

“JUST LIKE SOMEONE WITHOUT MENTAL ILLNESS, ONLY MORE SO”: NORMALIZING BELIEFS AND THEIR BUFFERING EFFECTS ON PSYCHIATRIC SYMPTOMS

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Self-stigma leads sufferers of psychiatric conditions to experience reduced self-efficacy and self-esteem as well as avoid treatment, employment, and social opportunities. There is a dearth of research on the mechanisms underlying individuals' ability to resist stigmatizing beliefs; furthermore, research has revealed limitations in current popular approaches to de-stigmatization, such as emphasizing the biological and genetic characteristics of symptoms. We propose normalization—the understanding of psychiatric phenomena as varying degrees of normative, understandable, and common experiences—as a cross-diagnostic protective factor against self-stigma. We recruited a sample of 137 online study participants to pilot an assessment of normalization, predicting that normalizing beliefs about psychiatric symptoms would positively influence quality of life, especially for those who report personal experience of symptoms. We found evidence for this prediction: belief that psychiatric symptoms were relatively common, buffered the negative effect of people's own psychiatric symptoms on quality of life. Cross-diagnostic symptom normalization may function as a protective factor against the negative effects of psychiatric symptoms and associated stigma.

Keywords: stigma, self-stigma, normalization, social comparison

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Just Like Someone Without Mental Illness, Only More So
—title of Mark Vonnegut's (2010) memoir

Those with psychiatric disorders face a “double problem” (Rüsch, Angermeyer & Corrigan, 2005; p. 529). Their symptoms not only generate distress and dysfunction, but also make them vulnerable to becoming targets of stigma (Corrigan, Markowitz, & Watson, 2004). Stigmatizing beliefs about those with psychiatric disorders (Angermeyer & Schomerus, 2012; Rüsch et al., 2005) include beliefs that they are dangerous, incompetent, or childlike (Brockington, Hall, Levings, & Murphy, 1993; Sadler, Meagor & Kaye, 2012; Taylor & Dear, 1981). These beliefs not only shape public awareness and endorsement of stereotypes and approach-avoidance behavior (e.g., fear due to perceived danger, approach due to perceived childlike qualities), but also manifest in concrete forms of separation, prejudice, and discrimination (Harangozo et al., 2014; Link & Phelan, 2001). These beliefs affect individuals with psychiatric disorders as well, as self-stigma is linked to reduced self-efficacy, self-esteem, and quality of life (Firmin, Luther, Lysaker, Minor, & Salyers, 2016; Mashiach-Eizenberg, Hasson-Ohayon, Yanos, Lysaker, & Roe, 2013) and subsequent avoidance of treatment, employment, or social opportunities (Clement et al., 2015; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001).

Attitudes toward mental illnesses are heavily influenced by medicalization, or the conceptualization of mental illness as the result of aberrant genetic or biological processes (Rüsch et al., 2010). Though individuals prompted to view psychiatric conditions from this perspective assign less blame to those affected (Deacon & Baird, 2009), they also view them as more dangerous (Jorm & Griffiths, 2008) and are more likely to avoid them (Angermeyer & Matschinger, 2005; Lauber, Nordt, Falcato, & Rössler, 2004). The biogenetic view (Kvaale, Haslam, & Gottdiener, 2013, for meta-analytic review) corresponds with views that see mental illness as more serious (Phelan, 2005) and less treatable (Lam & Salkovskis, 2007; Phelan, Yang, & Cruz-Rojas, 2006). These findings have led to new research examining other methods of stigma reduction that eschew a biogenetic view for one that regards mental illnesses as variant forms on the high end of a continuum of human experience (Wiesjahn, Jung, Kremser,

Rief, & Lincoln, 2016). When individuals embrace this continuous view of mental illness, they are less likely to hold stigmatizing beliefs, as shown in both online (Thibodeau, 2016) and in-person (Thibodeau, Shanks, & Smith, 2018) studies.

There is a dearth of research, however, on the mechanisms underlying individuals' ability to resist or counteract stigma related to their own experiences of symptoms. One key mechanism through which individuals counteract stigma is normalization—the act of reframing psychiatric phenomena as varying forms of normative, understandable, common experiences. Normalization is already a centerpiece in some evidence-based treatment approaches for psychiatric conditions, including psychosis (Morrison & Barratt, 2009), anxiety (Norton, 2012), and substance use disorders (Sobell & Sobell, 2011). However, normalization beliefs have not been studied as a construct applied broadly to psychiatric phenomena; individuals who see psychological symptoms in this normalizing manner may be buffered against some of these symptoms' deleterious effects.

This conceptualization of normalization stems from Leon Festinger's (1954) social comparison theory, which posits that people possess an intrinsic drive to use others as reference groups for comparison; the results of these comparisons shape beliefs and subsequent emotional experiences. These social comparisons appear to be an important determinant of physical health, as upward social comparisons about health concerns are related to psychological distress after controlling for symptoms (VanderZee, Buunk & Sanderman, 1995). Upward social comparisons shape individuals' coping strategies, motivation to seek affiliation, and subjective evaluation of their own symptoms (Buunk Gibbons, & Buunk, 2013). These social comparisons may lead those suffering from psychiatric disorders to interpret symptoms as abnormal and unmanageable, leading them to experience further reductions in self-esteem and self-efficacy. Conversely, if they regard these symptoms as relatively normal and manageable, this individual may be buffered against the threats to self-esteem and self-efficacy posed by stigmatizing beliefs.

The present study aims to generate a standardized assessment of individuals' differences in how normal they perceive psychiatric symptoms to be, and whether normalizing these symp-

toms can buffer the negative effects of people's own experienced symptoms on quality of life. To the extent that normalizing psychiatric symptoms can buffer negative outcomes, mental health providers might actively modify patients' normalizing beliefs about symptoms to help them resist stigma.

METHOD

PARTICIPANTS

We recruited 137 participants from Amazon Mechanical Turk (MTurk) to participate in our study in exchange for compensation of \$2.20. Seven participants failed one of our attention checks, leaving 130 total participants (46% female, 58% White, 17% Black, $M_{age} = 36$ years).

MATERIALS

Symptoms and Normalization. Self-reported symptom levels and normalization of symptoms were collected with the Symptom Universality and Normalization Scale, which comprises two measures, each consisting of 53 items (see Appendix 1), chosen for this study from selections of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (American Psychiatric Association, 2013). Items were a semi-exhaustive list of unique symptoms sampled from the following adult psychiatric disorders: major depressive disorder, generalized anxiety disorder, social phobia, specific phobia, panic disorder, bipolar disorder, schizophrenia, anorexia nervosa, bulimia nervosa, and binge eating disorder. An additional 11 items were also administered that covered items that are not specifically psychiatric symptoms, but rather describe behaviors or qualities common in both clinical and non-clinical populations. A complete list of items can be found in Appendix 1. In the self-report questionnaire, participants were asked to denote on a Likert scale from 1 (very rare or never) to 6 (very common) "the extent to which each experience is a common or rare experience for you." In the normalization questionnaire, participants were asked to denote on an analogous Likert scale from 1 (very abnormal) to 6 (very normal)

“how normal for the average person” they found each experience to be. Items were randomized within each block, and blocks were randomized to occur either first in the study questionnaire administration or last.

Quality of Life Enjoyment and Satisfaction Questionnaire, Short Form (QLES; Endicott, Nee, Harrison, & Blumenthal, 1993). The QLES is a 15-item overview of participants’ self-reported sense of quality of life and enjoyment, wherein higher scores denote better functioning and quality of life. The QLES covers physical health, emotions, work, household activities, and social life. Total scores are averages across all items.

Social Distance Scale (SDS; Link et al., 1987). The SDS is a 7-item scale assessing individuals’ attitudes toward a person who was “hospitalized in a mental hospital” two years ago. Questions range from “definitely willing” to “definitely unwilling” and pertain to situations that require social proximity to the person, including having him as a neighbor, working together, or having one of your children marry him. For ease of interpretation, the scale of the SDS was reversed to match the normalization scale and PDI, such that higher scores indicated higher levels of stigmatization.

Perceived Dangerousness Items (Link & Cullen, 1986). These 8 items require individuals to disclose their attitudes—ranging from strongly disagree to strongly agree—related to the dangerousness of peoples with mental illnesses. For example, one item asks individuals to endorse or reject, “If I know a person has been a mental patient, I am less likely to trust him or her.” Higher scores represent higher levels of belief in perceived dangerousness of individuals with mental illnesses.

PROCEDURE

Participants rated both their own symptoms and their normalization beliefs about these same symptoms. After finishing these items, they completed the QLES, provided demographic information, and received debriefing.

RESULTS

BUFFERING EFFECTS OF NORMALIZATION

We predicted quality of life by entering the normalization of symptoms, the self-report of symptoms, and their interaction in a linear regression. We hypothesized that normalization of symptoms would buffer negative effects of self-reported symptoms on QLES, especially for those with higher levels of self-reported symptoms.

To rule out the possibility that normalization effects are driven by shared variance with measurements of stigma, we controlled for both SDS and PDI in the analyses. SDS and PDI were positively correlated, $r = .41, p < .001$. SDS was marginally positively correlated with normalization of symptoms, $r = .16, p = .074$; PDI was also marginally positively correlated with normalization of symptoms, $r = .17, p = .054$.

Self-Reported Symptoms. Unsurprisingly, participants showed a main effect of self-reported symptoms, $\beta = -.76, t(122) = -8.72, p < .001$. Those who reported experiencing symptoms more frequently also reported lower quality of life.

Normalization of Symptoms. Participants also showed a main effect of the normalization of symptoms, $\beta = .41, t(122) = 4.42, p < .001$. Generally speaking, those who perceived psychiatric symptoms as more normal reported higher quality of life.

Normalization as a Buffer for Self-Reported Symptoms. The previous main effects were qualified by the key predicted interaction between self-reported symptoms and the normalization of symptoms, $\beta = .23, t(122) = 2.75, p = .007$. Those who reported higher levels of self-reported symptoms also benefited the most from holding normalizing beliefs about psychiatric symptoms. See Table 1 for all coefficients and p -values.

To decompose this interaction, we considered the effect of normalization of symptoms at three levels of self-reported symptoms. At $-1SD$ self-reported symptoms, the buffering effect of normalization is significant but relatively small, $\beta = .23, t(122) = 2.44, p = .016$; at mean self-reported symptoms, this coefficient is nearly twice as large, $\beta = .41, t(122) = 4.42, p < .001$; and at

TABLE 1. Regression Table for Primary Analyses

Predictor	Unstandardized Coefficient	Standard Error	Standardized Coefficient	t-value	p-value
PDI	.008	.008	.078	.992	.323
SDS	-.039	.013	.239	3.105	.002
Symptoms (self-report)	-.633	.073	-.764	-8.719	.000
Normalization score	.459	.104	.408	4.421	.000
Symptoms*Normalization	.247	.090	.226	2.746	.007

+1SD, the coefficient is still larger, $\beta = .61$, $t(122) = 4.26$, $p < .001$. Notably, a person who reports no experience of any psychiatric symptoms (i.e., someone with self-reported symptoms of 0) does not show any positive effects of normalization, $\beta = .13$, $t(122) = 1.32$, $p = .19$. These results support our key prediction that normalization would buffer negative effects of self-symptoms more strongly for those with higher levels of self-reported symptoms. See Figure 1.

DISCUSSION

The present study suggests that the normalization of psychiatric symptoms buffers against the negative effects of people's psychiatric symptoms on their perceived quality of life. Importantly, this buffering effect was especially strong for those who reported more frequent symptoms, suggesting that those who suffer most from self-reported symptoms gain the greatest benefit from adopting normalizing beliefs about psychiatric symptoms. This key finding was not accounted for by stigmatizing attitudes of perceived dangerousness and social distance; furthermore, normalization was not synonymous with these measures of stigma, as there were non-significant relationships between normalization and these measures, providing evidence that normalization is not just the absence of stigmatizing attitudes but instead the presence of beliefs that symptoms are relatively common in the general population.

Normalizing beliefs appear to be generally positive contributors to quality of life, even for participants in this subclinical sample who reported low levels of self-reported symptoms.

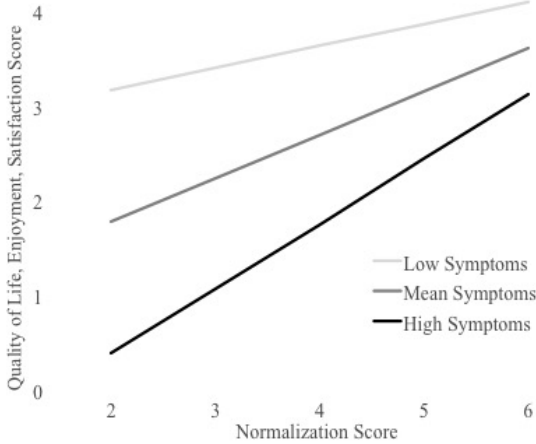


FIGURE 1. The effect of normalization scores on the QLES at low ($-1SD$), mean, and high ($+1SD$) levels of self-reported symptoms. Values are graphed at mean levels of PDI and SDS.

For this reason, normalizing accounts of psychiatric symptoms might significantly enhance anti-stigma campaigns and show broad positive impact. In particular, while public campaigns should still emphasize distress and dysfunction caused by psychiatric symptoms, such accounts should also emphasize the ways in which various psychiatric symptoms are understandable and relatively common experiences. One possibility is that combining biogenetic and normalizing accounts of stigma might retain the advantages of the biogenetic account while addressing its tendency to exacerbate judgments that mental illnesses are untreatable, dangerous, and/or bizarre (Angermeyer & Matschinger, 2005; Lam & Salkovskis, 2007; Lauber et al., 2004; Jorm & Griffiths, 2008; Phelan et al., 2006).

Second, these findings are informative on a clinical level, as normalizing beliefs actually ameliorated the harmful effects of psychiatric symptoms and did so more effectively for those who reported higher levels of psychiatric symptoms. This finding provides empirical support for evidence-based treatments (Morrison & Barratt, 2009; Norton, 2012) that encourage providers to normalize symptoms early in treatment. The present

research further suggests that the benefits of normalization are not limited to these specific instances—instead, the normalization of symptoms might be effectively incorporated in a variety of therapeutic approaches.

The present study shows a few limitations. First, the present study was conducted in a general population sample; we did not systematically sample individuals that have been diagnosed with psychiatric disorders. Second, the present study does not explicitly establish causality; specifically, we did not demonstrate whether normalizing beliefs about mental illness contributed to improvements in quality of life, or the other way around. However, given previous work demonstrating the effects of stigma on self-esteem and self-agency, it is reasonable to assume that belief about illnesses can affect quality of life (Corrigan, Larson & Rüscher, 2009). Conversely, there is no current model suggesting that quality of life would affect individuals' likelihood to see psychiatric symptoms as normal. Finally, the present study does not distinguish between ego-dystonic and ego-syntonic symptoms. Presumably, ego-syntonic symptoms that cause dysfunction, which are viewed as consistent with the self-concept (e.g., some forms of delusions, eating disorder cognition without insight) may be affected differently by normalization than ego-dystonic symptoms which are viewed as inconsistent with the self-concept (e.g., dysphoria, anxiety). We included a wide range of psychiatric symptoms in our study, avoiding issues with range restriction to primarily syntonic or dystonic symptoms; however, future research might more clearly address whether the buffering effect of normalization generalizes across these symptom types.

Future research might also consider the similarity and differences between the constructs of stigma and normalization (i.e., whether these are overlapping, synonymous, or orthogonal). Second, future research ought to examine how normalization specifically affects functioning for individuals diagnosed with psychiatric disorders. Future work might also address questions of directionality by experimentally manipulating normalizing beliefs or by examining whether normalizing beliefs affect future quality of life. Third, populations of participants with a higher frequency of psychiatric symptoms should be sampled; the pres-

ent study examined an online general population sample but did not specifically target individuals with diagnosed psychopathology. Data collection using a clinical sample would most directly test the utility of normalization for those with formal diagnoses.

Overall, the present study suggests that a normalizing view—one suggesting that mental illnesses are not defined by aberration from normal, universal human experience, but rather, by their universality—might have some utility in addressing self-stigma. Countless wise depictions of human experience—in film, literature, and history—present suffering as an experience that emphasizes people’s humanity, rather than undermining it. In the same way, mental illness might highlight the humanity inherent in its sufferers, as suggested by Mark Vonnegut (2010): “just like someone without mental illness, only more so.”

APPENDIX 1. Items of the Symptom Universality and Normalization Scale

Feeling sad
 Feeling hopeless
 Crying/being tearful
 Losing interest or pleasure in activities
 Significant loss of appetite
 Insomnia (inability to sleep)
 Hypersomnia (sleeping too much)
 Feeling fatigue
 Feeling worthless
 Difficulty concentrating
 Difficulty making decisions
 Low self-esteem
 Fear or anxiety about a social situation (having a conversation, meeting unfamiliar people, being observed, performing in front of others)
 Fear of showing anxiety symptoms that will be negatively evaluated
 Worry about work
 Worry about personal life
 Difficulty controlling one’s worrying
 Feeling restless
 Feeling irritable
 Feeling full-body muscle tension
 Having difficulty sleeping because of worry
 Panic attacks
 Fear of using public transportation
 Fear of being in open spaces (e.g., public events)
 Fear of being in enclosed spaces (e.g., elevators)

Fear of being outside the home alone
 Intrusive (sudden and involuntary) thoughts about being responsible for harm
 Intrusive (sudden and involuntary) thoughts about being contaminated, dirty, or germ-infested
 Intrusive (sudden and involuntary) thoughts about things needing to be arranged correctly or symmetrically
 Intrusive (sudden and involuntary) thoughts that one finds unacceptable
 Compulsion (sudden irresistible urge) to clean or wash something
 Compulsion (sudden irresistible urge) to pray, count, or mentally reassure oneself
 Compulsion (sudden irresistible urge) to check on something worrying (e.g., whether the stove is off)
 Compulsion (sudden irresistible urge) to arrange things in a right order or arrangement
 Feeling no need for sleep
 Feeling euphoric
 Feeling like one has special talents or abilities that no one else has
 Hearing sounds that others do not hear
 Hearing voices that others do not hear
 Seeing dots, spots, or visions that others do not see
 Having difficulty understanding others' emotions, intentions, or meaning
 Feeling suspicious of one's acquaintances
 Feelings as though one's thoughts are not one's own
 Believing that one is the subject of a coordinated plot (e.g., by the government or an exclusive group of friends)
 Believing that one has a special relationship with God compared to all other people
 Feeling shame about one's body size or shape
 Purging (forcing vomiting, laxative, or excessive exercise) food one has eaten
 Restricting the intake of one's calories to a degree that one's functioning is impacted
 Feeling strong influence of body weight on self-esteem
 Fear of becoming fat or gaining weight
 Eating large amounts of food within a short period (2 hours)
 Feeling out of control when one eats a large amount of food

REFERENCES

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.
- Angermeyer, M. C., & Matschinger, H. (2005). Causal beliefs and attitudes to people with schizophrenia. *The British Journal of Psychiatry*, *186*, 331–334.
- Angermeyer, M., & Schomerus, G. (2012). A stigma perspective on recovery. *World Psychiatry*, *11*, 163–164.
- Brockington, I. F., Hall, P., Levings, J., & Murphy, C. (1993). The community's tolerance of the mentally ill. *British Journal of Psychiatry*, *162*, 93–99.
- Buunk, B. P., Gibbons, F. X., & Buunk, A. (Eds.). (2013). *Health, coping, and well-being: Perspectives from social comparison theory*. New York: Psychology Press.
- Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., & Thornicroft, G. (2015). What is the impact of mental health-relat-

- ed stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, 45, 11–27.
- Corrigan, P. W., Larson, J. E., & Ruesch, N. (2009). Self-stigma and the “why try” effect: Impact on life goals and evidence-based practices. *World Psychiatry*, 8, 75–81.
- Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin*, 30, 481–491.
- Corrigan, P., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behavior*, 44, 162–179.
- Corrigan, P. W., Schmidt, A., Bink, A. B., Niewegłowski, K., Al-Khouja, M. A., Qin, S., & Discont, S. (2017). Changing public attitudes with continuum beliefs. *Journal of Mental Health*, 26, 411–418. <https://doi.org/10.1080/09638237.2016.1207224>. Advance online publication (2016).
- Crisp, A. H., Gelder, M., Goddard, E., & Meltzer, H. (2005). Stigmatization of people with mental illness: A follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry*, 4, 106–113.
- Deacon, B. J., & Baird, G. L. (2009). The chemical imbalance explanation of depression: Reducing blame at what cost? *Journal of Social and Clinical Psychology*, 28, 415–435.
- Endicott, J., Nee, J., Harrison, W., & Blumenthal, R. (1993). Quality of Life Enjoyment and Satisfaction Questionnaire: A new measure. *Psychopharmacology Bulletin*, 29, 321–326.
- Festinger, L. (1954). A theory of social comparison processes. *Human Relations*, 7, 117–140.
- Firmin, R. L., Luther, L., Lysaker, P. H., Minor, K. S., & Salyers, M. P. (2016). Stigma resistance is positively associated with psychiatric and psychosocial outcomes: A meta-analysis. *Schizophrenia Research*, 175, 118–128.
- Harangozo, J., Reneses, B., Brohan, E., Sebes, J., Csukly, G., López-Ibor, J. J., . . . Thornicroft, G. (2014). Stigma and discrimination against people with schizophrenia related to medical services. *International Journal of Social Psychiatry*, 60, 359–366.
- Jorm, A. F., & Griffiths, K. M. (2008). The public’s stigmatizing attitudes towards people with mental disorders: How important are biomedical conceptualizations? *Acta Psychiatrica Scandinavica*, 118, 315–321.
- Kvaale, E. P., Haslam, N., & Gottdiener, W. H. (2013). The ‘side effects’ of medicalization: A meta-analytic review of how biogenetic explanations affect stigma. *Clinical Psychology Review*, 33, 782–794.
- Lam, D. C., & Salkovskis, P. M. (2007). An experimental investigation of the impact of biological and psychological causal explanations on anxious and depressed patients’ perception of a person with panic disorder. *Behaviour Research and Therapy*, 45, 405–411.
- Lauber, C., Nordt, C., Falcato, L., & Rössler, W. (2004). Factors influencing social distance toward people with mental illness. *Community Mental Health Journal*, 40, 265–274.
- Link, B.G., & Cullen, F.T. (1986). Contact with the mentally ill and perceptions of how dangerous they are. *Journal of Health and Social Behavior*, 27(4), 289–302.

- Link, B.G., Cullen, F.T., Frank, J., & Wozniak, J.F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology*, *92*, 1461-1500. <https://doi.org/10.1086/228672>
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*, 363–385.
- Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services*, *52*, 1621–1626.
- Mashiach-Eizenberg, M., Hasson-Ohayon, I., Yanos, P. T., Lysaker, P. H., & Roe, D. (2013). Internalized stigma and quality of life among persons with severe mental illness: The mediating roles of self-esteem and hope. *Psychiatry Research*, *208*, 15–20.
- Mittal, D., Sullivan, G., Chekuri, L., Allee, E., & Corrigan, P. W. (2012). Empirical studies of self-stigma reduction strategies: A critical review of the literature. *Psychiatric Services*, *63*, 974–981.
- Morrison, A. P., & Barratt, S. (2009). What are the components of CBT for psychosis? A Delphi study. *Schizophrenia Bulletin*, *36*, 136–142.
- Norton, P. J. (2012). *Group cognitive-behavioral therapy of anxiety: A transdiagnostic treatment manual*. New York: Guilford Press.
- Phelan, J. C. (2002). Genetic bases of mental illness—a cure for stigma? *Trends in Neurosciences*, *25*, 430–431.
- Phelan, J. C. (2005). Geneticization of deviant behavior and consequences for stigma: The case of mental illness. *Journal of Health and Social Behavior*, *46*, 307–322.
- Phelan, J. C., Yang, L. H., & Cruz-Rojas, R. (2006). Effects of attributing serious mental illnesses to genetic causes on orientations to treatment. *Psychiatric Services*, *57*, 382–387.
- Rüsch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry*, *20*, 529–539.
- Rüsch, N., Todd, A. R., Bodenhausen, G. V., & Corrigan, P. W. (2010). Biogenetic models of psychopathology, implicit guilt, and mental illness stigma. *Psychiatry Research*, *179*, 328–332.
- Sadler, M. S., Meagor, E. L., & Kaye, K. E. (2012). Stereotypes of mental disorders differ in competence and warmth. *Social Science & Medicine*, *74*, 915–922.
- Sobell, L. C., & Sobell, M. B. (2011). *Group therapy with substance use disorders: A motivational cognitive behavioral approach*. New York: Guilford Press.
- Taylor, S. M., & Dear, M. J. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin*, *7*, 225–240.
- Thibodeau, R. (2016). Continuum beliefs and schizophrenia stigma: Correlational and experimental evidence. *Stigma and Health*, *2*, 266–270. Advance online publication.
- Thibodeau, R., Shanks, L. N., & Smith, B. P. (2018). Do continuum beliefs reduce schizophrenia stigma? Effects of a laboratory intervention on behavioral and self-reported stigma. *Journal of Behavior Therapy and Experimental Psychiatry*, *58*, 29–35.

- VanderZee, K. I., Buunk, B. P., & Sanderman, R. (1995). Social comparison as a mediator between health problems and subjective health evaluations. *British Journal of Social Psychology, 34*, 53–65.
- Vonnegut, M. (2010). *Just like someone without mental illness only more so: A memoir*. New York: Delacorte Press.
- Wiesjahn, M., Jung, E., Kremser, J. D., Rief, W., & Lincoln, T. M. (2016). The potential of continuum versus biogenetic beliefs in reducing stigmatization against persons with schizophrenia: An experimental study. *Journal of Behavior Therapy and Experimental Psychiatry, 50*, 231–237.
- Wright, E. R., Gronfein, W. P., & Owens, T. J. (2000). Deinstitutionalization, social rejection, and the self-esteem of former mental patients. *Journal of Health and Social Behavior, 41*, 68–90.