Perry et al., 2007; Perry et al., 2011). While more research is needed to understand this relationship, it appears that increased stigmatization of children is due to increased fear associated with a childhood diagnosis of depression than an adult diagnosis (Perry et al., 2007).

While these characteristics differ by individuals, societal beliefs or normative attitudes around or within race and ethnicity, gender, or age are culturally embedded in larger social contexts. Thus, it is also important to consider the context in which they occur.

The Macro Level: Institutions

Initially, individuals adopt ideas about mental illness from the structural and cultural contexts in which they interact (Schomerous et al., 2015). These beliefs affect our understanding of and interactions with mental illness. Among other things, the media and national context significantly impact our views.

Media

Media provides ideas of and images about mental illness that influence the ways that those in the United States come to view the world. Unfortunately, in the United States, media consistently portrays individuals with mental illness negatively. When examining news media portrayals of mental illness, although there appears to be a reduction in news stories that link mental illness to violence, at least 1/3 of news about mental illness focuses on dangerousness (Corrigan et al., 2004; Corrigan et al., 2005). In addition to news outlets, movies and television

consistently depict individuals with mental illness as dangerous, unpredictable, and incompetent (Diefenbach & West, 2007; Signorielli, 1989; Wahl, 1997).

National Context & Treatment Systems

Our national context affects our understandings of mental illness. Social structures such as welfare and healthcare affect the extent to which people with mental illness are included in (or excluded from) mainstream society. The extent to which people with mental illness are systematically excluded from social processes affects how citizens view themselves and others (Foucault, 1980; Parker and Aggleton, 2003; Schomerus et al., 2015). These views are often reflected in the media. Indeed, countries with more institutional support for those with mental illness (i.e., social democratic welfare states such as Iceland) have media discourse surrounding themes such as social inclusion of people with mental illness, whereas those with less social support (i.e., liberal welfare states such as the U.S.), emphasize danger and criminalization of mental illness (Olafsdottir, 2007; Pescosolido et. al., 2008c; Schomerus et al. 2015). In addition, both the emphasis on diagnosis and ideas about normative behavior that occur within treatment systems may also function to increase stigma (Corrigan and Watson, 2007; Cresswell, 2005; Pescosolido, 2008b).

The Meso Level: Connecting Structure and the Individual

On the meso-level, our social networks and contact/familiarity with mental illness appear to affect proliferation of stigmatizing beliefs. Our immediate networks and the extent of our contact with people with mental illness impact our understanding of and opinions towards mental illness (Chandra & Minkovitz, 2006; Corrigan & Penn, 1999). Although it seems intuitive that individuals with more contact with those with mental illness should hold less stigmatizing beliefs, research has not supported this proposition.

IMPLICATIONS FOR REDUCING STIGMA TOWARDS MENTAL ILLNESS

Perhaps the best approach to reducing the stigmatization of people with mental illness is a two-pronged approach that includes both research and intervention. Specifically, prior to implementing interventions, interventionists should consult past research on stigma. This would enable the inclusion of multi-level conceptualizations of stigma and nuanced understandings of demographic eccentricities into strategies for intervention. Similarly, researchers and interventionists should do formative research on potential program and policy effects, examining characteristics of interventions and their varying levels of success. These examinations may reveal new features of stigma, generating informed and central research questions, and evidence-based interventions. In addition, researchers should examine naturally occurring phenomena (e.g., media events, policy implementations), and monitor their potential effect on levels of stigma. Insights from these naturally occurring phenomena would then benefit future research, interventions, and policy initiatives. In summary, to reduce stigma towards people with mental illness, it is imperative that interventions and research work in tandem and learn from one another.

REFERENCES

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review, 31*(6), 934–948. doi:10.1016/j.cpr.2011.05.003

Anglin, D. M., Link, B. G., & Phelan, J. C. (2006). Racial differences in stigmatizing attitudes toward people with mental illness. *Psychiatric Services (Washington, D.C.), 57*(6), 857–862. http://doi.org/10.1176/appi.ps.57.6.857

Chandra, A., & Minkovitz, C. S. (2006). Stigma starts early: Gender differences in teen willingness to use mental health services. *Journal of Adolescent Health, 38*(6), 754-e1.

Chang, C. K., Hayes, R. D., Perera, G., Broadbent, M. T. M., Fernandes, A. C., Lee, W. E., … Stewart, R. (2011). Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London. *PLoS ONE, 6*(5). http://doi.org/10.1371/journal.pone.0019590

Corrigan, P.W. (2000). Mental health stigma as social attribution: implications for research methods and attitude change. *Clinical Psychology: Science and Practice, 7*(1), 48–67.

Corrigan, P.W. (2004). How stigma interferes with mental health care. *The American Psychologist, 59*(7), 614–25. http://doi.org/10.1037/0003-066X.59.7.614

Corrigan, P. W., Larson, J. E., & Rüsch, N. (2009). Self-stigma and the "why try" effect: impact on life goals and evidence-based practices. *World Psychiatry : Official Journal of the World Psychiatric Association (WPA), 8*(2), 75–81. doi:10.1002/j.2051-5545.2009.tb00218.x

Corrigan, P.W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin, 30*(3), 481–491. http://doi.org/10.1093/oxfordjournals.schbul.a007096

Corrigan, P.W., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behavior, 44*(2), 162–179. http://doi.org/10.2307/1519806

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: a meta-analysis of outcome studies. *Psychiatric Services, 63*(10), 963-973.

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist, 54*(9), 765.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. Clinical Psychology: Science and Practice, 9(1), 35-53.

Corrigan, P. W., & Watson, A. C. (2007). The stigma of psychiatric disorders and the gender, ethnicity, and education of the perceiver. Community Mental Health Journal, 43(5), 439-458.

Corrigan, P.W., Watson, A.C., Gracia, G., Slopen, N., Rasinski, K., & Hall, L.L. (2005). Newspaper stories as measures of structural stigma. Psychiatric Services, 56, 551-556.

Cresswell M. (2005). Psychiatric “Survivors” and Testimonies of Self-Harm. *Social Science & Medicine.* 61, 1668–1677.

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *The Handbook of Social Psychology Vols 1 and 2 4th ed* (pp. 504–553). McGraw-Hill.

Diefenbach, D. L., & West, M. D. (2007). Television and attitudes toward mental health issues: Cultivation analysis and the third-person effect. Journal of Community Psychology, 35(2), 181–195. doi:10.1002/jcop.20142

Fok, M. L. Y., Hayes, R. D., Chang, C. K., Stewart, R., Callard, F. J., & Moran, P. (2012). Life expectancy at birth and all-cause mortality among people with personality disorder. *Journal of Psychosomatic Research*, *73*(2), 104–107. doi.org/10.1016/j.jpsychores.2012.05.001

Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings, 1972-1977*. Pantheon.

Fung, K. M., Tsang, H. W., Corrigan, P. W., Lam, C. S., & Cheng, W. M. (2007). Measuring self-stigma of mental illness in China and its implications for recovery. *International Journal of Social Psychiatry*, *53*(5), 408-418.

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

Jones, E., Farina, A., Hastorf, A., Markus, H., Miller, D., & Scott, R. (1984). *Social Stigma: The Psychology of Marked Relationships*. New York: Freeman.

Komiti, A., Judd, F., & Jackson, H. (2006). The influence of stigma and attitudes on seeking help from a GP for mental health problems: A rural context. *Social Psychiatry and Psychiatric Epidemiology*, *41*(9), 738–745. http://doi.org/10.1007/s00127-006-0089-4

Link, B. (1982). Mental Patient Status, Work, and Income: An Examination of the Effects of a Psychiatric Label. *American Sociological Review*, *47*(2), 202–215.

Link, B., Cullen, F., Frank, J., & Wozniak, J. (1987). The social rejection of former mental patients: understanding why labels matter. *American Journal of Sociology*, *92*(6), 1461–1500.

Link, B. G., Cullen, F. T., Struening, E., Shrout, P., & Dohrenwend, B. P. (1989). A modified labeling theory approach to mental disorders: an empirical assessment. *American Sociological Review*, *54*(3), 400–423.

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, *71*(12), 2150-2161.

Lucas, J. W., & Phelan, J. C. (2012). Stigma and Status: The Interrelation of Two Theoretical Perspectives. *Social Psychology Quarterly*, *75*(4), 310–333. http://doi.org/10.1177/0190272512459968

Major, B., & O’Brien, L. T. (2005). The social psychology of stigma. *Annual Review of Psychology*, *56*, 393–421. http://doi.org/10.2307/3089335

Martin, J. K., Pescosolido, B. a, Olafsdottir, S., & McLeod, J. D. (2007). The construction of fear: Americans' preferences for social distance from children and adolescents with mental health problems. *Journal of Health and Social Behavior*, *48*(1), 50–67. http://doi.org/10.1177/002214650704800104

Martin, J. K., Pescosolido, B. A., & Tuch, S. A. (2000). Of Fear and Loathing: The Role of "Disturbing Behavior," Labels, and Causal Attributions in Shaping Public Attitudes toward People with Mental Illness. *Journal of Health and Social Behavior*. http://doi.org/10.2307/2676306

McGinty, E. E., Goldman, H. H., Pescosolido, B., & Barry, C. L. (2015). Portraying mental illness and drug addiction as treatable health conditions: Effects of a randomized experiment on stigma and discrimination. *Social Science & Medicine*, *126*, 73-85.

McLeod, J. D., Fettes, D. L., Jensen, P. S., Pescosolido, B. a, & Martin, J. K. (2007). Public knowledge, beliefs, and treatment preferences concerning attention-deficit hyperactivity disorder. *Psychiatric Services (Washington, D.C.)*, *58*(5), 626–631. http://doi.org/10.1176/appi.ps.58.5.626

McLeod, J. D., & Kaiser, K. (2004). Childhood Emotional and Behavioral Problems and Educational Attainment. *American Sociological Review*, *69*(5), 636–658. http://doi.org/10.1177/000312240406900502

McLeod, J. D., Uemura, R., & Rohrman, S. (2012). Adolescent mental health, behavior problems, and academic achievement. *Journal of Health and Social Behavior*, *53*(4), 482–97. http://doi.org/10.1177/0022146512462888

Olafsdottir, S. (2007). Fundamental causes of health disparities: stratification, the welfare state, and health in the United States and Iceland. *Journal of Health and Social Behavior*, *48*(3), 239–253. http://doi.org/10.1177/002214650704800303

Parcesepe, A. M., & Cabassa, L. J. (2013). Public stigma of mental illness in the United States: a systematic literature review. *Administration and Policy in Mental Health and Mental Health Services Research*, *40*(5), 384-399.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science and Medicine*, *57*(1), 13–24. http://doi.org/10.1016/S0277-9536(02)00304-0

Perry, B. L. (2011). The labeling paradox stigma, the sick role, and social networks in mental illness. *Journal of Health and Social Behavior, 52*(4), 460-477.

Perry, B. L., Pescosolido, B. A., Martin, J. K., McLeod, J. D., & Jensen, P. S. (2007). Comparison of public attributions, attitudes, and stigma in regard to depression among children and adults. *Psychiatric Services (Washington, D.C.)*, *58*(5), 632–5. http://doi.org/10.1176/appi.ps.58.5.632

Pescosolido, B. A. (2007). Culture, children, and mental health treatment: special section on the national stigma study-children. *Psychiatric Services (Washington, D.C.)*, *58*(5), 611–612. http://doi.org/10.1176/appi.ps.58.5.611

Pescosolido, B. A. (2013). The Public Stigma of Mental Illness: What Do We Think; What Do We Know; What Can We Prove? Journal of Health and Social Behavior, 54(1), 1–21. http://doi.org/10.1177/0022146512471197

Pescosolido, B. A., Jensen, P. S., Martin, J. K., Perry, B. L., Olafsdottir, S., & Fettes, D. (2008a). Public knowledge and assessment of child mental health problems: findings from the National Stigma Study-Children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*(3), 339–49. http://doi.org/10.1097/CHI.0b013e318160e3a0

Pescosolido, B. A., Martin, J. K., Lang, A., & Olafsdottir, S. (2008b). Rethinking theoretical approaches to stigma: A Framework Integrating Normative Influences on Stigma (FINIS). Social Science and Medicine, 67(3), 431–440. http://doi.org/10.1016/j.socscimed.2008.03.018

Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., & Link, B. G. (2010). A Disease Like Any Other? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence. American Journal of Psychiatry, 167(11), 1321–1330. http://doi.org/10.1176/appi.ajp.2010.09121743.

Pescosolido, B. A., Olafsdottir, S., Martin, J. K., & Long, J. S. (2008c). Cross-cultural aspects of the stigma of mental illness. Understanding the stigma of mental illness: Theory and interventions, 19-36.

Pescosolido, B. A., Perry, B. L., Martin, J. K., McLeod, J. D., & Jensen, P. S. (2007). Stigmatizing attitudes and beliefs about treatment and psychiatric medications for children with mental illness. *Psychiatric Services (Washington, D.C.)*, *58*(5), 613–618. http://doi.org/10.1176/appi.ps.58.5.613

Phelan, J.C. (2005). Geneticization of deviant behavior and consequences for stigma: the case of mental illness. J Health Soc Behav. 2005 Dec;46(4):307-22.

Phelan, J. C., Link, B. G., & Dovidio, J. F. (2008). Stigma and prejudice: one animal or two? *Social Science & Medicine (1982)*, *67*(3), 358–67. http://doi.org/10.1016/j.socscimed.2008.03.022

Phelan, J. C., Link, B. G., Stueve, A., & Pescosolido, B.A. (2000). Public Conceptions of Mental Illness in 1950 and 1996: What Is Mental Illness and Is It to be Feared? *Journal of Health and Social Behavior*, *41*(2), 188. http://doi.org/10.2307/2676305

Rao, D., Feinglass, J., & Corrigan, P. (2007). Racial and ethnic disparities in mental illness stigma. *The Journal of Nervous and Mental Disease*, *195*(12), 1020-1023.

Rosenfield, S. (1997). Labeling mental illness: The effects of received services and perceived stigma on life satisfaction. *American Sociological Review*, *62*(4), 660–672. Retrieved from http://www.jstor.org/stable/2657432

Schnittker, J. (2000). Gender and Reactions to Psychological Problems: An Examination of Social Tolerance and Perceived Dangerousness. *Journal of Health and Social Behavior*, *41*(2), 224. http://doi.org/10.2307/2676307

Schomerus, G., & Angermeyer, M. C. (2008). Stigma and its impact on help-seeking for mental disorders: what do we know? *Epidemiologia E Psichiatria Sociale*, *17*(1), 31–37. http://doi.org/10.1017/S1121189X00002669

Schomerus, G., Evans-Lacko, S., Rüsch, N., Mojtabai, R., Angermeyer, M. C., & Thornicroft, G. (2015). Collective levels of stigma and national suicide rates in 25 European countries. *Epidemiology and psychiatric sciences, 24*(02), 166-171.

Shifrer, D. (2013). Stigma of a label: educational expectations for high school students labeled with learning disabilities. *Journal of Health and Social Behavior*, *54*(4), 462–80. http://doi.org/10.1177/0022146513503346

Shifrer, D., Callahan, R. M., & Muller, C. (2013). Equity or Marginalization? The High School Course-Taking of Students Labeled with a Learning Disability. *American Educational Research Journal*, *50*(4), 656–682. http://doi.org/10.3102/0002831213479439

Signorielli, N. (1989). The Stigma of Mental Illness on Television. *Journal of Broadcasting & Electronic Media*, *33*(3), 325–331. http://doi.org/10.1002/j.1556-6678.2008.tb00491.x

Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Raue, P., Friedman, S. J., & Meyers, B. S. (2001). Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *American Journal of Psychiatry*, *158*(3), 479-481.

Tsang, H. W. H., Fung, K. M. T., & Chung, R. C. K. (2010). Self-stigma and stages of change as predictors of treatment adherence of individuals with schizophrenia. *Psychiatry Research*, *180*(1), 10-15.

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology*, *54*(1), 40–50. http://doi.org/10.1037/0022-0167.54.1.40

Wahl, O. F. (1997). *Media madness: Public images of mental illness*. Rutgers University Press.

Whaley, A. L. (1997). Ethnic and racial differences in perceptions of dangerousness of persons with mental illness. *Psychiatric Services*.