How Clinical Diagnosis Might Exacerbate the Stigma of Mental Illness

Patrick W. Corrigan

Stigma can greatly exacerbate the experience of mental illness. Diagnostic classification frequently used by clinical social workers may intensify this stigma by enhancing the public's sense of "groupness" and "differentness" when perceiving people with mental illness. The homogeneity assumed by stereotypes may lead mental health professionals and the public to view individuals in terms of their diagnostic labels. The stability of stereotypes may exacerbate notions that people with mental illness do not recover. Several strategies may diminish the unintended effects of diagnosis. Dimensional approaches to diagnosis may not augment stigma in the same manner as classification. Moreover, regular interaction with people with mental illness and focusing on recovery may diminish the stigmatizing effects of diagnosis.

KEY WORDS: diagnosis; DSM; empathy; stigma

Autistic children never play normally with other children. They often do not respond normally to their mothers' affections or to any tenderness. (Freedman, Kaplan, & Sadock, 1976, p. 449)

The sociopath persistently violates the rights of others, shows indifference to commitments, and encounters conflict with the law. (Rathus, 1984, p. 451)

These quotes are two examples of how the use of diagnostic terms can sometimes worsen the stigma of mental illness. Stigma can significantly undermine the quality of life of people with mental illness. The social opprobrium that results from stigma can rob people labeled mentally ill of a variety of work, housing, and other life opportunities commonly enjoyed by adults in the United States. It can also prevent some people who might otherwise benefit from clinical services from pursuing treatment in an effort to avoid the label.

One important part of the system of care—clinical diagnosis—may strengthen the stereotypes that lead to stigma. Diagnosis may intensify both the "groupness" and the "differentness" aspects governing public perceptions of people with mental illness.

THE PROBLEM OF THE STIGMA OF MENTAL ILLNESS

Stigma harms people with mental illness in three ways: label avoidance, blocked life goals, and self-stigma.

Label Avoidance

Epidemiological research has consistently shown that the majority of people who might benefit from mental health care either opt not to pursue it or do not fully adhere to treatment regimens once begun. As an example, consider people with schizophrenia, the group that might be construed as being most in need of services. Results from the Epidemiologic Catchment Area Study showed that only 60 percent of people with schizophrenia participated in treatment (Regier, Narrow, Rae, & Manderscheid, 1993). Taking into account symptom severity, Narrow and colleagues (2000) found that people with serious mental illness were no more likely to participate in treatment than those with relatively minor disorders. The National Comorbidity Survey showed similar results (Kessler et al., 2001); fewer than 40 percent of respondents with a serious mental illness such as schizophrenia had received medical treatment in the past year.

Research has suggested that many people choose not to pursue mental health services because they do not want to be labeled a "mental patient" or suffer the prejudice and discrimination that the label entails. Results from the Yale arm of the Epidemiological Catchment Area data showed negative attitudes about mental health inhibit service use in those at risk of a psychiatric disorder (Leaf, Bruce, Tischler, & Holzer, 1987). Findings from the National Comorbidity Survey identified stigmatizing beliefs...
that might sway people from treatment (Kessler et al., 2001). These included concerns about what others might think and the desire to solve one’s own problems. Sirey and colleagues (2001) found a direct relationship between stigmatizing attitudes and treatment adherence. Endorsing stigma was associated with whether 134 adults were compliant with their antidepressant medication regimen three months later. Hence, people may opt not to pursue treatment where labels are conferred to avoid the egregious effects of stigma.

**Blocked Opportunities**

A primary goal of mental health and rehabilitative services is to assist people in accomplishing their work, independent living, and relationship goals. In part, difficulties achieving goals occur because of the disabilities that result from serious mental illness (Corrigan, 2001). Some people with serious mental illness lack the social and coping skills to meet the demands of the competitive workforce and independent housing. Nevertheless, the problems of many people with psychiatric disability are further hampered by labels and stigma. People with mental illness are frequently unable to obtain good jobs or find suitable housing because of the prejudice of employers and landlords. Several studies have documented a consensus about the public’s widespread endorsement of stigmatizing attitudes (Bhugra, 1989; Brockington, Hall, Levings, & Murphy, 1993; Hamre, Dahl, & Malt, 1994; Link, 1987). These attitudes have a deleterious impact on people’s ability to obtain and keep good jobs (Farina & Felner, 1973; Farina, Felner, & Boudreau, 1973; Link, 1982, 1987; Wahl, 1999) and lease safe housing (Farina, Thaw, Lovern, & Mangone, 1974; Hogan, 1985a, 1985b; Page, 1977, 1983, 1995; Wahl). Similar research has shown that stigma may undermine the general medical care received by people with mental illness (Druss, Bradford, Rosenheck, Radford, & Krumholz, 2000).

**Self-Stigma**

People with mental illness who live in a society that widely endorses stigmatizing ideas may internalize these ideas and believe that they are less valued because of their psychiatric disorder (Link, 1987; Link & Phelan, 2001; Ritsher, Otilingam, & Graja-les, 2003). Like public stigma, self-stigma includes “buying into” a set of stereotypes: “That’s right; I am weak and unable to care for myself!” Self-stigma leads to automatic thoughts and negative emotional reactions; prominent among these are shame, low self-esteem, and diminished self-efficacy. Self-stigma may also have a behavioral effect. Low self-efficacy and demoralization have been shown to be associated with people’s failing to pursue work or independent living opportunities at which they might otherwise succeed (Link, 1982, 1987). Fueled by shame, their consequent behavior is to escape and avoid future similar situations.

**A SOCIAL COGNITIVE DEFINITION OF STIGMA**

Researchers working at the interface of social work and psychology have framed the stigma process in terms of four cognitive structures: cues, stereotypes, prejudice, and discrimination. This model (Figure 1) parallels a cognitive behavior model of action by specifying signal, cognitive mediator, and behavioral result (Corrigan, 2000). The process begins with stigmas, which are the cues that signal subsequent prejudice and discrimination.

Goffman (1963) adopted the term *stigma* from the Greeks who defined it as a mark meant to publicly and prominently represent immoral status. Stigmas are typically the marks that, when observed by a majority group member, may lead to prejudice. Goffman noted that some stigmas are readily apparent and based on a physical sign such as skin color (a cue for ethnicity) or body size (a cue for obesity). Other stigmas are relatively hidden; for example, the public cannot generally tell who among a group of people falls into such stigmatized groups as gay men, Catholics, undereducated people, and people with mental illness. Instead of an unequivocal physical cue, hidden stigma is signaled by label or association (Link, Cullen, Frank, & Wozniak, 1987; Penn & Martin, 1998). Labels may be self-promoted (“I am a gay male”) or given by others (“That person is mentally ill”). Hidden stigma can also be ascertained based on association; for example, observation of someone leaving a psychiatric clinic might lead to the assumption that the person is mentally ill.

Theorists in this area of study view stereotypes as knowledge structures that are learned by most members of a cued social group (Augoustinos, Ahrens, & Innes, 1994; Judd & Park, 1993; Krueger, 1996). Stereotypes are especially efficient means of categorizing information about social groups. Just because most people have knowledge of a set of stereotypes does not imply that they agree with them (Devine, 1989; Jussim, Nelson, Manis, &
Figure 1: Cognitive and Behavioral Structures that Comprise the Experience of Public Stigma against an Out-Group

<table>
<thead>
<tr>
<th>Cue</th>
<th>Stereotype</th>
<th>Prejudice</th>
<th>Discrimination</th>
</tr>
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<tbody>
<tr>
<td>The signal that evokes stereotypes, prejudice, and discrimination</td>
<td>Beliefs about all members of a minority group</td>
<td>• Endorse the belief</td>
<td>• Out-group behavior</td>
</tr>
<tr>
<td>• manifest—physical marks</td>
<td>• Negative emotional evaluation</td>
<td>• coercion</td>
<td>• avoidance</td>
</tr>
<tr>
<td>• hidden—labels</td>
<td></td>
<td>• In-group favoritism</td>
<td>• association</td>
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<thead>
<tr>
<th>Diagnostic Label</th>
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<td></td>
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Note that the model also outlines how elements of diagnosis may parallel and hence augment this process.

Soffin, 1995). For example, many people can recall stereotypes about different racial groups but do not agree that the stereotypes are valid. People who are prejudiced, on the other hand, endorse these negative stereotypes (“That’s right; all people with mental illness are violent”) and generate negative emotional reactions as a result (“They all scare me”) (Devine, 1995; Krueger). In contrast to stereotypes, which are beliefs, prejudicial attitudes involve an evaluative (generally negative) component (Eagly & Chaiken, 1993).

Prejudice, which is fundamentally a cognitive and affective response, leads to discrimination, the behavioral reaction (Crocker, Major, & Steele, 1998). Discriminatory behavior manifests itself as negative action against the out-group. Out-group discrimination includes outright violence (for example, lynching experienced by African Americans and assaults directed at gay men) and coercion (for example, laws that restrict the full rights of people in an ethnic or religious minority group, such as the Jim Crow laws of the late 1800s through the early 1960s). Out-group discrimination may also appear as avoidance, not associating with people from the out-group. This can be especially troublesome when employers decide not to hire and landlords decide not to rent to people from an ethnic or religious minority group to avoid them.

DIAGNOSIS AS STEREOTYPE

Stereotypes are one way in which a naïve public identifies and describes a stigmatized group, in this case people with mental illness. Mental health professionals use diagnosis and nosology to describe this group. As outlined in systems such as the Diagnostic and Statistical Manual of Mental Disorders (4th ed., or DSM-IV) (American Psychiatric Association [APA], 1994) and the International Statistical Classification of Diseases and Related Health Problems (10th ed.) (World Health Organization, 1992), diagnosis is fundamentally a classification enterprise. (Classification is not the only approach to diagnosis; continuous dimensions, which are discussed more fully later in this article, provide an alternative paradigm that is less prone to the stigma associated with categorization.) Thus, diagnosis assumes that all members of a group are homogeneous and that all groups are distinguished by definable boundaries (APA, 2000). Diagnostic classification serves several goals. It neatly corresponds with a dominant cognitive efficiency used by humans to understand a large amount of information (First, Frances, & Pincus, 1997; Rosch & Mueller, 1978). It provides clinicians with an efficient means for describing their patients that includes not only presentation of symptoms, but also expected course and prognosis. Diagnostic categorization may also suggest the causes of a syndrome as well as specific interventions that may ameliorate the disorder.

Despite these benefits, mental health professionals also recognize pitfalls to diagnosis and categorization (APA, 2000); one of these pitfalls is their impact on stigma. (The role of diagnosis in the stigma process is outlined in the bottom half of...
Figure 1.) First, the label provided by a diagnosis may act as a cue that signals stereotypes. Second, the criteria that define a diagnosis may augment the stereotypes that describe mental illness. Three processes—groupness, homogeneity, and stability—that influence the cognitive structures of stigma (that is, cues, stereotypes, prejudice, and discrimination) illustrate how diagnosis may exacerbate stigma. They are used here to further illustrate how diagnosis may exacerbate stigma.

Perceived Groupness

Groupness, or entitativity, is the degree to which a collection of people is perceived as a unified or meaningful entity (Campbell, 1958; Hamilton & Sherman, 1996). Groups have a sense of differentness from the population, based on a salient and socially important characteristic. Eye color and foot size are generally not qualities that lead to meaningful groups, whereas skin color and bizarre behavior are. Diagnosis adds to the salience of groupness for the collection of people with mental illness (Link & Phelan, 2001). It distinguishes people who are somehow different in terms of their psychiatric status from the general population. Note that the collection of people with mental illness still has a sense of groupness even without diagnostic systems. Research has shown a nonspecific prejudice against people who are mentally ill compared with people with other health conditions (Corrigan et al., 2000; Weiner, Perry, & Magnusson, 1988). However, diagnostic labels such as schizophrenia and psychosis seem to worsen the level of prejudice (Phelan, Link, Stueve, & Pescosolido, 2000).

Groupness and stereotypes have a bidirectional causal relationship (Crawford, Sherman, & Hamilton, 2002; Yzerbyt, Leyens, & Schadron, 1997; Yzerbyt, Rocher, & Schadron, 1997; Yzerbyt, Schadron, & Leyens, 1997). Stereotypes only make sense in terms of a meaningful group of people; the public fails to regularly recall stereotypes for amorphous classes. Hence, diagnoses that increase the sense of groupness will strengthen the stereotypes associated with mental illness. Conversely, stereotypes are the negative attributes that provide description to the group (Link & Phelan, 2001). Perceptions of groupness do not endure when not associated with attributes that describe them.

Is It the Label or the Bizarre Behavior? Does diagnosis make the stereotypes worse or does it merely highlight meaningful differences from the population that in fact occur because of abnormal psychiatric symptoms? Put another way, is aberrant behavior and not labels per se the source of stigma from the public (Gove, 1982; Clausen & Huffine, 1979)? According to Gove (1975), the label does not elicit negative stigmatizing reactions; rather, negative reactions result from the bizarre behaviors displayed by people with mental illness.

In an effort to resolve differences between labeling theory and actual symptoms, Link (1987) conducted a study in which label and aberrant behavior were independently manipulated in a series of vignettes. Results indicated that members of the general public were likely to stigmatize a person labeled mentally ill even in the absence of any aberrant behavior. Subsequent studies have replicated this finding (Link et al., 1987; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Link and colleagues (1987, 1999) posed a modified labeling theory to make sense of the diverse literature, concluding that psychiatric labels are associated with negative societal reactions that exacerbate the course of the person’s disorder. Although the debate over the mechanics of labeling remains unresolved, it seems clear that stigmatization has a negative impact on the lives of people with mental illness (Link & Cullen, 1983; Mechanic, McAlpine, Rosenfield, & Davis, 1994).

Homogeneity of Group Membership

Members of stereotyped out-groups are seen as more homogeneous than in-groups (Ashton & Esses, 1999; Rothbart, Davis-Stitt, & Hill, 1997; Tajfel, 1978). This leads to an overgeneralization error; namely, that all members of a group are expected to manifest the characteristics attributed to that group. All people diagnosed with schizophrenia are expected to hallucinate and all people with depression are assumed to be suicidal. Diagnosticians have noted this concern when advising clinicians in the text revision of the DSM-IV (APA, 2000) to use clinical judgment and flexibility to ensure that the description of individual cases is not solely voiced in terms of the diagnostic criteria: “There is no assumption that all individuals described as having the same mental disorders are alike in all important ways” (p. xxxi).

Despite this concern, clinical writings are replete with examples in which people with specific disorders are reduced to caricatures based on their diagnoses. In his classic text on neurotic styles, Shapiro (1965) described diagnoses thusly:
Hysterical people, we know, are inclined to a
Prince-Charming-will-come-and-everything-will-turn-out-all-right view of life. (p. 118)

In the paranoid person, even more sharply and severely than in the case of the obsessive-compulsive, every aspect and component of normal autonomous functioning appears in rigid, distorted, and in general hypertrophied form. (p. 80)

More recently, Millon (1981) described people with personality disorders in terms of the group with which they are classified:

Narcissists feel justified in their claim for special status, and they have little conception that their behaviors may be objectionable, even irrational. (p. 167)

Most borderlines exhibit a single, dominant outlook or frame of mind, such as a self-in-gratiating depressive tone, which gives way periodically, however, to anxious agitation or impulsive outbursts of inappropriate temper or anger. (p. 349)

These examples are more than 20 years old, and there is evidence that diagnosticians are writing in a less stigmatizing tone now. The Institute of Medicine (2001) provided a comprehensive summary on the international state of neurological, psychiatric, and developmental disorders. This text is remarkable in the ways in which people with specific disorders were portrayed: not in terms of specific characteristics that automatically represent them because of diagnosis but instead as a range of dimensional probabilities. The Institute of Medicine text did a marvelous job of describing diagnoses while respecting the heterogeneity of individuals with that diagnosis. Nevertheless, there continue to be contemporary examples of professional texts that equate diagnosis with person. For example, a book by Fischler and Booth (1999) attempted to explain vocational disabilities in terms of psychiatric diagnoses.

People in the “dramatic” cluster are rarely capable of empathy. They are often self-centered and prone to temper tantrums. They tend to be irresponsible, impulsive, and remarkably free of remorse. Deceit, superficiality, and arrogance cloud all of their relationships. (from chapter 5, p. 175)

Perhaps most troubling about these kinds of messages are the poor prognoses and limited implications for treatment that often accompany them. In writing further about people with diagnoses in the “dramatic” cluster, Fischler and Booth (1999) said, “They have great power to create confusion, disruption, and violence in the workplace; their presence there is a stick of dynamite waiting for a match” (p. 222). This clearly undermines any attempt to place an individual with this diagnostic label in a work setting. Tying diagnosis to vocational rehabilitation plan in this fashion is especially disconcerting given that research has largely suggested that diagnosis is not predictive of a person’s success in working with rehabilitation providers in obtaining employment (Bond et al., 2001).

Stability of Group Descriptors
Stereotypic descriptions about stigmatized groups often include a component of stability; namely, the traits that describe a group are believed to remain relatively static and unchanging (Anderson, 1991; Kashima, 2000). This quality of stereotypes can be especially problematic for health conditions because it suggests that people with specific disorders do not recover from those disorders. This can lead to unnecessarily pessimistic attitudes about prognosis and the treatment efficacy.

Research has suggested that stability attributions can be especially troublesome for people with psychiatric diagnoses. Studies have shown that people with psychiatric disorders are viewed by the public as less likely to overcome their disorders than those with physical illnesses (Corrigan et al., 2000; Weiner et al., 1988). This coincides with an especially egregious myth about people with mental illness, especially those with serious psychiatric disorders; namely, that people with mental illness do not recover (Harding & Zahniser, 1994). This kind of myth leads to a general pessimism that can undermine people’s sense of self-esteem and self-efficacy, which, in turn, prevents many people with psychiatric disorders from pursuing their life goals (Corrigan, in press).

SOLUTIONS TO THE STIGMA PROBLEM
Thus far, I have provided evidence that suggests that an unintended consequence of diagnosis is the exacerbation of the stigma of mental illness. In part, I hope that highlighting this link may diminish ways in which social workers and other professionals...
Rather than assign someone to a class of people with similar symptoms, course, and disabilities, dimensional diagnosis seeks to describe a person's profile of symptoms on a continuum.

write about, and otherwise describe, individuals with psychiatric disorders using stigmatizing language. In addition, there are three ways in which the stigma that results from diagnosis may be reduced.

Understand Diagnosis as a Continuum
As suggested earlier, an alternate way to understand diagnosis is dimensionally rather than categorically (Widiger, 2001). Rather than assign someone to a class of people with similar symptoms, course, and disabilities, dimensional diagnosis seeks to describe a person's profile of symptoms on a continuum. This changes the question of diagnosis from "yes or no, the person is mental illness 'X'" to "the person is having the following sets of problems compared with a standard." This also changes the notion of treatment from moving the person out of the diagnostic class to decreasing his or her problems as indexed by the symptom and disability continua.

Experimental psychopathologists have convincingly argued that diagnoses may be better described in terms of dimensions, which vary continuously on symptom and other deficit indicators, rather than as independent classes or taxa, which are described by discrete syndromes (Widiger & Clark, 2000). In part, support of a dimensional view is based on the inability to support taxometric models with empirical research (Widiger, 2001). Support of dimensional models also rests on the descriptive and prognostic benefits sowed by multidimensional, continuous models of disorder (Widiger, 1983). In terms of diagnosis as an instrument of stigma, a dimensional model diminishes the groupness of psychiatric disorders. Instead of people with mental illness being qualitatively distinct from the "normal" population, mental illness falls on a continuum that includes normalcy. Interestingly, although the DSM-IV already recognizes the utility of a dimensional approach, it has not yet adapted this view because dimensions are less familiar to clinicians and less descriptive than categorical labels (APA, 2000). Perhaps future iterations of the DSM will move toward a dimensional approach that will decrease the stigmatizing effects of diagnosis.

Have Contact with the Individual
One problem with diagnosis as classification is replacing idiographic perceptions of the individual with normative statements about the group. One way to overcome this problem is to stress the individual over the group. Research on stigma change shows that contact between the public and people with mental illness leads to significant change in stereotypes about mental illness (Corrigan, 2001; Corrigan et al., 2002). Contact counters the stigma by highlighting people as individuals with complex lives that exceed the narrow descriptions of diagnosis.

There are nevertheless significant limitations to contact. Mental health providers, for example, have frequent contact with people labeled mentally ill but unfortunately tend to endorse the stigma (Chaplin, 2000; Lyons & Ziviani, 1995; Mirabi, Weinman, Magnetti, & Keppler, 1985). In part, this may reflect their focus on diagnosis and psychopathology; largely seeing people in terms of diagnostic groups rather than as individuals. This may also be a consequence of the type of contact that professionals have with people with mental illness; namely, professionals tend to interact with people when they are most in need of services, when they are acutely ill. Professionals are much less likely to interact with their clientele when they have recovered and when they are living a life that challenges the stigma. Stigma might be better challenged if professionals round out their picture of individuals with mental illness by purposefully interacting with those who have recovered (Corrigan & Lundin, 2001). Student training, for example, may include encounters with people in recovery so trainees can learn early that psychopathology is only one side of the illness coin; recovery is the other.

Replace Assumptions of Poor Prognosis with Models of Recovery
The stability of stereotypes has led to the notion that many people with mental illness fail to respond to treatment and recover. This phenomenon is reflected in classic writings about the prognoses of people with serious mental illness. Kraepelin (1913), for example, said that people with schizophrenia and other serious mental illnesses will inevitably experience a progressive downhill course, ending
up demented and incompetent. The impact this has had on treatment is insidious; why try valiant interventions if the person is going to eventually end up on a back ward of a psychiatric hospital? Longitudinal research, however, has failed to support Kraepelin’s assertion. For example, researchers in Vermont and Switzerland followed several hundred adults with severe mental illness for 30 years or more to find out how mental illness affected the long-term course of the disorder (Harding, 1988). If Kraepelin was right, the majority of these people should have ended up on the back wards of state hospitals. Instead, researchers discovered that between half to almost two-thirds of the sample no longer required hospitalization, were able to work in some capacity, and lived comfortably with family or friends; they recovered. Although Kraepelin’s work is almost 100 years old, it is still reflected in modern psychopathology tests and even in the third revised edition of the DSM (APA, 1987). Professionals need to broaden their perspectives to include notions of recovery.

CONCLUSIONS
Sociologists have developed models of stigma that are helpful for understanding the impact of diagnosis. They defined structural stigma as institutional efforts that unintentionally lead to discrimination of a group (Hill, 1988; Wilson, 1990). For example, many universities and colleges use the SAT or ACT to limit admission to students who have earned high scores, believing this to be an unbiased way to select students. However, given that African American and Hispanic students typically score lower than white students on these tests, universities that rely on the SAT and ACT are likely to prevent a disproportionate number of black and Hispanic students from receiving an education with them (Pincus, 1999).

In this case, structural stigma unintentionally leads to race discrimination. Diagnosis is an example of structural stigma as applied to mental illness. Although diagnostic systems are developed by social work and other mental health professionals to better understand mental illness, they unintentionally exacerbate the stigma of mental illness. Diagnostic classifications augment public perceptions of the groupness and differentness of people with mental illness. These classifications are perceived as homogeneous, and composite traits are seen as stable. As a result, individual members of a diagnostic class tend to be seen in terms of their diagnosis instead of the idiosyncratic nature of their problems. One way to change this kind of stigma is to challenge the very foundation on which it rests. Changing to a dimensional perspective of diagnosis undermines the sense of difference perpetuated by diagnosis and replaces psychiatric classification with a continuum that includes normal life. Stressing the evidence that supports recovery will diminish the stigma related to diagnosis. Facilitating interactions between professionals and people in recovery will also challenge the stigma.

The diagnostic enterprise has much value for clinical care. I do not mean to suggest that it be discarded. Instead, my effort here is to alert the reader to the insidious effects of diagnosis on stigma. Following the recommendations in this article may ensure that diagnosis does not add to the prejudice and discrimination experienced by many people with mental illness.

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