

# A Social Marketing Approach to Challenging Stigma

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Providing psychological support to people with mental illness continues to be hampered by negative stigma. This article presents tools that help psychologists form partnerships with consumers to address the deleterious practice implications of stigma. This article describes a 3-stage persuasive method for attitude change regarding people with mental illness, developed and piloted in 2 antistigma social marketing campaigns by Idaho State University's Institute of Rural Health and the state of Idaho. The approach incorporates (a) methods to empower people with mental illness through a unique interactive process, (b) campaign design and distribution, and (c) methodology for evaluating effectiveness in the context of stigma. The model was applied to 2 Idaho projects, a multifaceted antistigma campaign pertaining to adult and child consumers and another regarding people of all ages with all disabilities, including mental illness. Participating in social marketing campaign development and evaluation provides new options for psychologists' practice.

*Keywords:* community mental health, mental health, social change, social marketing, stigma

People with mental illness and their caregivers often point to stigma as a major barrier to treatment seeking, treatment adherence, and overall well-being. Nationally, many antistigma campaigns exist, but it is not clear if they bring about social changes in attitudes and behaviors (Corrigan, 2005). Social marketing is increasingly used to address social change. In this article, we present a method to challenge stigma by empowering people with mental illness—through the support and assistance of mental health providers—to address stigma and its barriers to successful mental health interventions. The method is differentiated from public education campaigns for three reasons: (a) It is driven by

the people it is about, (b) it includes evaluation, and (c) the social marketing goals of attitude and behavior change are distinct from education and the heightened awareness it represents (Kotler & Roberto, 1989). The method uses a systematic strategy leading to a careful match between the message, the audience, and the delivery medium, making it both obligatory and possible to evaluate the campaign. Following this approach, we offer two campaign case examples from Idaho: (a) addressing stigma relating to mental illness and (b) addressing disabilities of all types (mental, physical, and developmental) for people of all ages. The method was applied to both examples, which are offered here to demonstrate the developmental stages of model design and its implementation. Although driven by consumers, the method relies on professionals, often psychologists, to come to fruition. Consequently, a new, empowering relationship can exist between people with mental illness and psychologists. In addition, this creates a new role for psychologists, expanding practice options.

Negative attitudes toward people with disabilities are learned early through influences such as school and the media (Wahl, 1995). This culturally constructed stigma is a critical issue facing people with mental illness and other disabilities (cf. Brown & Bradley, 2002; Corrigan, Edwards, Green, Diwan, & Penn, 2001; Corrigan & Watson, 2002; Haight, 2001; Henry & Lucca, 2002; Hinshaw & Cicchetti, 2000; Johnstone, 2001; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Struening et al., 2001; Wilson & Lewiecki-Wilson, 2001). People with mental illness often face hostile, oppressive community environments filled with bias and discrimination and that isolate them from community life. These negative attitudes and behaviors affect treatment seeking (Rost, Smith, & Taylor, 1993; Teachman, Wilson, & Komarovskaya, 2006) and may affect access to community living across life areas. For example, stigma may result in education and housing discrimination, a lack of public services and jobs, and other restricted opportunities. In turn, these barriers may prevent people with mental illness from living full and productive lives (Charlton, 1998).

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In order to open community doors formerly closed because of stigma, social marketing can employ persuasive communication strategies to encourage people to change their attitudes and/or behaviors (Kotler & Roberto, 1989; MacStravic, 2000). Social marketing, like traditional persuasion tenets on which it is based (Harper, 1979; Infante, Rancer, & Womack, 1990), maintains that the right message (stimulus) will change the attitudes and/or behaviors of the target adopter (response). Change is voluntary and results from exposure to a properly positioned persuasive message. Successful social marketing is organized and collective; one group (change agent) persuades another group (target audience) to accept, change, or discard certain ideas, attitudes, practices, or behaviors (Kotler & Roberto, 1989). For mental illness, social marketing encourages the target audience to change negative attitudes and annul stigma, thus opening up community life for people with mental illness and other disabilities.

### Challenging Stigma With Social Marketing

In the method we present here, a work group of people with disabilities is formed to guide the design, distribution, and evaluation of the campaign. The work group is not an advisory group; instead it is responsible for self-directing and managing all facets of the campaign, within budget limitations. Although the work group completes the campaign, how they achieve that goal is essential to their empowerment, and supporting the success of the empowerment is the responsibility of the facilitators (Freire, 1970/2003). Impartial facilitators, such as psychologists, focus on a Freirean dialogue<sup>1</sup> to address the worldview of people with mental illness, allowing them to explore stigma as it impacts their personal lives and to select subsequent social marketing activities. The method departs from traditional social marketing strategies that use experts to develop the campaign. In this model, the people for whom the campaign is about (people with mental illness and other disabilities) lead their partner professionals to guide the design of and the distribution of the campaign materials and then to participate in evaluation of the communication strategy.

Two statewide projects were involved in development of the model: a health insurance enrollment program and a second mental health project that identified stigma as an integration barrier. The mental health program, initiated in 1997 by the Idaho Department of Health and Welfare (IDHW) to identify assets and barriers in the state's public mental health system, included people with mental illness, providers, friends, and family members. The State Children's Health Insurance Program, launched in 1999, used media advertising as well as face-to-face and intermediary communication strategies that included trusted mediators to carry messages to target audiences. This multilayered strategy reached its 2-year enrollment goal in 8 months.

### A Method and Its Stages

The model used the specific implementation method outlined below. As with any skill, the mechanism is supported by the competency of the implementer. Implementers should have group process skills to facilitate participation and they should understand Freire's (1970/2003) emancipatory dialogue. Psychologists may serve as facilitators, but like any facilitator in this phase of the process, they should not permit their personal opinions to guide the

project or its outcomes. The facilitators' interpersonal skills should support all group members' meaningful participation, leading to the empowerment of people with disabilities. Not only should they feel in charge of the project, they should *be in charge*.

#### *Stage I: Establishing the Audience and Message*

This stage involves merging social marketing techniques with an empowering dialogue among those people with the characteristics of the group targeted by the communication campaign for an attitude and/or behavior change, in this case, mental illness. Per Freire's (1970/2003) emancipatory dialogue, action emerges from open discussion of life experiences; thus, a social marketing plan for reducing stigma emerges from the open discussion of persons who have been stigmatized. The model uses a matrix to structure the empowering dialogue. It includes a discussion guide that focuses on identifying (a) target audiences and how they stigmatize, (b) what persuasive messages might counteract the stigma, and (c) what behavior and/or attitude changes are desired. Again, although the matrix follows general principles of marketing, the methods for following the matrix are aligned with emancipatory dialogue. Participants are permitted to share their personal stories, frustrations, and concerns in a nonjudgmental environment. Unlike any previous social marketing campaigns, this model anticipates participant and/or client sharing from which social action emerges.

The group may identify one or several target audiences. Or, they may wish to target an amorphous general public, believing a campaign to the population at large is a higher priority. However, this has limitations. Kotler and Roberto (1989) noted that mass media campaigns can work for public education purposes and an emotional appeal via mass media can be effective in promoting social products that correspond to personal goals, yet attitudes and/or behaviors may not change. Facilitators work to ensure that work group members' expectations are realistic. In Phase I, the group also develops the persuasive message concepts, the desired attitude and/or behavioral change, and the communication tools. This is difficult and may be contentious. Using the model along with strong facilitation skills provides the dialogue essential to empowerment and assures that all information is compiled before moving to Stage II.

#### *Stage II: Developing and Launching the Campaign*

This stage focuses on product positioning. The goal, which may be iterative depending on the number of audiences, is to develop a compelling message and distribution plan, drawing on the matrix from Stage I.

In Step 1 of Stage II, communication tools are evaluated and selected for each target audience. For example, people with mental illness and other disabilities may identify a group they feel has stigmatized them. Reaching this group may be accomplished, for example, through a professional association. Parents might be reached through schools. Targeted communication can be accomplished through inexpensive means, such as articles in newsletters. For general audiences, mass media such as radio or television may

<sup>1</sup> Paolo Freire believed that dialogue involves more than just discussion—it requires respect, and instead of one person acting on another, it entails people working with each other to make a global difference.

be indicated, although costs are high and results are difficult to measure. Communication tools are evaluated for efficacy and practicality of target audience access as well the project's access to them, taking into account fiscal and political issues. In Step 2, the work group—with the assistance of media professionals if appropriate—guides the completion of the media strategy. Step 3 is market testing the campaign with each of the target audiences. Focus groups of target audiences are convened to assess their opinions about the campaign. Before making campaign changes based on focus group results, the work group must approve those changes to maintain empowerment. Step 4 is the distribution plan, which must fit the budget, although participants need not be deterred by a limited budget. Lower-cost alternatives exist depending on the target audience. For example, working through a health care association can be inexpensive, reputable, and compelling to health professionals. Each approach is individual, and each distribution plan will be unique. There is no single formula.

### *Stage III: Campaign Evaluation*

This stage addresses three criteria: (a) Did the involved work group see the process as empowering, (b) did the campaign materials compel and attract the target audience, and (c) did the campaign achieve the desired attitude and/or behavioral change? Focus groups, discussion groups, or surveys can be used to measure the campaign's outcomes (Corrigan, 2005; Kotler & Roberto, 1989). The method used to measure attitude change will vary based on the target audience, communication tool, and dissemination channel. In actual field settings, measurement should address a core concern in stigma research of social distance (cf. Young, 1990) and overall campaign effectiveness (Kotler & Roberto, 1989). Psychologists are perhaps uniquely trained to address the difficulties of measuring the outcomes of marketing campaigns and attitude change. Campaign effectiveness focuses on whether attitudes and/or behaviors changed among the target audience. One possible measure is social distance, a measure of the level of stigma as it relates to a person's willingness to become socially intimate with a person with mental illness or other disabilities.

### Case Examples

In this section, we discuss two campaigns initiated in Idaho that used the model: a multiphased "mental health" campaign and a "people with disabilities" campaign. Although the work groups for each type of campaign included different stakeholders, both examples addressed stigma as it relates to disenfranchised populations of people with disabilities (Charlton, 1998).

#### *Case 1: Mental Health Campaign*

In 1998, following the 1997 public participation process that identified stigma as a major barrier to full community participation, IDHW convened a work group of 36 people to address stigma, including adult and teen consumers, providers, family members, and advocates. The group was facilitated with the empowerment method to complete a matrix, selecting four audiences and sets of communication tools: (a) general population through TV ads, (b) upper socioeconomic strata (most likely to change) through public TV documentary, (c) high school students through

a 27-min video for health classes, and (d) middle school students in the *Better Today's. Better Tomorrow's.* (B2T2) program via face-to-face communication with adult gatekeepers and/or caregivers (as intermediaries to reach the youth). As part of the matrix activities, the group also identified a single overriding communication objective (SOCO), or single most compelling message of the campaign. Using the codified language established in Stage I, they chose the SOCO "Mental Illnesses Are Biological Brain Disorders: They Are No One's Fault" to guide the campaign.

*Mass media.* Idaho Public TV received a contract (\$119,000) to underwrite the documentary and high school video as well as a 5-min video to use for public speaking. Because the campaign was multifaceted, multiple distribution strategies were used, including commercial TV ads, public TV, materials distribution by IDHW to their personnel and school counselors, and the B2T2 training program. The campaign target audience was any person in Idaho, and there were severe budget constraints that prohibited a state-wide pre- and postcampaign marketing survey, so the establishment of an evaluation method was difficult. Thus, proxy measures were selected. The process measure was the number of videos distributed and the number of broadcasts made. The outcome measure was calls regarding mental health to the state's free 2-1-1 Idaho CareLine. From 2000 to 2004, 333 copies of the video were distributed, and the commercial was shown 995 times between January and March of 2001. Calls to the Idaho CareLine increased fivefold, from 19 in 2000 to 114 in 2001. In addition to these planned measures, the campaign was recognized by multiple awards. The documentary and video, which were designed on the basis of the consumer plan, received the International George Peabody award and recognition from the National Educational Television Association and the National Alliance for the Mentally Ill. The television ads were nominated for a Telly Award. Consumers who designed the campaign expressed pride, gratification, and ownership of the awards, enhancing their feelings of empowerment.

*Intermediaries via face-to-face communication.* B2T2 is funded by the Idaho Governor's Generation of the Child Initiative (\$700,000 over 5 years) with support from the National Institute of Mental Health Outreach Partnership Program (263-MD-509293). B2T2 trains gatekeepers and caregivers on the signs and symptoms of mental disorders in school-age children. The curriculum addresses the deleterious consequences of stigma, urging participants to examine their attitudes. Participants are given print information and referred to further information ([www.isu.edu/irh/bettertoday's](http://www.isu.edu/irh/bettertoday's)). They are encouraged to share this knowledge with parents and children at risk for mental disorders or in need of mental health referrals. Goals of the trainings are (a) to raise awareness about mental disorders in school-age children (education), (b) to reduce stigma relating to mental illness (attitude change), and (c) to increase treatment seeking by caregivers on behalf of children in their care (behavior change).

Copious data are available for B2T2. In addition to training frequency, geographical distribution, and types of gatekeepers trained, there is a self-report evaluation completed immediately posttraining and at a 1-year follow-up (12–15 months posttraining). After 5 years, this program has trained 2,367 community caregivers and gatekeepers and 2,629 teens in 66% of Idaho's towns that contain 90% of the state's population. Posttraining evaluation data are available on 80% of participants ( $n = 1,821$ ),

and 1-year follow-up data (Years 1–4) are available on 25% ( $n = 341$ ) of participants. Follow-up data indicated that approximately half (53.4%,  $n = 163$ ) reported changes in attitudes and/or behaviors as a result of the training. Among those who did not report change, the most frequent reason for not changing was that their attitudes were already consistent with the B2T2 messages. Most participants (80%,  $n = 268$ ) reported adding new knowledge, and 90% ( $n = 302$ ) said they would recommend the program. Respondents to the follow-up survey reported sharing B2T2 information with 1,585 children and 2,098 adults, and half (48.3%,  $n = 154$ ) reported that they had referred a child for mental health services. Like the mass media portion of the campaign, national recognition also reinforced the positive outcome. Being selected as a promising practice by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration again shows the strength of a method that combines the empowered consumers' voice with professionals' implementation.

### *Case 2: Idaho Real Choices System Change*

The Real Choices Systems Change Project<sup>2</sup> studies ways to assist people with disabilities to live full, productive lives in their communities. The antistigma campaign addresses the role of stigma reduction in making the community more welcoming for people with disabilities. The Real Choices Work Group (RCWG) had 12 participants, including people with disabilities, advocates, and providers. The RCWG identified family physicians, housing providers, employers, and mental health providers as key audiences (those they feel stigmatize them). They also targeted a general audience and chose TV and radio advertisements as their mode of communication. Their SOCO was "People With Disabilities: We Have Hopes, We Have Goals, We Are Just Like You" with a slogan of "Everyday People, Everyday Lives." A mass media emotional appeal was selected and four 30-s TV ads and one radio ad were completed. To maximize limited funds, we entered into an agreement with the Idaho Broadcasters Association to provide a \$50,000 donation for their association's scholarship fund for a \$1.3 million donation in advertising. A stigma brochure to facilitate one-on-one dialogue was supported by the Idaho Department of Transportation and distributed by intermediaries such as the Idaho Community HealthCorps/Americorps, Idaho CareLine, and the Idaho State Library outreach staff. Through these partnerships, 15,000 brochures were distributed. Research indicated that Idaho's Spanish-speaking population, primarily migrant farm workers, was most accessible via radio, especially at the lunch hour. A six-part novella (serial radio ads) was created to meet this niche. The Spanish-language radio stations provided a one-to-one match for airtime.

The Real Choices campaign was evaluated through the collection of process and outcome data. The process data focused on the satisfaction of those involved in creating the campaign and on frequency of distributed materials. Two outcome measures were selected: (a) calls to the Idaho CareLine and (b) a population-based statewide telephone pre- and post survey. Because of budget issues, no specific outcome measures for Spanish speakers were used, but Spanish speakers were included in the stratification for the population-based survey.

On the basis of a thematic analysis of narrative survey responses from a postcampaign work group survey, we found that 5 of 12

members indicated they were empowered by the process and would participate in similar activities. A statewide consortium of disability organizations requested monthly campaign updates, indicating goal ownership and commitment. The media spots aired 56,234 times, and 15,000 brochures were distributed. In the statewide stratified (market, gender, language) random sample, pre- and postcampaign telephone survey (presurvey  $n = 486$ , postsurvey  $n = 387$ ;  $N = 873$ ) participants demonstrated a high level (95%) of familiarity with any disabilities; this level did not vary pre- or postcampaign, nor did social distance. Respondents were comfortable or very comfortable (a) living, working, or going to school in a community with people with disabilities ( $n = 370$ ; 43%); (b) living next door to someone with a disability ( $n = 520$ ; 61%); and (c) living with someone with a disability ( $n = 344$ ; 41%). The postcampaign data showed no evidence of attitude change, likely because of a lack of message exposure, leaving open whether the message could cause change. Among those surveyed postcampaign, only 9% ( $n = 34$ ) reported they had seen or heard the campaign, and less than 5 people (<12%) reported an attitude change as a result. Although the number of media spots, 56,234, and their costs, \$1,376,630, seem large, in terms of commercial media, this is a low penetration rate for 1.36 million people. When supplemented with a community development project, in which community members worked to make changes to be more welcoming to people with disabilities, the antistigma campaign did reflect attitude and behavior change.

### Implications for Practitioners

This article presented a method for challenging stigma. Two case examples illustrate the method as a way for psychologists to form collaborative partnerships with consumers, state organizations, and other stakeholders in efforts to change attitudes and reduce stigma. Psychologists, who have long been agents of social change, can both initiate and support efforts to reduce stigma. Although changing attitudes, such as reducing stigma, is but one goal for social change, it is a significant step on the path to changing behaviors. During the two projects described in this article, attitude change did occur, even if not at the sweeping scope that the work groups dreamed. The empowerment component of the campaign development achieved its two goals: (a) that people with mental illness and disabilities controlled the process of developing the campaign and (b) that consumers envisioned the outcome of the campaign by designing the social marketing campaign themselves. As guides of this process, psychologists play a significant role in helping consumers shape and implement their social change and evaluation plans throughout the process. Ultimately, bringing about changes in stigma will benefit not only consumers and patients but also psychologists, who are often secondary targets of stigma directed at those with mental illnesses because of their chosen profession. Stigma is a major barrier to treatment seeking (Rost et al., 1993; Teachman et al., 2006) and can be a barrier to treatment. As the stigma lessens, not only are consumers more willing to seek treatment, the work of the psy-

<sup>2</sup> Funded by the Center for Medicaid and Medicare Services to Idaho State University's Institute of Rural Health through the state of Idaho (Grants P-91537/0 and P-92045/0).

chologist can focus on treatment of a person's disorder rather than the consumers' or the psychologists' distress at fighting stigma to seek treatment from psychologists; thus, the community will be composed of healthier and more empowered members.

Attitude change leading to new behaviors is the overwhelming task of social marketing. Although it is difficult to achieve, change can occur. Because of Idaho's statewide availability of the mental health campaign and materials, calls to the Idaho CareLine are up (even if not causally), and training on signs and symptoms of mental health problems has occurred in the towns that contain over 90% of the state's population, accounting for over 5,000 adult gatekeepers and teens in 66% of Idaho's communities. Requests for new and continued gatekeeper training continue, increasing the potential roles for psychologists to participate in trainings as instructors. The Real Choices campaign allowed people with disabilities, and the agencies that serve them, to participate meaningfully in attempts to change their state, involving organizations not typically involved in social services, such as the Idaho Broadcasters Association. All of these changes indirectly support the work of psychologists.

Two statistical outcomes—one positive and one negative—add to our knowledge. The positive learning is that most people know someone with a disability and will interact with them. The equally important negative learning is that over 50,000 media spots valuing over a million and a half dollars is insufficient for a market of 1.36 million people. By contrast, McDonald's Corporation spends in excess of 100 million dollars a year on marketing, not including what is spent by their individual franchises. The high cost of media campaigns is an argument for focusing attention on low- or no-cost communication channels, such as association newsletters or direct mail. However, direct contact by a trusted individual is usually an effective agent of social change. There again, psychologists have an important opportunity to step out of the consulting room and share with the community their beliefs about the reality of mental illness and the hope treatment provides.

Brief campaigns to inform and persuade cannot hope to make permanent changes in deeply held attitudes and/or behaviors. Campaigns must be maintained over an extended period and accomplished through a variety of means. In the past 5 years, we spent over \$2 per citizen and can barely detect population attitude change. Yet, the changes that did occur—both to the campaign developers and campaign participants—cannot be discounted, nor can the 1,779 people who referred a child for mental health care. The campaign costs seem a small price in exchange.

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