

Running Head: THE MONSTER IN THE CLOSET

The Monster in the Closet: Misperception of Mental Illness

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Abstract

Mental illness affects all major aspects of an individual's life. From basic needs such as shelter and employment, to interactions with family, partners, and friends, the diagnosis represents likely difficulties due to stigma and negative attitudes.

Efforts to bring forth the recognition and acceptance of mental illness in the United States, as well as around the world, start by confronting misconceptions through examination of causes. Increased access to needed resources and funding for treatment are also needed and may be accomplished through the use of media, education, and rising voices lobbying for the rights of people with mental illness.

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Introduction: Mental Illness Defined

Mental illness is a pervasive disease that impacts all major aspects of a person's life. According to the medical definition, mental illness is "considered a clinically significant behavioral or psychological syndrome experienced by a person and marked by distress, disability, or the risk of suffering disability or loss of freedom" (Varcarolis, 2009, p. 12). But from the perspective of an individual who experiences mental illness, a mental illness feels more like "you're a prisoner in your own mind [that does not] know who you are....It feels like wanting to kill all your emotions so you don't hurt anymore....It feels like fear...." ("What mental illness...", 2008, para. 1, 3 & 6).

Suffering from a mental illness presents a challenge that arises from many factors. From receiving a medical diagnosis to coping with illness and societal reactions to the disorder, the individual often faces obstacles.

The diagnosis and reaction of mental illness varies according to what culture the person is from. According to research, mental illness varies according to the values and beliefs that shape the culture (Watters, 2010). For example, some cultures have symptoms that would be considered a mental illness according to biomedical healthcare systems, but for that group are indicative of common behavior seen in everyday life (Clark, 2008). This can be a result of behavior exhibited through hallucinations and phobias that stems from important aspects of life in the particular culture (Varcarolis, 2009). Because cultures differ so greatly across the world, there are many distinct

behaviors that are unique to specific populations. Therefore, behavior that contrasts from one's known culture may be seen as peculiar, even if normal in another culture. For

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example, in Southeast Asia, running amok is a mental illness in which someone, usually a male, demonstrates rage that is uncontrollable (Varcarolis, 2009). In Greenland, Alaska, and parts of Canada, pibloktoq is recognized as a psychological disorder that involves exposing one's body to the extreme cold (Varcarolis, 2009). Therefore, the recognition and perception of what is classified as a psychiatric disorder has the potential to vary across cultures. What is classified as a mental illness in one country may not have ever been thought of as a mental illness in another country.

Increasingly over the last generation, however, the West has spread its beliefs about mental illness throughout the world (Watters, 2010). Depression and post-traumatic stress disorders are examples of mental illnesses that are appearing in indigenous cultures whereas they were not seen before in other countries (Watters, 2010). Therefore, the concept of mental illness, beliefs about mental illness, and treatments in the United States may be spreading as well.

In the United States, mental health disorders are diagnosed through the Diagnostic and Statistical Manual of Mental Disorders, or the DSM. The DSM contains diagnostic criteria and disorder information that assists professionals in diagnosing whether an individual suffers from a certain mental illness. Serving as the guide for diagnoses in the biomedical healthcare system, the DSM includes mental health diagnoses that range from more prevalent disorders, such as depression and anxiety, to less common ones, such as schizophrenia (Varcarolis, 2009).

With such a range of different societies, mental illness is viewed in diverse ways. From what is classified as mental illness to how the individual with mental illness is treated, one must understand where information about the psychological disorder comes from and how these attitudes are shaped, as well as what consequences these issues pose for the person with the psychological disorder. Understanding these issues will also aid in attempts to remedy any negative outcomes as well as to live with tolerance and be able to promote equality.

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Background: Attitudes towards Mental Illness and Where They Originate
Those Affected and Theory Behind the Concept of Mental Illness

While a number of Americans may suffer from a mental illness at some point in their lives, the steadfast attitude of the majority of Americans towards mental illness remains one of non-acceptance. Research shows that about one-fourth of Americans met criteria for a diagnosis of mental illness and that, when compared to twenty-seven other countries, the United States is ready to rank number one around the world with the largest number of people with mental illness (Weiss, 2005). Thus, the United States has a large number of people with mental illnesses, yet our general perspective of mental illness seems to be one of shame and embarrassment when many of these disorders can be treated. In addition, under half of people in need of treatment do so; those who postpone treatment, sometimes a decade or more, are prone to more health issues (Weiss, 2005). The stigma associated with mental illness, too, deters the recognition and potential treatment that some people may need.

Meanwhile, beliefs about mental illnesses have not significantly changed in the United States. A 2008 study shows that Americans have not become more tolerant of mental illness during the last decade despite the growing acceptance that many types of

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mental illness, especially schizophrenia and bipolar disorder, are caused largely by genetics (University of Pennsylvania, 2008). Nevertheless, despite the attribution theory, which says there should be less stigma and discrimination as a result of less blame due to chromosomal or genetic alterations causing the mental illness, studies reveal that the opposite is usually true (Phelan, 2005). In addition, besides the growing acceptance of links between genetic causes of mental illness and the disorder, tolerance towards various mental illnesses still varies according to the illness. For example:

‘In the case of schizophrenia, genetic arguments are associated with fears regarding violence,’ Schnittker said. ‘In fact, attributing schizophrenia to genes is no different from attributing it to bad character — either way Americans see those with schizophrenia as ‘damaged’ in some essential way and, therefore, likely to be violent. However, when applied to depression, genetic arguments have very different connotations: they are associated with social acceptance. If you imagine that someone’s depression is a genetic problem, the condition seems more real and less blameworthy: it’s in their genes, they’re not weak, so I should accept them for who they are’ (University of Pennsylvania, 2008, para. 4)

Therefore, genetic considerations have different associations depending on which mental disorder is being discussed. Schizophrenia, for example, tends not to be accepted by Americans although depression may be accepted even though both are classified as mental health issues.

Accordingly, if an individual acknowledges that genes could cause mental disorders, this may actually contribute to the stigma that those diagnosed often receive. This is due to genetic essentialist thinking, which states that genes form the basis of human behavior (Phelan, 2005). This thinking could then increase stigma by perpetuating the perception of illness severity, degree of difference, and ability of the

illness to be transmissible, thus increasing social distancing, a problem often faced by people with mental illness that results in isolation (Phelan, 2005). This makes some members of society more concerned about mental illnesses and how they may be treated

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and maintained. Consequently, the realization that genes can cause mental illness may increase undeserved stigma and intolerance toward the sufferer.

Other research has found different conclusions regarding the influence of biological mechanisms on stigma. Research finds that Americans who connect mental illness issues to structural causes, such as genetics or stress, are more tolerant and more likely to interact with individuals who have mental illness (Martin, Pescosolido, & Tuch, 2000). Americans who attribute individual causes, such as how a person was raised, as the root of the problem, are less likely to interact with people with a mental illness (Martin et al., 2000). Similarly, the attribution model holds that behavior is controlled by cognitive and emotional processes. This includes factors such as cause and controllability that lead to inferences about responsibility of the mental illness (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). In turn, the factors yield emotional responses that determine if reactions will be positive or negative. For example, when applying the attribution theory to people with physical diagnoses such as cancer, blindness, or heart disease, those afflicted with the disorders were perceived as not in control of the disorder (Corrigan et al., 2003). Therefore the people with these diagnoses received more sympathy and less anger. On the other hand, other mental-behavioral conditions, such as obesity, drug abuse, and AIDS, were elicited as controllable (Corrigan

et al., 2003). Consequently these subjects did not elicit as much sympathy. Rather, they received a greater amount of anger directed towards them. Thus, applying the attribution

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model to mental illness further determines how a person with mental illness will be treated depending upon whether an individual without mental illness views it as controllable or not controllable.

Other areas of psychology also offer explanations to tie together etiology and the resulting level of discrimination. Some research contends that mental illness elicits negative stereotypes that lead to rejection in society (Corrigan et al., 2003). Other research enforces the idea that mental illness is very stigmatizing; this leads members of society not afflicted with mental illness to attribute characteristics to people with mental disorders as having traits different from them (Corrigan et al., 2003). Categories of “us” and “them” may occur. This is another factor that may contribute to the stereotypes, prejudice, and discrimination towards people with mental illnesses. Overall, when one looks at the stereotypes through specific theories, it becomes clear how the labels affect everyone involved.

Stigma toward People with Mental Illnesses

Studies have found that there are two types of stigma, public stigma and self-stigma (Corrigan et al., 2003). Public stigma is composed of three types: stereotypes, prejudice, and discrimination (Corrigan et al., 2003). Stereotypes are collective thoughts about a certain group of people that allow one to make a quick assessment or judgment

about another person. When one has prejudice, that person believes the negative stereotypes about a certain group. In turn, these beliefs generate negative emotions towards the members in the group (Corrigan et al., 2003). An example of this relates to

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fear or anger directed towards a person with mental illness due to the belief in the stereotype that all people with mental illness are dangerous. Lastly, discrimination is a behavior directed towards a minority group, such as people with mental illness, that can result in harm, either emotionally, physically, or financially (Corrigan et al., 2003). This kind of discrimination may result in declining people with mental illness from jobs or housing or could result in physical harm of the individual.

The other recognized form of stigma, self-stigma, is often internalized and is a result of public stigma. It is stigma directed toward oneself that affects the individuals' self-esteem, motivation, and interactions with other members of society. Ergo, stereotypes, prejudice, and discrimination are three forms of stigma through which negative attitudes toward people with mental illness may be displayed.

The stigma of mental illness goes on to affect not just the diagnosed, but the people who associate with the diagnosed; this is called a courtesy stigma (Byrne, 2000). The courtesy stigma carries negative connotations simply by associating with the mentally ill. In addition, in a study of 156 participants who were spouses and parents of those with mental illness, about half indicated attempts to mask it (Byrne, 2000). This is due to fear of stigma or being treated differently from family members of those without mental illness. Professionals, too, may hide psychiatric illness they experience or in

their families (Byrne, 2000). This may include healthcare professionals who work with individuals with psychiatric disorders.

Moreover, the stigma about mental illness also transfers to professionals who work with people with psychological disorders: some healthcare professionals report

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stigma regarding their work with the mentally ill. In a questionnaire done in 2000, 67% percent of psychiatrists reported that they were laughed at for working with psychiatric patients while 29% reported that their family discouraged them from joining the profession (Lai, Hong, and Chee, 2000). About 58% of psychiatric nurses, as well, responded that they were laughed at for working with psychiatric patients while 31% had been discouraged from joining the profession (Lai et al., 2000). Laughing at healthcare professionals for working with patients with mental illnesses, then, seems to occur more frequently than not. It is clear that even healthcare professionals receive the stigma associated with mental illness due to their ties to treating those with psychological disorders.

It is this stigma and perceived intolerance that has a large impact on the quality of life a person diagnosed with mental illness can experience. If society rejects or disapproves of the mental illness, it is difficult to remain open about the mental illness, leading some to be more ashamed or angry about the mental illness, or have other emotions about living with the mental illness and how they are treated by others because of it.

How Attitudes are Shaped

One issue that contributes to the beliefs about mental illness concerns myths or false portrayals of those with a mental illness. Forming attitudes toward mental illness begins as a child and continues into adulthood. Once these attitudes develop, it is a challenge to reshape these thoughts. For example, a study found that one cohort of participants held the same beliefs eight years later when questioned about their thoughts

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about people with psychological disorders (Byrne, 2000). These thoughts included stereotypical labels such as pathetic and sad, indulgent, psycho-killers, people to make fun of, maniacs, and that mental illness is used as an excuse (Byrne, 2000). These negative labels contribute to the stigma that people with mental illness often experience, either directed from someone without a mental illness or even from others with mental illnesses that may be similar to or different from the victim's.

The media also remark on the mentally ill, and this appears to influence viewer responses. Research shows that seventy-seven percent of consumers agreed that they had seen hurtful or offensive portrayals of mental illness on television (Wahl, 2003). In addition, studies have concluded that psychiatric illnesses, such as schizophrenia and hysterical blindness, were the number one health issues most seen on soap operas (Wahl, 2003). As well, many detective shows depict the main characters as confronting individuals said to possess a mental illness (Wahl, 2003). Characters on television that experience mental illnesses are also often depicted as villains or criminals and receive derogatory slang words to describe their illness (Wahl, 2003).

Research also shows that Americans report television and mass media to be their main source of information about mental illness (Wahl, 2003). Thus, exaggerated or

false images of mental illness may influence the misperception of these psychological disorders. For example, the author of a book entitled *Media Madness* reported that when he participated in career week at schools to share what he does as a psychologist, he received questions that related to misunderstandings from television shows. For

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example, one student questioned whether a character on a cartoon that was described as having two brains and being schizophrenic meant that people with schizophrenia have mutated brains (Wahl, 2003). This teenager may be representative of a population that is influenced by television shows and popular culture.

More research shows that the prominent influence of news and entertainment media link views on mental illness to Americans (SAMHSA, 2008). For example, according to a survey from the Screen Actors' Guild, characters in prime time TV portrayed with a mental illness were often noted to be the most dangerous in comparison to other characters (SAMHSA, 2008). Research finds that 60% of the characters were involved with crimes or violence, which is three times as much as the average character (SAMHSA, 2008). In addition, the majority of stories primarily related to negative qualities, such as unpredictability and aloofness (SAMHSA, 2008). Furthermore, analyses of film have identified three themes that contribute to misconceptions about people with mental disorders that contribute to the response of stigmatizing dispositions (Corrigan & Watson, 2002). The themes hold that those with mental illnesses should be feared, are childlike, and have weak dispositions that caused the illness (Corrigan & Watson, 2002). Furthermore, according to research, characteristics most associated with

mental illness on television shows include simple, asocial, unpredictable and unproductive, vulnerable, and untrustworthy (Stout, Villegas, & Jennings, 2004). All of these labels and stereotypes contribute to the attitudes of the public about people with mental illnesses.

Society also makes judgments about healthcare professionals who interact with people experiencing mental illnesses. Studies suggest that some people may have warped perceptions of psychiatrists, due to media portrayal. According to research, female clinicians are more likely to be portrayed as sexualized and male clinicians as incompetent in American cinema (Stout et al., 2004). This affects the way the general public perceives mental health professionals as well as those who need treatment for mental illnesses; it sends the wrong message and potentially deters people from seeking treatment. With these stereotypes appearing in movies, it is important to combat myths about healthcare professionals in order to help clients understand how therapy and other clinical interactions are conducted (Stout et al., 2004).

Additionally, when the media focuses on rare, tragic events that do involve someone with a mental illness, it increases fear (Kobau, DiIorio, Chapman, & Delvecchio, 2010). Fear contributes to stigma. When someone does not have correct knowledge or is misinformed, this often leads to uneasiness and trepidation, which leads to anger and negative attitudes that often compose stigma. Instead, media coverage of success stories, recovery, or experiences with mental illness may contribute to improved beliefs (Kobau et al., 2010). This is because misconceptions and misunderstandings without clarification may cause viewers to take what they see on television and apply it to

actual life. This affects everyone's lives, both the sufferer of the mental disorder and the individual with the incorrect beliefs.

There are two theories that explain how the media is a factor in influencing the way people view mental illnesses, the cultivation theory and social learning theory (Stout et al., 2004). The cultivation theory suggests that the more television presents recurring,

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similar themes about the portrayal of people with mental illnesses, the more likely the viewer is to agree with these portrayals and connect them to actual people with mental illness (Stout et al., 2004). The social learning theory contends that learning occurs through direct experience as well as through observation (Stout et al., 2004). This suggests that television teaches people in society how to treat people with mental illnesses (Stout et al., 2004). These two theories serve as possible explanations for how and why the media is able to influence with such magnitude society's views of people who have mental illnesses.

Portraying individuals with mental disorders in an unflattering light has an effect on those individuals as well. The fact that many U.S. citizens obtain their knowledge about people with mental illness through largely inaccurate portrayals on television needs to be changed.

Research shows that not only is the general public influenced by media such as television and cinema, but so are people preparing for a career in the health field as well as those who are currently practicing in it. For example, one study showed the reaction of the public and students toward people with schizophrenia. Among the general public as well as undergraduate nursing and psychology students, there was a general belief that

people with schizophrenia are different from them and therefore unpredictable (Stout et al., 2004). These rates go up as there is more evidence of observation of characters from television who have schizophrenia. Interviews with health care providers showed high levels of anxiety when personal contact occurred with an individual with mental illness; it

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is partially caused by the media (Stout et al., 2004). This anxiety was shown to decrease as contact levels were higher (Stout et al., 2004). Therefore, the attitudes of future and current healthcare providers may benefit from contact with patients with mental illnesses and additional information or education about mental illnesses.

Moreover, there are numerous television shows and songs, for example, which reference individuals with mental illnesses in disparaging ways. Even movies geared for children can contain noticeable episodes of damaging words about mental illness. According to a study in the *Canadian Journal of Psychiatry*, popular Disney movies that are classics for children could be teaching them to fear people with mental illness as well as allow the children to laugh at their expense (Parmar, 2004). Research shows that after analysis of 34 Disney movies, 85% of them disparage mental illnesses by portraying their cartoon characters under such labels as nuts or crazy (Parmar, 2004). Movies such as *Beauty and the Beast*, where Belle's father is hauled off in a lunacy' wagon, often feature stereotypes (Parmar, 2004). Another example of this is from the Disney movie *Aladdin*: In one scene Aladdin refers to his love interest, Jasmine, as his crazy sister in order to get them out of trouble. Besides cartoons, movies may feature characters with mental illness. For example, one popular movie, *Terminator 2*, opened with the main character walking

in an old fashioned asylum. Other movies, such as *Silence of the lambs* and *American Psycho*, feature psychotic killers. As well, many songs reference labels society often uses to implicate a mental illness.

Additional data establishes that references to mental illness are common. It was found that 46.1% of the 128 TV episodes studied, including animated, non-animated, and

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real life shows, included at least one reference to mental illness (Wilson, Nairn, Coverdale, & Panapa, 2000). Cartoons had the most references. Furthermore, many of the references to mental illness were used in connection with actions rather than the character's actual mental state (Wilson et al., 2000). This indicates that words have the potential to be applied in ways that have varied uses. Also, many of the characters with mental illness were also male, and the characters either served as comic roles or as villains (Wilson et al., 2000).

Lastly, the Internet and video games may also be a factor influencing society's thoughts about mental illnesses. Unfortunately, there is limited information about how the Internet and videogames affect the public's perception of mental illness. It has been shown, though, that while the Internet is often used by the public for knowledge of medical disorders, it is less often used to find out information about mental illness. For instance, one study found that 63% of people who surf the web in the United States searched for general health information, but only 21% searched for mental health topics (Stout et al., 2004). It is also important to note that some websites may not have credibility or validity in order to provide correct health information. Therefore it is

necessary to ensure that the content is accurate by using appropriate resources if an individual chooses to use the internet to learn more about mental illnesses.

Who Believes What

The demographics of who may perceive mental illness as the most unacceptable seem to depend on various factors, such as socioeconomic status. Accordingly, family

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income and the size of housing have an impact on the amount of avoidance of social interactions with a person with mental illness (Martin et al., 2000). In addition, people at with higher incomes are more likely to avoid contact with those with mental illness (Martin et al., 2000).

More elements that contribute to the formation of negative attitudes include demographic factors, knowledge, and possible personal experiences (Addison & Thorpe, 2004). Other research also suggests a consistent finding that those who are older, less educated, and in lower classes to have less favorable attitudes of people with mental illness (Addison & Thorpe, 2004). Interestingly enough, this exact demographic group is the most likely to suffer from mental illness (Addison & Thorpe, 2004). This is a major disadvantage because their own attitudes and demographic group attitudes will make it harder to give and receive support (Addison & Thorpe, 2004). If someone in this demographic becomes afflicted with a mental illness, it is likely that they will not accept the diagnosis, not receive treatment, and therefore progress with the psychological disorder.

The attitudes in this group seem to stem from inadequate knowledge about mental illness (Addison & Thorpe, 2004). Research finds a positive relationship between the amount of knowledge one holds about mental illness and tolerance of mental illness (Addison & Thorpe, 2004). Likewise, the less knowledge one has about mental illnesses, the less tolerant they would become of people with them. As support, studies showed that negative or stigmatized attitudes about mental illness were associated with lack of knowledge about mental illness (Addison & Thorpe, 2004).

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In addition, gender seems to have an impact on attitudes toward people with mental illness. Research finds that men tend to have higher scores of the level of negativity associated with various aspects of mental illness, including the ability to recover from the mental illness (Kobau et al., 2010). Men's scores on negative stereotypes, recovery, and outcomes may be a result from the traditional and assumed roles of masculinity in society (Kobau et al., 2010). Efforts to address the issue include recent public anti-stigma campaigns, like Real Men, Real Depression, have made efforts to expose myths about mental illness in men (Kobau et al., 2010). These campaigns may help some men understand more about mental illness and accept treatment of a mental illness or help others to seek treatment.

Adults in the age group 18-24 who do seem to have slightly more negative attitudes towards those with mental illnesses may also suffer as a result of this viewpoint (Kobau et al., 2010). This is significant to the people in this age group because many mental illnesses have an onset during early adulthood. Negative attitudes may hinder

when or what type of treatment is sought out, if any. Stigma associated with mental illness also reaches the people in this age group.

Children and younger teenagers also seem to have more negative attitudes toward people living with mental illness. For example, research conducted with 14 year olds indicated biased, negative attitudes towards people with mental illnesses. In addition to less favorable attitudes toward people with mental illness, children might be exposed to more stigma than adults (Rose, Thornicroft, Pinfold, & Kassam, 2007). Research finds

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that young people often feel that mental illness is embarrassing and needs to be kept and handled in a private manner (Rose et al., 2007). There is a need to keep the mental illness to oneself rather than to disclose it in order to avoid the stigma, prejudice, and discrimination that they feel people with mental illnesses often receive.

A study that included 14 year old participants analyzed respondents' avoidance of treatment due to stigma attached to being diagnosed with a mental illness and what they think about others with mental illnesses (Rose et al., 2007). The main themes found in the data were derogatory terms, which comprised about half of the responses, emotional states, psychiatric diagnoses, violence, and a theme which recognized confusion in young people between physical and mental health issues (Rose et al., 2007). The popular derogatory words were all mainly slang words used to describe people with mental illnesses. They included such words as freak, screw loose, and weird (Rose et al., 2007). Examples of negative emotional states included embarrassed, confused, and disturbed (Rose et al., 2007). This also indicates a reflection of many of the attitudes that

people with mental illnesses often encounter on a daily basis: negative. The use of psychiatric diagnoses included schizophrenia and depression (Rose et al., 2007). There was also evidence of confusion among different types of mental illnesses and connecting or inter-relating them to physical disabilities and/or learning disabilities. This was evidenced by responses to people with mental illnesses through the use of words such as wheelchairs, spastic, dumb, and demented (Rose et al., 2007). Finally, results of the study showed that three-quarters of the most commonly occurring words towards people with mental illness were negative, 16% were neutral and only 9% were empathetic

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responses (Rose et al., 2007). This also reflects a need for more education about mental illness for this age group.

Ethnicity and cultural background may also influence what beliefs are held about people with mental illnesses. For example, adults of Hispanic background held more negative beliefs about people with mental illness (Kobau et al., 2010). This may stem from traditional practices and beliefs about symptoms and causes of mental illness. For example, Hispanic-Americans with less education often believe that epilepsy results from sinful acts (Kobau et al., 2010). Applying the same rationale behind the causes of mental illnesses, it is likely that exposing traditional cultural beliefs impacts views and attitudes toward people with mental illness. Furthermore, studies done surveying diverse respondents from a community college show that those with more familiarity with people who have mental illnesses are those who are married (Corrigan et al., 2003). Males tend to have less familiarity with mental illness than female respondents do (Corrigan et al.,

2003). Therefore certain races or ethnicities may affect how one perceives mental illnesses.

As far as labeling goes, studies show that there is reluctance in some groups to self-label. In dealing with the recognition of a mental illness, research shows that African-American men were the least likely to self-label, with 4.2% (Estroff, Lachicotte, Illingworth, & Johnston, 1991). White men were the most likely to self-label with 43.6% (Estroff et al., 1991). African-American and white women self-labeled in similar proportions around 37.5% and 36.4%, respectively (Estroff et al., 1991). Over time, though, white women and white men are more likely to un-label themselves by

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disregarding the presence of the mental illness later in life (Estroff et al., 1991). African American women were consistent with self-labeling and African American men were likely to continue not labeling themselves (Estroff et al., 1991). Research also shows that married people and those with children are also less likely to label themselves as having a mental illness. The reluctance of not recognizing the possibility of mental illness has detrimental effects on the individual because the result is delayed care. People who denied the mental illness or symptoms looked for treatment about seven years later and, if hospitalized, occurred about four years later than the others (Estroff et al., 1991). Overall, the denying or refusal of the diagnosis was detrimental to their health.

In conclusion, the diagnosis of a mental illness can label an individual right from the beginning. After the shock or relief that there is finally a diagnosed cause of symptoms of mental illness, the individual now moves on to continue life and face the consequences of the attitudes toward psychological disorders in their society.

Consequences

Effects on Society's Attitudes

As a result of the average Americans' outlook on mental illness, those who have a diagnosis are likely to be negatively affected. Judgments and attitudes affect interactions with people experiencing mental illness, receiving proper treatment or medications, patient adherence with treatment, and quality of life issues. Basically, mental illness diagnoses often come with the additional burden of a negative label that can prevent people from seeking care and cause social effects that encompasses family problems,

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difficulty obtaining jobs or obtaining public office positions (Lai et al., 2000; Clark, 2008).

Persuasive images and portrayals of those with mental illnesses leave many Americans hesitant or fearful to interact with individuals with these diagnoses; they may also contribute to decreased self-esteem. As examples, research finds that 38% were not willing to be friends with someone with a mental health issue and more than 68% were not willing to have someone with mental illness marry into their family (SAMHSA, 2008). It is clear that having a mental illness has social effects that strain relationships with family, friends, and everyday interactions for the majority of people.

As well, many parents do not want their children to closely associate with other children who have mental illnesses: according to a research team at the University of Indiana, Americans were also more likely to socially reject children with mental health issues (Center for the..., 2007). Research points out that many parents did not want their

children becoming friends with children diagnosed with mental illness nor let them over to their houses for socializing (Center for the..., 2007). More specifically, 30% of participants would not like their child to be friends with a child with depression (Center for the..., 2007). Almost one in four participants said the same thing about ADHD (Center for the..., 2007). Roughly 20% said they did not want a child with either ADHD or depression living next door (Center for the..., 2007). These numbers reflect the attitude of many Americans towards those with psychological disorders, which also spreads to children. Therefore, beliefs from parents concerning mental illness may transfer to their children. The sheltering of children from others with some forms of

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mental illness may make the child fearful of the unknown; this can contribute to the child not accepting the person with mental illness and allow him to form misconceptions. This allows negative philosophies a new population to carry on any prejudices as opposed to tolerance.

In another study, it was found that a significant amount of participants said that they would avoid an individual with schizophrenia or major depression (Martin et al., 2000). Almost half of the respondents said they would shun the person with schizophrenia and almost four out of ten, or 37.4%, indicated a similar unwillingness to have social interactions with a person suffering with major depression (Martin et al., 2000). More numbers indicate similar findings: on average, almost seven out of ten respondents, 68.4%, said they were not willing to have someone with drug or alcohol dependency, schizophrenia, or depression, marry into the family (Martin et al., 2000). Therefore, a majority of families are against forming intimate relationships with people with a range of psychological disorders. Also, 58.1% were also not willing to have

people suffering from a mental illness as coworkers (Martin et al., 2000). Even as coworkers, a majority of people are hesitant to have relationships with people who experience mental illnesses.

Other studies show that 70% of participants disagreed that a person with mental illness could pull himself together if he tried, but 30% disagreed that a person with mental illness could recover eventually (Kobau et al., 2010). The majority of individuals think that a person with a mental illness could not work through a mental illness even if there was an attempt. This indicates beliefs that a person with a mental illness may only recover with the urging of an authoritarian person ensuring the recovery, maintenance,

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and treatment of the individual. Additionally, society members feel differently about people who have a mental illness and are not in treatment versus people who have a mental illness and are not in treatment (Kobau et al., 2010). This confirms that there may be more acceptances if the individual is actively going to treatment.

There is a common theme about the stigma of mental illness, and not just in the United States. In the United Kingdom, for example, a public survey indicated that over 80% of the participants agreed that the majority of people are embarrassed by individuals with a mental illness and that 30% agreed that they themselves were embarrassed by people with a mental illness (Byrne, 2000). If this is the case, then other research studies may not be reflecting high enough numbers of the amount of discrimination that actually occurs. Another possibility of the study's results may be due to a response bias. These numbers show that a lesser number of people are willing to admit that they possess negative feelings about mentally ill people and are more ready to share that they believe

others have those thoughts. There is an unwillingness to admit prejudice. Again, this could stem from their own embarrassment, absence of knowledge, or fear of provoking negative thoughts towards them for feeling prejudices or stigma.

Effects on People with Mental Illnesses

Due to the effects of media on attitudes, people with mental illnesses receive the aftermath of biased behaviors and interactions, both directly and indirectly. According to research, people with mental illness experience all of the features of the stigma process (Stout et al., 2004). People with psychological disorders are cast aside after labels are designated; this connects them to unfavorable characteristics and thus allows for

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discrimination to occur (Stout et al., 2004). Many factors determine how this discrimination occurs. Some sources that contribute to negative attitudes regarding mental illness include labels, misinformation, and lack of contact (Stout et al., 2004). In fact, the Surgeon General's first major report on mental illness in 1999 identified discrimination and stigma as one of the major barriers of seeking treatment for a mental illness (Stout et al., 2004). Some contend that stigma is the main reason why many Americans do not seek treatment (Stout et al., 2004).

Additionally, research finds that people generally paralleled several perceptions toward those with mental illnesses: fear and therefore exclusion, the belief that people with mental illness need life decisions made by others because they are not responsible, and that people with mental illness need to be taken care of like children (Corrigan & Watson, 2002). These stereotypes that influence how others interact with people with mental illness may not apply to the majority of people with the diagnoses. Additionally,

fear may spread and the thought that people with mental illnesses are irresponsible and childlike is degrading to the individual when it is neither applicable nor warranted.

People with mental illnesses experience more negative effects, both from societal views and from the illness itself. Research notes that suffering and disability contribute significantly to the prominent effects of mental health issues for those they affect (Clark, 2008). Although there is no sure measure of the suffering a mental health issue poses for the diagnosed individual, measures do show that the disability caused by mental illness is substantial. For example, results from a study done by the National Alliance on Mental Illness involving 465 participants with severe mental illness found that about 23% of

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people with psychological disorders needed help with basic activities of life, 74% needed help with skills for living in a community, and 73% required assistance with finding jobs (Clark, 2008). The same study also showed that 63% of people diagnosed with a serious mental illness needed help from family when interacting with friends socially (Clark, 2008). Thus, basic life issues can be affected from mental illness that influences other's perceptions of the diagnoses as well as the sufferer. Social lives are often severely affected by altered self-esteem and previous encounters with stigma.

Another effect of societal attitude towards those with mental illness is evidenced by the large number of mentally ill who are incarcerated. Research finds that some people with mental illness are incarcerated as an alternative due to the scarcity of mental health resources (Clark, 2008). Furthermore, almost three fourths of juveniles who are arrested have at least one mental disorder (Clark, 2008). The lack of facilities for

adolescents represents a significant obstacle in providing a resource for treatment opportunities.

Moreover, almost 16% of inmates have been previously diagnosed with severe mental illness or hospitalized due to the illness (Clark, 2008). Thus, people with mental illness may be placed in jail rather than receiving appropriate treatment.

Although people with mental illnesses are often stereotyped as dangerous, the facts indicate this risk is greatly exaggerated (Clark, 2008). According to the Substance Abuse & Mental Health Services Administration, the connection between people with mental illness and the perceived amount of violence is the source of discrimination and stigma (2003). For example, according to a mental health report from the General

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Surgeon, 61% of Americans believed that a person diagnosed with schizophrenia would be dangerous to others (SAMHSA, 2008). In actuality, there is little evidence between criminality and violence simply due to the fact of mental illness (SAMHSA, 2008). Studies have shown that people with severe mental illness are attacked, raped, and mugged two and a half times more than people without mental illness (SAMHSA, 2008). Thus, people suffering from mental illness are more often the victims of violence and criminality. This should help dispel myths about the majority of people with mental illnesses posing a threat to society's safety (Clark, 2008). Furthermore, studies showed that people with anxiety disorders were the victims of sexual assault more often than those without mental illness (Clark, 2008). Similarly, people with schizophreniform disorders were the recipients of more threats of assault as well as actual physical assaults than individuals without mental illness (Clark, 2008). These misconceptions can hurt

those diagnosed, make others fearful of interactions with those with psychological disorders, and allow those who hold them to possess false knowledge.

Studies have also found that there are certain mental illnesses that people feel the most strongly about in relation to how much danger the diagnosed individual poses to society. The top three include schizophrenia, alcoholism, and drug dependence (Kobau et al., 2010). Interactions with specific illnesses are then affected if it is known that an individual suffers from mental illness. Research also shows that violence that does occur is often related to violence experienced in the physical environment, personal experience of being a targeted victim, and substance abuse (Clark, 2008). Consequently, past

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experience with fighting to survive as related to various causes is a main cause of the violence.

Moreover, various stigma and societal perceptions that influence many factors of life and daily interactions mold psychosocial factors. Psychosocial factors are prominent issues that need to be addressed in order for a quality life. While every individual life varies according to experience, patterns exist that link those living with mental illness and their views on life. According to research, psychosocial affects in their lives are the cause of making people with mental illness lonely due to social isolation (Ernder, Andersson, Magnusson, & Lutzen, 2009). This feeling of being an outsider deters the individual from seeking out healthy relationships and maintaining them. Also, it has been found that those with mental illness may be afraid to form and maintain relationships, therefore contributing further to the existing loneliness (Ernder et. al,

2009). Mixed feelings prevent a number of people with psychological disorders from sorting out their feelings in order to fulfill meaningful social interactions; this confirms a notion of deviant identity and makes people suffering from a mental illness pessimistic about the capability to change this identification (Ernder et al, 2009). Without motivation to keep trying to forge meaningful relationships, the cycle of loneliness and depression is able to continue. Because of the loneliness, studies show that many people with mental illness claim that having pets helps them because they are more loyal and able to adapt to the owner's health (Ernder et al., 2009). The attributes that some of the participants in the study attach to animals, such as dogs and cats, are not often seen by people. People

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are not seen as adaptable, tolerant, and accepting, while the animals have no prejudice and unconditionally show positive characteristics.

Family members, too, share the impact of stigma on their lives. According to one personal account of a sibling talking about the stigma towards her brother's schizophrenia:

For me stigma means fear, resulting in a lack of confidence. Stigma is loss, resulting in unresolved mourning issues. Stigma is not having access to resources... Stigma is being invisible or being reviled, resulting in conflict. Stigma is lowered family esteem and intense shame, resulting in decreased self-worth. Stigma is secrecy... Stigma is anger, resulting in distance. Most importantly, stigma is hopelessness, resulting in helplessness (Byrne, 2000, p. 66).

This account shares that stigma makes it hard to accept the illness and seek treatment.

The family member also shares that the mental illness causes strains on family relationships and conjures up many difficult emotions.

Studies also show that siblings of individuals with mental illness are also affected. The genetic attribution of mental illness also increases social distance of individuals

towards the sibling, especially with relationships that are romantic, including dating and marriage, which also affects reproductive matters (Phelan, 2005). This further supports the courtesy stigma that family members often receive if related to someone with mental illness.

The experience of stigma also conjures up words such as what is described in personal accounts. Thoughts include shame, secrecy, the outsider of the family, social exclusion, and discrimination (Byrne, 2000). Stigmatization as a result is often recognized through distrust, fear, embarrassment, anger, and avoidance (Clark, 2008). With such unfavorable characteristics, stigma deeply affects the victim being addressed by it. This can lead to internalized stigma that may worsen the presenting symptoms of

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the mental illness (Corrigan et al., 2003). This allows a cycle that consists of public stigma, self-stigma, and low social support to occur.

Labeling: How it Happens and its Effects

The degree of stigma and labels also varies with what type of mental illness is diagnosed (Clark, 2008). For example, depression is often more accepted than schizophrenia, in which eccentric behavior may occur (Clark, 2008). In addition, depending on what diagnosis is found, there are often specific words that label the individual. For example, one study notes unpredictable, strange, and dangerous as stereotypes that describe schizophrenia (Lai et al., 2000). Depression often receives labels such as emotionally weak and unproductive (Lai et al., 2000). Patients who have attempted suicide often receive labels such as bad, disturbed, or unbalanced (Lai et al., 2000). These types of studies show that stigma often occurs as a result of labels, not

from the illness (Lai et al., 2000). Labels are what instigate the formation of stereotypes, which may or not apply to any individual, not just those with a psychological disorder. For example, when compared with cardiac patients, there are diverse associations between physical and mental illness. Cardiac patients in the study were generally free of stigma and instead carried connotations such as fragile and received sympathy instead of negative attributes (Lai et al., 2000).

People with mental illness are also often depicted as inadequate and unlikeable (Stout et al., 2004). Individuals with mental illness were also not favored as employees and were thought of as unsuccessful when employed (Stout et al., 2004). Other research

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reflecting the amount of dangerousness in these individuals has found that 72% of characters on television were presented as such (Stout et al., 2004).

One study also points out that society often has different beliefs about what causes mental illness and how to treat it than those people in the mental health profession (Addison & Thorpe, 2004). While many mental health professionals accept people with mental illness and assist in their treatment and maintenance with empathy and tolerance, the general public still largely does not. An example of this is demonstrated in another research experiment that suggested that the majority of participants felt that someone suffering from a mental illness brought up in the study would be difficult to talk to (Addison & Thorpe, 2004). They may feel like those with psychological disorders are different and therefore cannot relate to them.

Therefore, negative attitudes demonstrated by many people in society affect the lives of people living with psychological disorders. Another significant consequence that occurs as a result of actions such as labeling is effort to hide the mental illness. The attempts of secrecy towards mental illness present a challenge in treating mental illness (Byrne, 2000). In turn, this contributes to the stigma associated with mental illness. Unlike physical illnesses, people with mental illnesses are often ostracized from any potential support that might have been received (Byrne, 2000). The removal of potential supports is often due to intolerance, fear, shame, and prejudice and usually results in poorer outcomes because social networks may not be available (Byrne, 2000). Like a double-edged sword, patients' choices seem to be either to hide the illness and therefore resist recognition and treatment of the illness, or to recognize the mental illness and risk

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the loss of social networks, the same social networks that would be needed in the patients' attempts to recover or treat the illness with support rather than stigma and prejudice.

There are also common factors that contribute to the prejudices and labels that can be formed towards those with mental illness: unkempt appearance, the presentation of an acute episode of the mental illness, and low socioeconomic standing (Byrne, 2000). The perception that a mental illness is chronic and incurable, that treatments are needed like drugs to stay well, the perceived notion of violence, the perceived knowledge about the disorder, the thought that they are not in control of actions, and the number of hospital admissions also drive discrimination (Byrne, 2000). These perceived thoughts toward mental illnesses are detrimental for the diagnosed and leads to intolerance from those

who possess the prejudices; this has a major effect on people trying to cope with mental illness.

The importance of not categorizing people with mental illness versus people without mental illness would reflect movements towards change. Meanwhile, these categories are still happening. An example of this is highlighted: The author of *Media Madness* shares his account of trying to open a group home for six females with mental illnesses to return to their communities from hospitalization: one resident at a public meeting about the group home objected to the placement of the home because the neighborhood had elderly and children living there (Wahl, 2003). This resident believed that the patients posed a danger to the older and younger population of the community and were vulnerable victims. Another community member rejected the idea of the group

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home because he was small, in reference to his stature (Wahl, 2003). He believed that he himself could be a victim to the members of the group home, unable to defend himself. This is another example of beliefs in society that people with mental illnesses pose a danger to others in communities and that his height would be a detriment in fending off the clients and to his safety. Lastly, another member argued that their neighborhood would not be suitable for the group home because the community was near a busy intersection and the clients would not be able to cross the street safely (Wahl, 2003). This comment in support of opposing the establishment of the group home argued that the potential clients would not be able to take care of themselves and need authoritarian figures in their lives. Overall, the members of this community represent others across the United States in their misconceptions and stereotypes of people with mental illnesses.

Personal Accounts

The only people who know what it feels like to be discriminated against for having a mental illness are the people who suffer through the discrimination. There are long-term effects, stresses, and worries that in turn affect their lives. Personal accounts and feelings about their own mental illness and others' reactions toward their mental illness demonstrate how much it affects their quality of life. For example, in one research study, a patient with schizophrenia shared how it made her feel like her life was over when she was diagnosed by describing it as a death sentence (Estroff et al., 1991). Other patients try to minimize the diagnosis: "I think everyone's got a little mental illness. It's just some know it and some don't" (Estroff et al., 1991, p. 331). Another patient explained

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that she disappeared from the world after being diagnosed as schizoaffective (Estroff et al., 1991).

In efforts to cope with the diagnosis of a mental illness, some patients reject the diagnosis. This may lead to the worsening of symptoms and noncompliance with medications. Others, like people who have schizophrenia and may hear voices, may excuse the voice as a religious experience and not mental illness (Estroff et al., 1991). Others may go the opposite route and believe they are possessed by demons or Satan rather than acknowledging the mental illness.

During a study that analyzed the way informants discussed their mental illnesses, researchers found that there was a method that some of the participants used in order to minimize the illnesses. Researchers called this normalizing talk, an attempt to relate to

the researchers and prove that they were both just people (Estroff et al., 1991). A researcher explained that there were different types of normalizing talk, ranging from defiant to urgent tones (Estroff et al., 1991). Despite the tone, normalizing talk always had the same purpose: to persuade the researcher to realize that they were just like them, regardless of the mental illness (Estroff et al., 1991). An example of a patient demonstrating normalizing talk occurred through this account that claimed everyone has mental illness: “I don’t think I’ve got anything unusual. People just want to argue with you. To me, someone who’s impotent and can’t get it up is in worse shape. If you listen to everyone, you’ll go crazy” (Estroff et al., 1991, p. 338). The informant took a medical disorder and said it would be worse to have that than her mental illness. Another participant attempted to take the focus off of her mental illness and move it towards

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psychiatrists: she claimed she was healthy and normal and that they did not have enough knowledge on how to treat her (Estroff et al., 1991). Another instance in the study of normalizing talk was expression of being able to relate to another person with the same mental illness diagnosis (Estroff et al., 1991). This also demonstrates the importance of support groups and the understanding that the person is not alone, that there are others with the same diagnosis that are going through possible difficulties as well.

Many times after the informants’ normalizing talk was finished, the researchers noted that they moved on to discussing the possible chronicity and disability that may result from mental illness (Estroff et al., 1991). One informant shared how she did not want to spend her whole life knitting: “And sure I could do it now, but it upsets me to think about doing it now, because I get afraid that I’ll settle for that. I’ll spend my life

being mentally ill knitting, you know. And God, I don't want to do that" (Estroff et al., 1991, p. 345). She explains what she thinks her future could hold for her as a result of her mental illness; it entails one simple activity representative of losing a meaningful life according to how she thinks the diagnosis will affect her.

Stigmatization of the mentally ill may also affect access to community resources, such as those connected to housing and employment (Clark, 2008). This creates additional stressors in their lives and may contribute to progression or symptoms of the mental illness.

Furthermore, stigmatization results in to low self-esteem, further isolation, and hopelessness (Clark, 2008). At the population level, the degree of stigmatization affects the choice to allow or fund mental health facilities (Clark, 2008). This is also a deterrent

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in allowing people to be treated and affects the allocation of appropriate resources for the mentally ill in the community. This also contributes to other potential psychiatric disorders, such as depression, which could lead to suicidal thoughts.

Changes in the Lives of People with Mental Illnesses

Awareness of the stigma and stereotypes that attach to mental illness causes a number of aspects of life to be affected for individuals. For example, a number of people with schizophrenia or depression believed that stigma had a negative effect on many aspects in their lives, including social relationships, their perception of self-worth, and employment (Lai et al., 2000). Furthermore, research finds that a majority of patients believed that the public needed to be more aware and knowledgeable about mental illness (Lai et al., 2000). The voicing of this in large numbers will be needed in an attempt to aid this in

happening. Additionally, some people reported that they were treated differently, ignored, or talked to in a condescending way that lowered their self esteem (Lai et al., 2000). In a questionnaire containing responses from those with schizophrenia, 52% of the participants felt lowered self-esteem, 47% felt ashamed of the illness, 51% expected social rejection, 73% found difficulty getting a job, and 40% were reject for insurance coverage (Lai et al., 2000). For those with depression, 57% of the population felt lowered self -esteem, 33% were ashamed of depression, 28% expected social rejection, 44% found difficulty getting a job, and 10% were rejected for insurance coverage (Lai et al., 2000). With so many areas of daily life being affected, having a psychological disorder complicates life in ways that should not occur.

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In addition, studies show relationships with religion also change as a result of the mental illness diagnosis. Studies show that over 54% of participants experienced a change in their religious beliefs, either with a stronger or weaker relationship (Rogers, Malony, Coleman, and Tepper, 2002). About 66% of people believed the change to be for the better (Rogers et al., 2002). A larger number of patients diagnosed with mental illness turn to religion or the strengthening of religion while a lesser majority turn away from it. But research shows that those who believed their religious change was positive showed less symptoms of their mental illness while those who believed it was negative did not (Rogers et al., 2002). Thus, these findings may offer a possibility of becoming an issue that people with mental illness may face and could be considered in the treatment (Rogers et al., 2002). People who adopted positive changes in religion were able to live

more quality lives. In order to deal with difficulties or frustrations, such as the stigma experienced by others in society, individuals who reported a strengthened, more positive relationship with religion after mental illness reported the use of prayer as the most used form of religious activity (Rogers et al., 2002). Worshipping God, going to services, reading scriptures, and meditation were also reported as means of coping with difficulties in life (Rogers et al., 2002). In addition, those who reported a negative relationship with religion after being diagnosed with religion demonstrated more obsessive compulsive behavior, depression, and anxiety (Rogers et al., 2002). This reflects a need to find another option to cope with the daily frustrations and difficulties that having a mental illness brings. For this group, religion was not a factor in coping with a mental illness;

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this is a reason why their weakened connection with religion often occurs (Rogers et al., 2002).

Other facets of life affected by a mental illness are also evident. Besides daily interactions, sexual relationships, due to possible tension with social interactions, are also affected. Because the importance of having an intimate partner is likely to reflect upon mental and emotional and physical well-being, this area of their life may be a factor in coping with mental illness or not coping with it (Wright, Wright, Perry, & Foote-Ardah, 2007). But many people with severe mental illness face challenges when finding romantic relationships, especially if the person suffers from severe mental illness (Wright et al., 2007). Analysis explains various theories as to why sexual isolation is often seen. These include limited access to partners, sexual dysfunction, issues with forging

relationships, wanting to avoid sexually transmitted diseases or a pregnancy, environments that are restrictive sexually, such as with treatment centers, quality of relationships, the feeling that the mental illness just gets in the way, and feeling devalued and withdrawn from others (Wright et al., 2007). Reasons for sexual inactivity result from stigma, social isolation, loss of social status, rejection, and daily hardships (Wright et al., 2007). Another reason for sexual isolation is the fear of being rejected due to the diagnosis (Wright et al., 2007). This reduces the access of sexual and intimate partners. In addition, research shows that males with mental illnesses and those with lower levels of functioning were more likely to be sexually inactive (Wright et al., 2007).

People with severe mental illness also discriminate against others with severe mental illness, asserting that they would not have sexual relationships with their fellow

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clients. The cause of this varied from financial reasons to other stereotypes. For example, one woman expressed that she would not get married to another person with mental illness because they have too many problems, such as with employment, medications, and bills for treatment (Wright et al., 2007).

Another Caucasian gentleman with schizophrenia was not attracted to any of his fellow peers, claiming that all of the females were either fat or lazy they're lazy and that the less signs of mental illness they show, the more attractive they are (Wright et al., 2007). He perceives visible signs of mental illness in patients, even during maintenance stages, and is consequently not attracted to females with psychological disorders. Additionally, he stereotypes all women with mental illnesses as fat, lazy, or ugly.

Lastly, some people with severe mental illness feel superior to their peers due to delusions of grandeur. One patient claims that all of the patients in a state hospital are lower class and that most of the clients have an intelligent quotient below 100; for this reason he does not have anything in common with them (Wright et al., 2007). This patient in the state hospital separates himself from his fellow peers even though he has no way of knowing their intelligence without proof or contact.

Others cited that as soon as partners they were involved with left treatment centers, they left behind the partner as well. Some clients ascertained that they themselves need to cope with the mental illness as well as with experiences they have had with others as a result of stigma. So, they choose not to be in a relationship (Wright et al., 2007). In addition, dealing with issues such as education, housing discrimination, and employment discrimination takes up others' times, hindering their ability to find a

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mate or spouse (Wright et al., 2007). Internalized stigma and devaluing of self is also shown through other respondents in the study due to expressions of feeling undesirable or lacking some kind of quality that one needs in order to be a potential mate (Wright et al., 2007). Feelings such as these hinder the opportunity for support as well and the ability to find a spouse. This may contribute to symptoms of mental illness for studies show that people with severe mental illness have a better prognosis if they are able to find and maintain a romantic relationship with an intimate partner (Wright et al., 2007).

Recommendations

Recognizing Mental Illness

Bill Clinton once stated: “Mental illness is nothing to be ashamed of, but bias and stigma shame us all” (“Quotable Quotes,” 2007, p. 1). In order to remedy this bias and stigma, changes must happen in our society. Many steps will be needed in order to result in changes.

First, those diagnosed with mental illness must recognize that it is a health issue. Addressing attitudes of those with mental illness towards themselves is necessary to correct the perception of mental illness. Suggestions for how to accomplish the acceptance of mental illness may occur through therapy in order to form their attitudes as well as allow others to understand mental illness.

Looking For Causes

Discrimination is caused by many reasons. Looking into the causes of stigma toward people who have mental illness is a way to confront the behavior and attempt to remedy it. Various reasons include the perceived notion of violent tendencies

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from people with mental illness due to the media, misunderstandings such as that the disorder may be communicable, fear due to lack of knowledge, shame of having contact with someone that has illness, the inability to recover, or that the illness was caused by bad character (Arboleda-Florez, 2002; Noe, 1997; Byrne, 2000). In addition, other factors, such as homelessness and poverty, appearance such as hygiene and race or weight, and hospitalization may affect how society judges individuals with mental illness, rather than the actual illness itself (Byrne, 2000).

Discrimination also occurs from health insurance companies. Health insurance is often difficult to obtain for people with mental illness. This leads to many people not

being able to receive treatment and therapy that may be needed due to either the complete lack of insurance or possible limitations of available insurance (Noe, 1997). Additionally, research shows that people with mental illness are reimbursed less than those without mental illness and that 79% had more limitations regarding hospitalization as well as limitations regarding the number of outpatient visits (Noe, 1997). The need for reform with insurance coverage is apparent. Advocacy through organizations, such as the American Psychiatric Association, family, friends, and from those who have mental illness can work to demand greater parity with healthcare coverage. Petitions, media coverage, writing to representatives, and lobbying may help with the attempt. Although a gradual process, these steps bring the issue to the attention of the public.

The Americans with Disabilities Act also states that employment should be equal opportunity, yet there are still cases concerning job loss with complaints that the cause

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was the mental illness (Noe, 1997). Still, the most legal action concerning this act involves discrimination with those with mental illness (Noe, 1997). One way to improve employment includes supported employment. Supported employment allows individuals with mental illness to be gainfully employed and be part of the community and may include services such as job matching, counseling, and continuous support, such as with skills training (Drake, 2008).

As well, The Fair Housing Act was also put into place to help ensure the absence of discrimination when finding places of residence, yet many people with mental illness often face obstacles with obtaining housing. In addition stigma, toward mental illness

acts as a deterrent from funding in federal and state budgets. Claims should be reported to the U.S. Department of Housing and Urban Development. Other ways to fight for rights with housing include legal activity on the local level to higher level courts. Coalitions may also be formed to recognize and advocate equal housing rights. Outreach programs for public education regarding rights could also be initiated through grassroots organizations.

Once parity is truly achieved for people with mental illness, this type of discrimination may be eliminated, presenting an opportunity to alleviate stigma that impacts the major areas and basics of life.

Treatment Options

Various treatment and therapy options exist with goals to emphasize the belonging of people with mental illness in the community as strong contributors and aid with empowerment and self-esteem.

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For example, using recovery models with treatment impacts the lives of people living with mental illness. The psychiatric rehabilitation models as well as the recovery model, for examples, aim to improve the self-esteem and function of people with mental illness. The psychiatric rehabilitation model focuses on the individual's ability to cope with environmental stressors and then the skills to reduce them (Rossler, 2006). By aiming to reduce stressors involving relationships, leisure activities, and employment, quality of life improves. Issues in daily living are addressed, and the individual is able to work on strengthening the ability to control life; this goal is similar to the recovery model. The recovery model encourages the empowerment of the individual to make

decisions regarding important issues. People with mental illness should be actively involved in treatment decisions and then transfer this empowerment to other aspects of life. Using these models may help people with mental illness overcome and combat stigma by recognizing the ability to be strong.

One possible complementary treatment for a person with mental illness is to become involved in the arts. Doing so also allows them to evaluate their own thoughts as well as offer insight to society on what mental illness may feel like. According to art therapist Carol Coder, recovery is possible through gaining skills such as decision making and evaluation, reinforced through art (Romaker, 2009). These skills aid with treatment and long term acceptance and coping skills to help overcome the diagnosis.

In addition, if one chooses to participate in an art program, a support group and social network will be available to the enrollee. This will help build a support system and encourage discussion about mental illness. The potential efficacy of interacting with

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peers who also have mental illness contributes to recovery (Davidson, Chinman, Kloos, Weingarten, Tebes, & Stayner, 1999). The ability to share and hear other experiences from those who experience similar issues may offer new resources of aid and information. Benefits from support groups such as these serve to build social networks which aid in recovery, self-esteem, support, and enhanced quality of life (Davidson et al., 1999).

In these groups, artists with psychiatric disorders are able to express themselves through their artwork in order to let out emotional distress, realize what their main issues

are, and cope with them (Rustin, 2008). This type of subsystem of care is beneficial because people may be unable to express their feelings through words (Rustin, 2008). Poems, too, can be used as artistic expressions of mental illness of what it means while sorting out possible mixed emotions. Overall, the expression of mental illness through art may help others understand how it affects their lives and deserves to be treated just like any other illness.

Watching Our Words

Another recommendation to recognize and combat stigma and prejudice against those with mental illness is to introduce vocabulary that identifies these actions. For example, racism, ageism, sexism, and homophobia all identify certain prejudiced beliefs. No such terminology exists to point out such discriminating behavior. Terminology that recognizes the fear of mental illness to the list would be the term psychophobic (Byrne, 2000). According to Thompson and Thompson, politically correct language has been a vital part in campaigns dealing with issues such as gender, religion, weight, and physical

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disability (Byrne, 2000). It is a possibility that if this vocabulary is introduced, it would make more people aware of what connotations and what affects the prejudiced thoughts towards the mentally ill hold.

Furthermore, it is vital to use appropriate terms when describing mental illness. Today's society uses words or phrases that depict people with mental illnesses as disorganized and chaotic. Derogatory, inaccurate, and hurtful phrases and terms are used daily and applied to those have mental illness as well as to everyday situations,

statements, and people. Efforts to combat this kind of vocabulary are steps towards changing the negative attitudes towards people with mental illness.

Another way to combat the prejudice against individuals with mental illness is to hold protests. These demonstrations can help build support to delete misconceptions that lead to stigma, fear, and bias by voicing in numbers those who oppose false portrayals of people with psychiatric disorders. A parallel to this is how there were movements held in the 1960s regarding racial discrimination against African-Americans. With marches, the power of many voices, and other gatherings focused on the rights of people with mental disabilities, it is possible to bring the core issues that people with mental illness face to the forefront in order to change the discrimination they face daily regarding housing, employment, and in society. But protests alone are not enough to change beliefs and give new information. Interaction and education would also assist in that area.

Encouraging Interaction

Furthermore, according to research, knowing someone with a mental illness is not enough to change attitudes or help an individual understand what it is actually like to

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have a mental illness (Byrne, 2000). Rather, it is necessary to interact with a person diagnosed with mental illness who has had had successful treatment or therapy (Byrne, 2000). This is in order to confront the stigmatiser with his or her irrational beliefs, in addition to enabling contact with “one of them.” An example of a study done by researchers Alexander and Link relates to this: by telephone, respondents shared how much social distance they would want with a homeless person with mental illness and how dangerous they thought the individual might be (2003). A sub-sample also read a

vignette about a character with mental illness and responded to similar questions. The study results show that with more contact with those with mental illness, the perceived dangerousness and amount of required distance from the character decreased (Alexander & Link, 2003). In conclusion, there is strong evidence supporting the amount of contact is important (Alexander & Link, 2003).

Education

The starting point to remedy ungrounded beliefs about mental illness starts with education. Research suggests that people who have more knowledge and information about mental illness are less prejudiced (Lai et al., 2000). One example of this is to publish articles regarding issues such as stigma aimed towards those with mental health issues. Campaigns may also be an integral part of education. Public health messages also work to reduce stigma. One campaign, called *Changing Minds*, has been successful with its attempts to publish these kinds of articles to initiate discussions about stigma (Byrne, 2000). Another discussion series that may be offered for students is MINDS, The Mental Illness Needs Discussion Series. As a school-based mental health awareness program in

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Michigan, it offers more information to the public, answers any questions, and confronts misconceptions. One day a year the program is offered in health classes at schools at participating schools. The program incorporates actual evidence of how mental illness is treatable by offering evidence such as visuals, such as magnetic resonance images of people with illness such as bipolar disorder (Bender, 2004). They also show posters of famous people who have mental illness in order to reiterate that mental illness can happen to anyone (Bender, 2004). The program surveyed students who participated and showed

solid evidence of its positive effects. For example, 82 % of students before the program agreed with the statement the mental illness are was treatable compared to 94% after the program (Bender, 2004). Furthermore, researchers also found that 31% of students agreed that people with mental illness were more likely to be retarded (Bender, 2004). Afterwards, the number declined to 12% of students who agreed with the statement. In addition, 47% of the students knew where to go to help someone or seek treatment for a mental illness; after the MINDS seminar the number rose to 80% (Bender, 2004). Lastly, the number of students who said they had experienced a mental illness increased from 17% to 27% (Bender, 2004). This included substance abuse (Bender, 2004). Changes in attitude and the level of knowledge an individual possesses can positively impact the lives of people who live mental illness. Positive attitudes, increased knowledge, and increased empathy will increase quality of life. For example, if society is able to be empathetic, they will be more able to offer help rather than discrimination (Kobau et al., 2010).

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Accordingly, educating Americans about what mental illness is is important. For example, 54.4% of Americans recognize schizophrenia as a mental disorder (Martin et al., 2000). Smaller percentages of Americans view depression and drug or alcohol dependency as mental illness, 20.4% and 13.3% respectively (Martin et al., 2000). It can be concluded that the definition of mental illness and overall education about mental illnesses is needed.

Additionally, it is suggested that psychiatrists need to be more exposed in the media as sources of information in order to help reduce the amount of stigma directed towards those with psychological disorders. (Stout et al., 2004). Instead, one study found that psychiatrists' opinions or thoughts about mental illness were not as respected due to the media attempting to create more entertaining news (Stout et al., 2004). Balancing newsworthiness and fairness must happen in order to help move media towards the change in how much negativity is portrayed to the public about mental illness (Stout et al., 2004).

These discussions and topic are helpful for professional circles, as well. The issue of stigma is an important one for fields such as nursing, social work, medicine, and other areas in the medical field. Educating the students in these fields is important because having the proper information about people living with mental illness gives students the power to change attitudes and stop the discrimination in their fields.

Fittingly, the field of nursing has the opportunity to contribute significantly in recognizing, preventing, and treating mental health disorders. Community health nursing, for example, may control mental health problems for the population as well as

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the individual. Using strategies such as mental health promotion, encouraging effective coping skills and resilience, and participating in risk-reduction interventions may help reduce the number of people that develop a mental illness (Clark, 2008). Nurses can also encourage the secondary level of prevention of illness, which is the adherence of medications or treatment. The tertiary level of prevention of further complications relates to maintenance of the illness. In order to manage the illness long-term, it is important to

combat stigma to enable the individual to continue to seek care for disease management rather than for crisis oriented care (Clark, 2008).

Combating Stigma

Another important way to combat stigma is to confront stigmatization from those who do deal with mental illness, such as mentioned earlier. Becoming an advocate of disseminating the correct information about their specific illness will help confront the incorrect beliefs.

The discrimination of people with one disorder can occur from those living with another disorder. For example, one man recovering from depression was opposed to a campaign that included both schizophrenia and depression by questioning why they wanted to “drag depression down to the level of the gutter” (Byrne, 2000, p. 70). When one shows intolerance towards a fellow sufferer of a psychiatric disorder, the person is also applying prejudice and stigma towards mental illness. This hinders the progress of combating the continuation of bias towards people with psychiatric disorders. Another example of discrimination came from a consultant psychiatrist: after listening to a woman living with schizophrenia give an articulate account about her experiences, the

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psychiatrist was noted as saying that the person could not be schizophrenic (Byrne, 2000). The recognition that every mental illness is displayed differently for every individual is vital in understanding the signs and symptoms of mental illness. Just like how physical illness may appear slightly differently in individuals, mental illness affects individuals slightly differently according to personality, life experience and severity of the illness. Understanding that every individual is unique and may showcase

different severities, symptoms, and signs of the mental illness is essential to decrease prejudice and negativity.

Combating the stigma directed toward people with mental illness in the media and in television shows may also be another way to minimize negativity. Informational segments would help the public gain accurate knowledge about mental illness. For example, news stations often show short segments highlighting medical disorders. Discussing mental illnesses on these segments offers a way to provide viewers with more knowledge about various disorders. Reality shows on television could also document the day-to-day life of individuals living with mental illness to show viewers how mental illness affects their lives and what it is like to have a mental illness as opposed to the portrayals shown on other fictional entertainment channels. In addition, more commercials through the public health administration may be shown to recognize people with mental illness and encourage acceptance in society by various aid campaigns. Public service announcements may also be made to indicate where possible treatment or information centers exist in order to seek treatment or learn more about mental illnesses or how to help others. Public figures, celebrities, and advocates may speak out about the

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issue of stigma and its relationship to mental illness using media. Political figures should also make the rights of people with mental illness a priority and people should be encouraged to write to their representatives regarding this issue. In addition, journal articles should be made accessible to the public and newspaper articles could also provide more information about mental illness. Another possible idea is to assign a national day of awareness to recognize mental illness. Campaigns, such as MINDS, can also be used

to target various demographics, such as with gender or age, to confront particular issues the group tends to have with mental illness.

Furthermore, studies also show that familiarity with mental illness, such as what occurs through interactions with the individual or from knowledge of the various disorders, reflects greater understanding and less negative interactions. For example, research shows that males tend to believe the person with mental illness is responsible for his mental illness (Corrigan et al., 2003). Therefore, there is a higher chance that people with mental illnesses will experience a greater deal of negative interactions, misconceptions, and fear from males. Males, and females, for that matter, who were more familiar with mental illness responded with less anger and fear and more pity (Corrigan et al., 2003). In addition, groups with more familiarity of mental illnesses more likely to oppose segregation (Corrigan et al., 2003). Coercion, such as endorsing forced entry into treatment centers for mental illness treatment, and segregation of people with mental illnesses, further complicate the lives of those with mental illness, separating people who live with mental illnesses into “us” and “them” categories.

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Conclusion

It is important to understand why stigma and negative perception of mental illness exists and what can be done to help those with these types of disorders live quality lives. It is vital that our society understand what mental illness is and not be afraid of it. In order to do this, misconceptions, misinformation and inaccurate or biased portrayals of mental illness need to be addressed as well as other factors that shape our attitudes.

While some Americans do report experiencing mental illness and subsequently receiving appropriate treatment or services, many do not. Increased funding for services, acceptance of diagnosis and treatment, and preventative measures are all needed (Mowbry & Holter, 2002). In the United States of America, as well as other countries around the world, there is work to be done in our efforts to overcome the stigma, prejudice, and discrimination toward people with mental illnesses. Whether it is through demeaning phrases, inequality in housing and employment, or everyday interactions, everyone must be conscious, respectful, and knowledgeable about mental illnesses in order to obtain full parity for people with mental illness.

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