

# ANNOTATED BIBLIOGRAPHY

## Volume I

### Research Findings on Strategies for Reducing the Stigma and Discrimination Associated with Mental Illness

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## I. Introduction

This annotated bibliography was developed in November 2008 by Kirsten Deichert, Office of External Affairs, California Department of Mental Health, for use in the development of the California Strategic Plan to Reduce Stigma and Discrimination. This is intended to compliment the research described in, “Eliminating Stigma and Discrimination against Persons with Mental Health Disabilities: A Project of the Mental Health Services Act (MHSA),” which was submitted in June 2007 to the Mental Health Services Oversight and Accountability Commission<sup>1</sup>. That report includes a great deal of information and research findings to establish and describe the problems of stigma and discrimination. Section III of this annotated bibliography provides some additional detail to establish the problem, but focuses primarily on strategies for addressing the problem. Reviewing literature and research studies is an ongoing process as new information becomes available nearly every day. Therefore, this is not intended to be a complete representation of all that is known on the topic, but rather a preliminary volume of information that may be useful to individuals developing the California Strategic Plan to Reduce Stigma and Discrimination. Additional information will be added over time. Suggestions are welcome, and should be sent to [kirsten.deichert@dmh.ca.gov](mailto:kirsten.deichert@dmh.ca.gov).

## II. Method

This annotated bibliography contains articles identified through database searches of Academic Search Complete, SocINDEX, MEDLINE, Education Research Complete, and Health Source. Articles were included in the annotated bibliography if they discussed and reached conclusions about the phenomena of stigma and discrimination, particularly toward people with mental illness, as well as reviewed the effectiveness of particular strategies to reduce the phenomena. Additional sources for information were American and other nations’ governmental and non-profit web sites devoted to this topic.

## III. Definitions

### a. Stigma, Discrimination, Prejudice, and Stereotypes

- In a discussion of the variations in the definition of “stigma,” the authors conclude that stigma exists when five interrelated components converge: (1) “people distinguish and label human differences;” (2) “dominant cultural beliefs link labeled persons to undesirable characteristics—to negative stereotypes;” (3) “labeled persons are placed in distinct categories so as to accomplish some degree of separation of ‘us’ from ‘them;” (4) “labeled persons experience status loss and discrimination that lead to unequal outcomes;” and (5) stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination.” Therefore, the term “stigma” is applied within the context of a power situation.<sup>2</sup>
- In a discussion of the roots of stigmatization, the author argues that people continuously assess others as a matter of basic survival, and this is the basis for negative stigmatization that leads to discrimination and exclusion of people with mental illness. Humans constantly assess others to determine if they should be feared, are a competitor, will be a burden, are disturbing the equilibrium in the group, or could be a possible partner to mate or join.<sup>3</sup>

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<sup>1</sup> Available online at: <http://www.dmh.ca.gov/MHSOAC/docs/StigmaAndDiscriminationReport07Jun12.pdf>

<sup>2</sup> Link, B.G., Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363-385.

<sup>3</sup> Jacobsson, L. (2002). The roots of stigmatization. *World Psychiatry*, 1(1), 25.

- In a discussion of what causes stigma, the author asserts that there are two fundamental elements: recognizing a differentiating “mark” (condition) and the subsequent devaluation of the person. In addition to stereotypes, prejudice, and discrimination, three other concepts perpetuate stigmatizing attitudes: the *visibility* of the mark/condition, the degree to which the person is perceived to have *control* of the mark/condition, and the extent to which it might *impact* others.<sup>4</sup>

#### **b. Social Inclusion**

- In an overview of voting rights for people with mental illness, the authors suggest that “social inclusion” means “equality of opportunity to access and participation in the rudimentary and fundamental functions of society,” including healthcare access, employment, education, good housing, recovery of status and meaning, and reduced impact of disability.<sup>5</sup>
- In contrast, in the UK, the Prime Minister set up a Social Exclusion Unit (SEU) in December 1997. The SEU defines “social exclusion” as “a shorthand for what can happen when individuals or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown.”<sup>6</sup>

#### **c. Social Marketing**

- A commonly used definition of social marketing is: “The application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of society.”<sup>7</sup>

### **IV. Establishing the Problem of Stigma and Discrimination**

#### **a. Consumers**

- Children and adults with experience of mental illness are at high risk of internalizing stigma and suffering diminished self-esteem, confidence, and mastery in their own abilities.<sup>8,9</sup>

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<sup>4</sup> Arboleda-Flórez, J. (2002). What causes stigma? *World Psychiatry*, 1(1), 25-26.

<sup>5</sup> Nash, M. (2002). Voting as a means of social inclusion for people with a mental illness. *Journal of Psychiatric and Mental Health Nursing*, 9, 697–703.

<sup>6</sup> Social Exclusion Unit (1998). *Preventing Social Exclusion: Social Exclusion and Why it Matters*, 1–12.  
<http://www.cabinet-office.gov.uk/seu/>

<sup>7</sup> Andreasen, A.R. (1995). *Marketing Social Change: Changing Behaviour to Promote Health, Social, Development, and the Environment*. Jossey-Bass Publications: San Francisco, CA.

<sup>8</sup> Corrigan, P.W. (1998). The impact of stigma on severe mental illness. *Cognitive and behavioral practice*, 5, 201-222.

<sup>9</sup> Link, B.G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the efforts of expectations of rejection. *American Sociological Review*, 5, 96-112.

- Fear of stigma and rejection can lead to limited social supports, poor life satisfaction, unemployment, or loss of income. A study of 70 members of a clubhouse program for people with mental illness found that perceptions of stigma strongly predicted self-esteem at follow-up when baseline self-esteem, depressive symptoms, demographic characteristics, and diagnosis were controlled for. The stigma associated with mental illness harms the self-esteem of many people who have serious mental illnesses. An important consequence of reducing stigma would be to improve the self-esteem of people who have mental illnesses.<sup>10</sup>
- Sixty women with borderline personality disorder and 30 women with social phobia who were recruited at three centers in Germany and Switzerland, completed stigma-related questionnaires. After depression and index diagnosis were controlled for, a low level of perceived discrimination and of the legitimacy of discrimination predicted high self-esteem and high empowerment. Identification with the group of people with mental illness did not predict self-esteem or empowerment.<sup>11</sup>
- Many people who would benefit from mental health services opt not to pursue them or fail to fully participate once they have begun. One of the reasons for this disconnect is stigma; namely, to avoid the label of mental illness and the harm it brings, people decide not to seek or fully participate in care.<sup>12</sup>

#### **b. Family Members**

- Family members of relatives with mental illness or drug dependence (or both) report that they are frequently harmed by public stigma. A national sample of 968 people was given a vignette describing a person with a health condition and a family member. Family stigma related to mental illnesses, such as schizophrenia, is not highly endorsed. Family stigma related to drug dependence, however, is worse than for other health conditions, with family members being blamed for both the onset and offset of a relative's disorder and likely to be socially shunned.<sup>13</sup>
- Focus group interviews with 122 members of advocacy groups from different parts of Germany found that discrimination and disadvantages encountered by relatives of schizophrenia patients reach far beyond the spheres of direct social interaction and social roles. The study revealed two additional domains in which relatives encounter stigmatization: structural discrimination and public images of mental illness. Furthermore, psychiatry has been identified as one important source of stigma. Relatives also suggested numerous anti-stigma interventions that can be grouped into five main categories: communication measures, support for the ill and their relatives, changes in mental health care, education and training, and control and supervision.<sup>14</sup>

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<sup>10</sup> Link, B.G., Stuenkel, E.L., Neese-Todd, S., et al. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services*, 52(12), 1621-1626.

<sup>11</sup> Rüsck, N., Lieb, K., Bohus, M., Corrigan, P.W. (2006). Self-stigma, empowerment, and perceived legitimacy of discrimination among women with mental illness. *Psychiatric Services*, 57(3), 399-402.

<sup>12</sup> Corrigan, P.W. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7), 614-625.

<sup>13</sup> Corrigan P.W., Watson A.C., Miller F.E. (2006). Blame, shame, and contamination: the impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology*, 20(2), 239-46.

<sup>14</sup> Angermeyer M.C., Schulze B., Dietrich S. (2003). Courtesy stigma--a focus group study of relatives of schizophrenia patients. *Social Psychiatry and Psychiatric Epidemiology*, 38(10), 593-602.

**c. Public Policy and Law**

- A study of American state legislation in 2002 found that legislation frequently confuses “incompetence” with “mental illness.”<sup>15</sup>
- The author asserts that people who “adopt resistance strategies may actually face less stigma, experience less social harm, and be better able to cope with any discrimination.” The author discusses that the legal protection against stigma is limited because it addresses behavior, but not the attitudes that produce behavior. Additionally, stigma may not take the form of overt acts. In America, since discrimination laws are tied to intent, judges “demand proof that a person actively disliked somebody and wanted to do harm, in order to show discrimination.”<sup>16</sup>
- Most disability discrimination complaints are never investigated by government enforcement agencies.<sup>17</sup>

**d. Media**

- A survey of over 3,000 newspapers found that 39% focused on dangerousness and violence, and were featured in the front section.<sup>18</sup>
- A study of over 1,700 newspaper articles found that cancer was used in a metaphorical way in only 1% of articles mentioning cancer, whereas schizophrenia was used metaphorically in 28% of articles that mentioned schizophrenia.<sup>19</sup>
- A study of 34 animated Disney films found that 85% contain verbal references to mental illness, with an average of 4.6 references per film. The references were mainly used to set apart and denigrate the characters to which they referred.<sup>20</sup>

**e. Age Groups**

- A survey of nearly 4,000 Australian adults 18 and older found that young adults (18-24) were better than older adults (70+) at recognizing depression and schizophrenia, but slightly less so with schizophrenia. Older adults were more likely to believe that schizophrenia could be caused by character weakness, and less likely to view treatments as helpful. The researchers conclude that programs to improve mental health literacy should involve messages that appeal to the unique interests and pre-existing beliefs of both younger and older age groups.<sup>21</sup>

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<sup>15</sup> Corrigan, P.W. et al. (2005). Structural stigma in state legislation. *Psychiatric Services*, 56:5.

<sup>16</sup> Burris, S. (2006). Stigma and the law. *The Lancet*, 367, 529-531.

<sup>17</sup> Moss, K., Phelan, J. (2001). Unfunded mandate: an empirical study of the implementation of the ADA by the Equal Employment Opportunity Commission. *Kansas Law Review*, 50, 1-110.

<sup>18</sup> Corrigan, P.W. et al. (2005). Newspaper stories as measures of structural stigma. *Psychiatric Services*, 56(5), 551-6.

<sup>19</sup> Duckworth, K. et al. (2003). Use of schizophrenia as a metaphor in US newspapers. *Psychiatric Services*, 54:10, 1402-4.

<sup>20</sup> Lawson, A. (2004). Mental illness in Disney animated films. *Canadian Journal of Psychiatry*, 49:5, 310-4.

<sup>21</sup> Farrer, L., Leach, L., Griffiths, KM, Christensen, H., Jorm, AF (2008). Age differences in mental health literacy. *BMC Public Health*, 8, 125.

- A survey of 116 undergraduate students found:<sup>22</sup>
  - Stigmatization of schizophrenia significantly higher than of depression;
  - No impact by changing the psychiatric terminology for mental illness; and
  - Higher stigmatization among males than females.
- The authors reviewed literature on social cognitive development and ethnic prejudice and its implications on mental illness stigma. Children as young as three show some endorsement of stereotypes about people of color, which slowly increases and seems to peak around age five to six. Older children, interestingly, show lower rates of ethnic prejudice. Differences between mental illness and ethnicity-related stigma may influence the form of this relationship. Strategies that are reviewed include education, contact, social cognitive skills training, role-play for empathy, peer interaction, protest and consequences.<sup>23</sup>
- According to a report by the American Sociological Society, children with mental illness are more likely to be socially rejected than children with physical illness. In addition, parents are skeptical about their child having an association with a child with depressive symptoms.<sup>24</sup>
- A study of children between ages five and eleven found that children's understanding of mental illness increases with age, and the older children demonstrated a more sophisticated and accurate thinking of mental illness. The study found that girls exhibited more compassion and social acceptance than boys.<sup>25</sup>
- A 2002 survey in which respondents either answered questions about a vignette in which an adult had depression or one in which a child had depression found that Americans are more concerned about children's depression than adults.' Respondents' also saw a greater potential for violence among children than adults. While treatment of all types was more endorsed for children, significantly fewer recommended talking to family and friends about a child's mental health problem than an adult's<sup>26</sup>.

#### **f. Involuntary Treatment**

- "Protection and Advocacy reported in 2003 that California follows the national trend: despite extensive federal reforms, 22 deaths occurred between 1999 and 2003 to people who were in seclusion and restraints."<sup>27</sup>
- A longitudinal study of 76 individuals court-ordered to outpatient treatment and a control group of 108 who were not were examined to test two competing perspectives on the role of stigma in coercive treatment. The first holds that stigma results from untreated mental illness symptoms. As such, providing access to treatment (even if coercive) will improve a person's symptoms, quality of life, and social acceptance. The second holds that stigma is worsened when a person is coercively treated because it removes them from the mainstream, decreases their self-esteem, and interferes with their recovery. Researchers concluded that

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<sup>22</sup> Mann, C.E. et al. (2004). Factors associated with stigmatization of persons with mental illness. *Psychiatric Services*, 55:2, 185-7.

<sup>23</sup> Corrigan, P.W., Watson, A.C. (2007). How children stigmatize people with mental illness. *International Journal of Social Psychiatry*, 53(6), 526-46.

<sup>24</sup> (2007) *Brown University Child & Adolescent Behavior Letter*, 23(5), 2.

<sup>25</sup> Fox, C., Buchanan-Barrow, E., Barrett, M. (2008). Children's understanding of mental illness: An exploratory study. *Child: Care, Health & Development*, 34(1), 10-18.

<sup>26</sup> Perry, B.L., Pescosolido, B.A., Martin, J.K., McLeod, J.D., Jensen, P.S. (2007). Comparison of public attributions, attitudes, and stigma in regard to depression among children and adults. *Psychiatric Services*, 58(5), 632-5.

<sup>27</sup> Corrigan, P.W., Watson, A.C. (2007). How children stigmatize people with mental illness. *International Journal of Social Psychiatry*, 53(6), 526-46.

both perspectives are needed. Participants ordered to outpatient treatment were no more likely to perceive they were being coerced, nor perceived devaluation/discrimination. However, those with longer histories of involuntary treatment did feel more coerced. Being ordered to outpatient treatment was associated with improvements in social functioning and quality of life. The study did not find evidence that the presence or absence of psychotic symptoms determined stigma, quality of life, or perceptions of coercion. Finally, perceived coercion was associated with increased devaluation-discrimination and decreased quality of life.<sup>28</sup>

#### **g. Ethnic Groups**

- “The lack of appropriate language services is one of the major barriers to accessing the mental health system...Federal and state laws, including the Civil Rights Act of 1964, grant rights to equal access to services and require that language services be provided free of charge. But despite these protections, discrimination in access because of language barriers continues to be a significant roadblock to treatment in the mental health system.”<sup>29</sup>
- “While underserved in the voluntary community system of mental health care, minority groups, particularly African-Americans and Native Americans, are overrepresented in coercive services involving involuntary inpatient hospitalization. In particular, African-Americans are disproportionately diagnosed with schizophrenia in many cases where a correct diagnosis is depression or bipolar disorder, resulting in incorrect treatment. Physicians are also less likely to prescribe the newer generation antidepressant or antipsychotic medications to African-Americans who need them...People of color receive higher doses of high side-effect medications, are subject to more involuntary medications, and are subjected to restraints at higher rates than whites. Longstanding federal anti-discrimination laws prohibit this treatment, but they have rarely been used to challenge practices in the mental health system.”<sup>30</sup>
- A study of community college students found that, at baseline, African Americans and Asians perceived people with mental illness as more dangerous and wanted more segregation than Caucasians, and Latinos perceived people with mental illness as less dangerous and wanted less segregation than Caucasians. Similar patterns emerged post-intervention, except that Asians' perceptions changed significantly such that they tended to perceive people with mental illness as least dangerous of all the racial/ethnic groups. These findings suggest that racial/ethnic background may help to shape mental illness stigma, and that targeting anti-stigma interventions to racial/ethnic background of participants may be helpful.<sup>31</sup>

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<sup>28</sup> Link, B., Castille, D.M., Stuber, J. (2008). Stigma and coercion in the context of outpatient treatment for people with mental illnesses. *Social Science and Medicine*, In press, doi:10.1016/j.socscimed.2008.03.015.

<sup>29</sup> Mildred, L. (2007). Eliminating the stigma and discrimination against persons with mental health disabilities: A project of the Mental Health Services Act.

<sup>30</sup> Mildred, L. (2007). Eliminating the stigma and discrimination against persons with mental health disabilities: A project of the Mental Health Services Act.

<sup>31</sup> Rao D., Feinglass J., Corrigan P. (2007). Racial and ethnic disparities in mental illness stigma, *Journal of Nervous and Mental Disease*, 195(12), 1020-3.

- A nationally representative sample of 968 individuals was asked to respond to a vignette describing a person with a health condition (schizophrenia, drug dependence, or emphysema) and his/her family member. The study found that women and people with higher education levels were less likely to endorse stigma, and nonwhite people were more likely to endorse stigma than whites.<sup>32</sup>
- The study utilized data generated from 30 individuals across 6 focus groups of Latino outpatients receiving antidepressants. Perceptions of stigma were related to both the diagnosis of depression and use of antidepressant medication. Antidepressant use was seen as implying more severe illness, weakness or failure to cope with problems, and being under the effects of a drug.<sup>33</sup>

#### **h. Violence**

- Authors find that rates of victimization for individuals with severe psychiatric disorders are shown to be high and far greater than those for the general population, despite the heterogeneity of studies in terms of sample characteristics, measures, methods and analyses. Certain types of factors - clinical, treatment, contextual - raise the probability of becoming a victim, as does the fact of having already been the author or the victim of a misdemeanor or crime.<sup>34</sup>

#### **i. Sexual Orientation**

- “For most of the history of this country, homosexuals have been... forced into treatment, been hospitalized against their will...”<sup>35</sup>

#### **j. Mental Health Staff**

- A study of 120 registered or assistant nurses in Sweden found that somatic care, to a higher degree than nursing staff in mental health, reported more negative attitudes with regard to people with schizophrenia as being more dangerous and unpredictable. In contrast, professional experience, intimacy with mental illness and type of care organization were found to be more associated with attitudes to specific mental illnesses concerning the prospect of improvement with treatment and the prospect of recovery.<sup>36</sup>
- Responses from 122 nurses indicated that psychiatric nursing is the least preferred specialty of 10 areas and psychiatric nurses were least likely to be described as skilled, logical, dynamic, and respected. The findings suggest that psychiatric nursing may be stigmatized by association.<sup>37</sup>

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<sup>32</sup> Corrigan P.W., Watson A.C. (2007). The stigma of psychiatric disorders and the gender, ethnicity, and education of the perceiver. *Community Mental Health Journal*, 43(5), 439-58.

<sup>33</sup> Interian A., Martinez I.E., Guarnaccia P.J., Vega W.A., Escobar J.I. (2007). A qualitative analysis of the perception of stigma among Latinos receiving antidepressants. *Psychiatric Services*, 58(12), 1591-4.

<sup>34</sup> Lovell A.M., Cook J., Velpry L. (2008). Violence towards people with severe mental disorders: A review of the literature and of related concepts. *Revue d'épidémiologie et de santé publique*, 56(3), 197-207.

<sup>35</sup> Platt, T. (2000). Religion, sexuality and social work. Unpublished paper.

<sup>36</sup> Björkman T., Angelman T., Jönsson M. (2008). Attitudes towards people with mental illness: a cross-sectional study among nursing staff in psychiatric and somatic care. *Scandinavian Journal of Caring Sciences*, 22(2), 170-7.

<sup>37</sup> Halter M.J. (2008). Perceived characteristics of psychiatric nurses: stigma by association. *Archives of Psychiatric Nursing*, 22(1), 20-6.

- A comparison of two representative Swiss samples, one comprising of 90 psychiatrists, the other including 786 individuals of the general population, found that psychiatrists' attitudes were significantly more positive than that of the general population. The statement that mental health facilities devalue a residential area has revealed most agreement. Psychiatrists and the public do not differ in their social distance to mentally ill people. Among both samples, the level of social distance increases the more the situation described implies "social closeness". The authors conclude that using psychiatrists as role models or opinion leaders in anti-stigma campaigns cannot be realized without accompanying actions. Psychiatrists must be aware that their attitudes do not differ from the general public and, thus, they should improve their knowledge about stigma and discrimination towards people with mental illnesses.<sup>38</sup>
- A survey of 1,073 mental health professionals and 1,737 members of the public found that psychiatrists had more negative stereotypes than the general population, but accepted restrictions toward people with mental illness 3 times less often than the public. Most professionals were able to recognize cases of schizophrenia and depression, but 1 in 4 psychiatrists and psychologists also considered the non-case as mentally ill. The study concludes that the better knowledge of mental health professionals and their support of individual rights neither entail fewer stereotypes nor enhance the willingness to closely interact with mentally ill people.<sup>39</sup>
- A study of mental health professionals' attitudes toward community integration of people with serious and persistent mental illness found that mental health staff at outpatient psychiatric clinics hold more exclusionary attitudes than staff in agencies providing residential services or advocating on behalf of people with severe and persistent mental illnesses.<sup>40</sup>

#### **k. Rural vs. Urban**

- In a study of 200 people from metropolitan and adjacent non-metropolitan counties in Arkansas found that rural residents with a history of depressive symptoms labeled people who sought professional help for depression somewhat more negatively. The more negative the labeling of a vignette about depression, the less likely depressed rural residents were to have sought professional help. The authors conclude that it is the labeling associated with seeking treatment – not the disorder itself – that predicts whether rural people with depression have sought professional help. As such, the public image of people who seek treatment for depressive symptoms needs to be a focus.<sup>41</sup>

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<sup>38</sup> Lauber C., Anthony M., Ajdacic-Gross V., Rössler W. (2004). What about psychiatrists' attitude to mentally ill people? *European Psychiatry*, 19(7), 423-7.

<sup>39</sup> Nordt C, Rössler W, Lauber C. (2006). Attitudes of mental health professionals toward people with schizophrenia and major depression. *Schizophrenia Bulletin*, 32(4), 709-14.

<sup>40</sup> Modovan, V. (2007). Attitudes of mental health workers toward community integration of the persons with serious and persistent mental illness. *American Journal of Psychiatric Rehabilitation*, 10(1), 19-30.

<sup>41</sup> Rost, K., Smith, G.R., Taylor, J.L. (1993). Rural-urban differences in stigma and the use of care for depressive disorders. *Journal of Rural Health*, 9(1), 57-62.

## I. Workplace

- Analysis of the 1994-95 National Health Interview Survey-Disability Supplement found that workers' self-reports of stigmatizing experiences in the labor market appear to be consistent with econometric measures on the effect of stigma on wages, suggesting that workers know when they are being discriminating against.<sup>42</sup>
- Compared with persons with different types of general medical disorders, those with mental disorders have the strongest stigma rankings, lowest employability rankings, and largest productivity-adjusted wage differentials.<sup>43</sup>
- Among the 117 businesses interviewed, 68% make an effort to hire minorities, 41% make an effort to hire people with general medical disorders, but only 33% made an effort to hire persons with mental disorders.<sup>44</sup>
- A 1995 survey of US employers showed that half would rarely employ someone with a psychiatric disability and almost a quarter would dismiss someone who had not disclosed a mental illness.<sup>45</sup>
- One in three mental health consumers in the US report being turned down for a job once their psychiatric status became known, and in some cases, job offers were rescinded when a psychiatric history was revealed.<sup>46,47</sup>
- Employers are less likely to hire people with mental disorders into executive positions.<sup>48</sup>
- Mental disorders are the second most common basis for charges of discrimination and workplace harassment under the ADA.<sup>49</sup> Of the 263 disability cases brought to trial in 2004, only 2% favored the employee. Of the 54 cases that were brought by people with mental disabilities, 76% favored the employer, 24% were unresolved, and none favored the employee.<sup>50</sup>
- Human resource officers in UK companies were provided vignettes of job applicants that were identical, except for their diagnoses. A label of depression significantly reduced the chances of employment, based on perceptions of poor work performance, but not based upon expectations of future absenteeism.<sup>51</sup>

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<sup>42</sup> Baldwin, M., Marcus, S.C. (2006). Perceived and measures stigma among workers with serious mental illness. *Psychiatric Services*, 57(3), 388-392.

<sup>43</sup> Baldwin, M.L., Johnson, W.G. (2004). Labor market discrimination against men with disabilities. *Journal of Human Resources*, 29, 1-19.

<sup>44</sup> Scheid, T.L. (2000). Compliance with the ADA and employment of those with mental disabilities in Employment, Disability, and the Americans with Disabilities Act: Issues in Law, Public Policy, and Research. Edited by Blanck PD, Northwestern University Press.

<sup>45</sup> Manning, C., White, P.D. (1995). Attitudes of employers to the mentally ill. *Psychiatry Bulletin*, 19, 541-543.

<sup>46</sup> Wahl, O.F. (1999). Mental health consumers' experiences of stigma. *Schizophrenia Bulletin*, 25, 567-478.

<sup>47</sup> Walh, O.F. (1999). Telling is risky business. Piscataway, NJ: Rutgers University Press.

<sup>48</sup> Nicholas, G. (1998). Workplace effects on the stigmatization of depression. *Journal of Occupational Environment Medicine*, 40, 793-800.

<sup>49</sup> Scheid, T.L. (1999). Employment of individuals with mental disabilities: business response to the ADA's challenge. *Behavioral Science and Law*, 17, 73-91.

<sup>50</sup> Allbright, A.L. (2004). Employment decisions under the ADA Title I – survey update. *Mental and Physical Disability Law Report*, 29, 513-516.

<sup>51</sup> Glozier, N. (1998). Workplace effects of the stigmatization of depression. *Journal of Occupational Environment Medicine*, 40(9), 793-800.

### m. Primary Care Physicians

- A study of English medical students' attitudes found they had a less favorable response to patients in a vignette with a prior diagnosis of mental illness (depression or schizophrenia) than patients in vignettes with diabetes or no prior diagnosed medical condition. This was found to be the case even after controlling for students' clinical and psychiatric training. In particular, the students reported they would not be as happy to have them on their patient list, believed they would consume more time, and would be less likely to comply with advice and treatment.<sup>52</sup>

## V. Strategies to Address the Problem of Stigma and Discrimination

### a. General

- In 1997, the New Zealand Mental Health Commission compared how discrimination had been tackled in other areas (physical disability, color, age, size, sexual preference) and concluded six lessons learned that would be useful to reducing discrimination against people with mental illness. Specifically, they suggest that people with mental illness:
  - Need an enforceable and accessible legal framework to support people's rights to be in place;
  - Have to be able to assert their rights easily;
  - Must be involved in decision-making about policy and practices which affect them; and
  - Need to be more visible and society has to have positive experiences of this.

Fifth, agencies have to spell out what they are going to do to make sure people with mental illness are treated fairly, and then do it. Last, positive discrimination and political activism might be necessary.<sup>53</sup>

- A sample of 193 graduate students had two study visits with an interval of 6 months and were randomly distributed into three study groups: some read anti-stigma printed materials, some studied an anti-stigma computer program, and the others in a control group. Scores significantly improved both the reading and computer program groups. Authors conclude that computers can be an effective mean in changing attitudes of students toward psychiatric patients.<sup>54</sup>
- A study in which a random sample among 163 individuals viewed a documentary about schizophrenia were found to make more benign attributions about schizophrenia (e.g., less likely to blame individuals with schizophrenia for the disorder), but did not change general attitudes about schizophrenia (e.g., perceived dangerousness) or increase participants' intentions to interact with persons with schizophrenia.<sup>55</sup>
- In a five-year follow-up study of the "Changing Minds" campaign in England, researchers found (small) reductions in the percentages of stigmatizing opinions about mental illness,

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<sup>52</sup> Dixon, R.P, Roberts, L.M., Lawrie, S., Jones, L.A., Humphreys, M.S. (2008) Medical students' attitudes to psychiatric illness in primary care. *Medical Education*, 42(11), 1080-1087.

<sup>53</sup> Mental Health Commission of New Zealand (1998). *A travel guide for people on the journeys towards equality, respect, and rights for people who experience mental illness*. Retrieved January 12, 2007, from <http://www.mhc.govt.nz/publications/1998/Travel-Guide.html>.

<sup>54</sup> Finkelstein J., Lapshin O., Wasserman E. (2008). Randomized study of different anti-stigma media. *Patient Education and Counseling*, 71(2), 204-14.

<sup>55</sup> Penn, D.L. et al. (2003). The effects of a documentary film about schizophrenia on psychiatric stigma. *Schizophrenia Bulletin*, 29:2, 383-91.

with the greatest proportion of negative opinions in the 16-19 year age group. Respondents with higher educations were less likely than others to express negative views.<sup>56</sup>

- An evaluation of a “Mental Health Awareness in Action” program in England, including educational interventions, found that personal contact was predictive of positive changes in knowledge and attitudes for school students, but not police officers or community adults. The key active ingredient was the testimonies of service users about their experience of mental health problems and contact with a range of services.<sup>57</sup>
- An evaluation of “Beyondblue,” a national depression initiative in Australia, during 2000-2004 found that there is insufficient evidence to directly ascertain whether, during the life of the initiative, there has been a decrease in the levels of stigma and discrimination experienced by people with depression.<sup>58</sup>
- A review of prior research concluded that contact with people with mental illness who do not fit the feared stereotype are often viewed as the exception to the stereotype. The author argues that the “solution to stigma will come from more effective treatments of mental illnesses, rather than voluntary or cajoled benevolence.”<sup>59</sup>
- In a study of 165 participants, it was found that participants who watched an accurate and empathetic movie portrayal of schizophrenia had increased knowledge, but those who also watched an educational trailer had increased knowledge and decreased stigma.<sup>60</sup>
- A project with U.K. <sup>61</sup> college students and mental health staff and consumers uses the performing arts to challenge stigma and promote social inclusion for people with mental health problems. Three years of evaluation data show the program successful in positively influencing students’ attitudes, knowledge, and empathy, as well as positively affecting consumers’ mood and feelings of achievement, confidence, and inclusion.

#### b. Messages

- Instructing people to ignore or suppress negative thoughts and attitudes toward a particular group can have paradoxical rebound effects and stigma can be augmented rather than reduced.<sup>62</sup> In a study to test this assertion, it was found that instructing participants to suppress their stereotypes of people with severe mental illnesses reduced negative attitudes, but did not impact behavior, and that rebound effects did not occur.<sup>63</sup>
- Referencing the book, “*Psychiatric patient to citizen*,” (Sayce, Liz, 2001), the author describes four models for addressing stigma, discrimination, and/or social exclusion.
  - The favored model is “Disability Inclusion,” in which discrimination in every arena must be addressed and the rights of people with mental health problems are promoted. The model promotes social inclusion on the grounds of civil rights –

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<sup>56</sup> Crisp, A., Gelder, M., Goddard, E., Meltzer, H. (2005). Stigmatization of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry*, 4(2), 106-113.

<sup>57</sup> Pinfold, V., Thornicroft, G., Huxley, P., Farmer, P. (2005). Active ingredients in anti-stigma programmes in mental health. *International Review of Psychiatry*, 17(2), 123-131.

<sup>58</sup> Pirkis, J. (2004). *An independent evaluation report of beyondblue: the national depression initiative*. University of Melbourne School of Population Health.

<sup>59</sup> Davidson, M. (2002). What else can we do to combat stigma? *World Psychiatry*, 1(1), 22-23.

<sup>60</sup> Ritterfield, U., Seung-A, J. (2006). Addressing media stigma for people experiencing mental illness using an entertainment-education strategy. *Journal of Health Psychology*, 11(2), 247-267.

<sup>61</sup> Twardzicki, M. (2008). Challenging stigma around mental illness and promoting social inclusion using the performing arts. *Journal of the Royal Society of Health*, 128(2), 68-72.

<sup>62</sup> Monteith, M.J., Sherman, J.W., Devine, P.G. (1998). Suppression as a stereotype control strategy. *Pers Soc Psychol Review*, 2, 63-82.

<sup>63</sup> Penn, D.L., Corrigan, P.W. (2002). *Schizophrenia Research*, 55(3), 269-276.

- not just paternalistic “help.” Disability is impairment + effects of socially imposed barriers and prejudices.
- The “Brain Disease” model holds that mental illness is like any other, and people who are ill are not at fault. People may not believe this, or if they do, may adopt a paternalistic approach and see the person as a victim.
  - The “Libertarian” model holds that mental health consumers should have equal rights, and equal criminal responsibility. The concern here is that people stand more to lose than gain, especially in the workplace and courts.
  - The “Individual Growth” model holds that mental health and illness are on a spectrum, and that emotional distress, bereavement, and enduring psychosis are related experiences. The concern here is that it does not address the “us” (those with depression or anxiety) and “them” (those with schizophrenia, bipolar disorder, psychosis) dynamic.<sup>64</sup>
- A study in 2006 compared American beliefs about mental illness with those found in a 1996 study. Despite the growing popularity of a medical view of mental illness, tolerance of people with mental illness has not increased. Specifically, genetic arguments applied to schizophrenia are associated with fears about violence. In contrast, genetic arguments applied to depression are associated with social acceptance. Genetic arguments are associated with recommending medical treatment, but not with perceived likelihood of improvement. In sum, the study found little change in overall levels of tolerance over time. The author concludes that the biomedical view of mental illness is unlikely to increase American’s tolerance of people with mental illness.<sup>65</sup>
  - The authors reviewed literature worldwide to assess the effectiveness of psychosocial versus biogenetic messages about mental illness, and conclude that an evidence-based approach is needed to provide a range of alternatives to the “mental illness is an illness like any other” approach.<sup>66</sup>

### c. Workplace

- Researchers from King’s College London present a variety of ideas and actions that may promote the social inclusion of people with mental illness at work, as well as actions at the local and national levels. They conclude that the strongest evidence currently is for direct social contact with people with mental illness, particularly in relation to police officers, school students, journalists, and the clergy.<sup>67</sup>
- The authors review published data about the costs of doing business when mental illness is stigmatized in the workplace. To counter stigma among employees, authors recommend personal communication with co-workers with mental illness rather than education or anti-stigma messages.<sup>68</sup>

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<sup>64</sup> Byrne, P. (2003). Stigma, discrimination or social exclusion? In *Reducing Stigma and Discrimination: What Works?* Conference Report from Rethink/Institute of Psychiatry conference on June 26, 2003 in England, 7.

<sup>65</sup> Schnittker, J. (2008). An uncertain revolution: Why the rise of a genetic model of mental illness has not increased tolerance. *Social Science and Medicine*, 67(9), 1370-1381.

<sup>66</sup> Read, J., Haslam, N., Sayce, L., Davies, E. (2006). Prejudice and schizophrenia: a review of the ‘mental illness is an illness like any other approach.’ *Acta Psychiatrica Scandinavica*, 114(5), 303-318.

<sup>67</sup> Thornicroft, G., Brohan, E., Kassam, A., Lewis-Homes, E. (2008). Reducing stigma and discrimination: Candidate interventions. *International Journal of Mental Health Systems*, 2:3.

<sup>68</sup> Gelb, B., Corrigan, P.W. (2008). How managers can lower mental illness costs by reducing stigma. *Business Horizons*, 51(4), 293-300.

#### d. Age Groups

- A study of 79 community college students found that they were less likely to seek services if they viewed people with mental illness as responsible for their disorder, did not pity them, reacted to them with anger, and were likely to withhold help.<sup>69</sup>
- A study of 303 adolescents found that those who agreed that persons with mental illness are responsible for their illness and are dangerous demonstrated more discrimination. However, those who reported more familiarity with mental illness were more likely to endorse the stigma of mental illness.<sup>70</sup>
- An Internet-based survey of U.M. undergraduate and graduate students from year 2005 found demographic differences among students' perceptions of public stigma associated with mental health care seeking. The study found that perceived stigma was not significantly associated with utilizing mental health services.<sup>71</sup>

#### e. Consumers

- The author described presentations made by three psychiatry residents at American Psychiatric Association's Institute on Psychiatric Services, which included descriptions of existing anti-stigma programs. The article describes the presenters' recommendations that psychiatry training directors are urged to discuss stigma with their trainees, psychiatrists to ask patients about experiences encountering stigma, and include consumers ("the experts") in anti-stigma efforts.<sup>72</sup>
- Consumer advocates believe that common messages used are ineffective. For example, stating that mental illness is a disease like any other tends to emphasize that treatment (medication compliance) is needed, and does not account for the role of environmental conditions or traumatic experiences in mental illness. It does not reflect the negative side effects of medications, nor the dependence on the mental health system that can be fostered. Stating that stigma keeps people from seeking services does not reflect the reality that voluntary, affordable, varied, outpatient services may not be available to every person seeking assistance.<sup>73</sup>
- "Empowerment strategies are effective in reducing self-stigma (protests, parades, economic development projects, belonging to a family self-help group). Empowerment strategies work in reducing self-stigma. Forms of empowerment are protests and parades (anti-psychiatry advocacy or Mad Pride parades, for example), economic development projects that offer employment and income, belonging to a family self-help group, or becoming involved in consumer peer support where, in both cases, people are free to talk openly among themselves away from negative social judgments. Members of these groups exchange coping strategies..."<sup>74</sup>
- Four hundred and twenty-six students were provided an informational session delivered by consumers and a faculty member from the University of Medicine and Dentistry of New

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<sup>69</sup> Cooper, A.E. et al. (2003). Mental illness stigma and care seeking. *The Journal of Nervous and Mental Disease*, 191:5, 339-41.

<sup>70</sup> Corrigan, P.W. et al. (2005). How adolescents perceive the stigma of mental illness and alcohol abuse. *Psychiatric Services*, 56:5, 544-50.

<sup>71</sup> Golberstein, E., Eisenberg, D., Gollus, S.E. (2008). Perceived stigma and mental health care seeking. *Psychiatric Services*, 59(4), 392-399.

<sup>72</sup> Bender, E. (2006). Patient input crucial to defeating stigma. *Psychiatric News*, 41(22), 9.

<sup>73</sup> Brody, D. (2007). *Normal people don't want to know us: First hand experiences on stigma and discrimination*. California Network of Mental Health Clients – Bay Area Region.

<sup>74</sup> Everett, B. (2006). *Stigma: The Hidden Killer*. Mood Disorders Society of Canada.

Jersey (UMDNJ). The content of these sessions included facts about mental illness, characteristic symptoms, recovery strategies, and personal stories told by the consumer presenters. After viewing these presentations, students reported less stigmatizing views toward people with mental illness on seven of the nine factors and the total scale score.<sup>75</sup>

- Research suggests that stigma may be reduced by three approaches: protest, education, and contact. The authors describe 3 programs that adapt these approaches for mass audiences (StigmaBusters: protest, Elimination of Barriers Initiative: education/social marketing, In Our Own Voice: contact), for which preliminary research offers initial support for the feasibility and impact of these programs.<sup>76</sup>

#### **f. Primary Care Physicians**

- A study of an anti-stigma program for medical students indicated that which consists of education, contact, and viewing a film that depicts an individual with schizophrenia, can change attitudes towards people with schizophrenia. The anti-stigma program was carried out with first-year medical students (n=25). Students' attitudes towards people with schizophrenia were assessed before and after the program. In parallel, a control group of first-year medical students were questioned (n=35). Assessment was repeated after 1 month. Favorable attitudinal changes were observed in terms of 'belief about the etiology of schizophrenia', 'social distance to people with schizophrenia', and 'care and management of people with schizophrenia'. In contrast, no significant change was observed in the control group. Attitude changes tended to decrease at the 1-month follow up. These results suggest that attitudes towards schizophrenia could be changed favorably with this program. To sustain changed attitudes towards people with schizophrenia, anti-stigma programs should be offered on a regular basis.<sup>77</sup>

### **VI. Social Marketing as a Strategy: Lessons Learned**

- Conducted by researchers at the London School of Hygiene and Tropical Medicine and the National Social Marketing Centre, the review sought to examine the potential of social marketing approaches to contribute to both national and local health-related programs and social marketing campaigns.<sup>78</sup> Researchers collected and analyzed campaign and evaluation materials and conducted interviews with key informants of each program. Among the eleven campaigns reviewed was a national Department of Health mental health campaign (years 2000-03), "Mind out," whose aim was to educate the general public about mental health issues and reduce discrimination towards consumers. Goals included promoting greater acceptance, dispelling myths and misconceptions, and supporting the network of local organizers engaged in promoting mental health. Target audiences were employers, young people, and the media. Strategies included a workplace toolkit; media guide for journalists; booklet, games, quizzes, and a web site for young people; and a photographic exhibition for the general public. The program targeted those with power (20 employers and 10 journalism schools) to change public attitudes and used a first-person voice.

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<sup>75</sup> Spagnolo A.B., Murphy A.A., Librera L.A. (2008). Reducing stigma by meeting and learning from people with mental illness. *Psychiatric Rehabilitation Journal*, 31(3), 186-93.

<sup>76</sup> Corrigan, P., Gelb, B. (2006). Three programs that use mass approaches to challenge the stigma of mental illness. *Psychiatric Services*, 57(3), 393-398.

<sup>77</sup> Altindag A, Yanik M, Ucoq A, Alptekin K, Ozkan M. (2006). Effects of an antistigma program on medical students' attitudes towards people with schizophrenia. *Psychiatry Clin Neurosci*. Jun, 60:3, 283-8.

<sup>78</sup> Wellings, K., Crosier, A., McVey, D., Jennings, T. (2006). National Social Marketing Centre. *National health-related campaigns review: A review of 11 national campaigns*.

Findings for the “Mind Out” campaign included:

- Process and audit research evaluation was conducted, but not outcomes. A “crude” evaluation of cost-effectiveness of the media work was to cost media coverage as if it had been purchased. This was a major contribution to the campaign’s discontinuation. Evaluation was built into the contract. However, the government’s Central Office of Information did not establish an evaluation framework, as requested; and
- Relationship dynamics were challenging at times, including historic hostility between community stakeholders (competition rather than collaboration) and stakeholders tended to be united against the government.

General conclusions for all 11 campaigns included:

- Scoping and strategy work, including audience segmentation, message exchange, and competition analysis, should be independently commissioned rather than relying on small-scale qualitative efforts;
- Advertising/PR agencies should not direct research, especially since their concern is often limited to short-term rather than longer-term effects;
- A common failing was insufficient attention being paid to non-target audiences, having research focused primarily on the primary target group;
- Making more nuanced distinctions between population categories (audience segmentation) that move beyond demographics was lacking. Greater focus on lifestyle, motivational, and attitudinal research in segmenting audiences is needed;
- Dual branding and partnership marketing (associating a health issue with a commercial brand identity) were not fully utilized, despite audience research finding differences in lifestyles, motivations, and attitudes among target groups. Campaigns often used one generic campaign;
- Exchange is challenging in social marketing because it often involves giving up a tempting/pleasurable behavior for little obvious gain or a valued personal behavior has to be giving up/not started. Cost/benefit ratio may not be as obvious, and the costs may be perceived as distant from or unrelated to current behavior (especially for young audiences). Immediate benefits of behavior change must be emphasized;
- There is a shift away from hard-hitting imagery and fear-related messages. Research urges conditional use of these approaches where the threat is seen to be real and pointers to preventative action/information/services are provided to support individual change;
- Supplementing traditional advertising with PR and direct marketing, such as responding to news stories, was not as utilized as it could have been. Opportunities to use media advocacy were not utilized;
- Some campaigns did not recognize that social marketing stresses the importance of communications integrating into a broader preventative strategy, including fiscal, economic, and legislative measures;
- Having a broad network of shareholders that can include local action is a strength, but very large networks have the potential to impact a campaign’s organization, execution speed, and treatment given to an issue. Very large networks may need extensive consultation, can stifle creativity, and may be challenging for advertising agencies. Changing stakeholder involvement/collaboration from a process to an outcome is beneficial;
- Campaigns often lacked integration within and across government departments. Isolated from wider government strategies, campaign expectations to change behavior may have been unreasonable;
- Research designs that showed attribution of effect were rare. As a result, short-term gains in awareness, attitude changed, and brand recognition were given disproportionate weight for measuring campaign success. There was insufficient strategic research to define the

most appropriate indicators at the outset and an absence of baseline data from which to measure progress;

- In order to maintain a public health focus (rather than political or other goals), a credible panel of public health experts should be included in the advisory group;
- Clear boundaries are needed to avoid perception that policy is determined by commercial agencies, and government communications staff should make more of a contribution to strategic development of campaigns;
- Elected officials may be drawn into campaigns where the subject is controversial, but can reduce freedom and censor the campaign;
- Government should use its brand selectively, as the public (especially young people) may not look first to governmental agencies on some subjects. Government branding can be needed if scientific evidence needs to be authoritatively presented. Hidden or covert government involvement may be more effective in some campaigns;
- Establishing a new and effective brand is expensive, so costs/benefits should be thoroughly analyzed;
- Joining national and local efforts is valuable since some resources are held at the local level, services are delivered at the local level, and national efforts can be reinforced by local action. Good communications with and support to locals and using nationally produced generic messages and materials (with autonomy at the local level) are useful. Too much control from the center can restrict the reach of the campaign and limit application of materials at the local level; and
- Improving sustainability can be achieved by demonstrating effectiveness, establishing mechanisms to build objectives into local performance indicators, continuing local efforts after campaign end, and involving key individuals over the long term.

## VII. Research Agenda Issues

- “The evidence base addressing ‘what works’ for anti-discrimination actions in mental health is poorly developed. We can learn lessons from other rights based movements – race, gender, sexuality, disability – but here too the evidence base is on the whole weak. Much more needs to be done to build a robust knowledge base of effective anti-discrimination actions.”<sup>79</sup>
- There are a number of problems with studies in the area of stigma and discrimination.
  - Many studies examined the effects of previous self-reported contact with people on their own stigma, rather than how contact changes stigma prospectively.
  - Studies of direct contact often take place in a contrived laboratory situation, or as part of a course and/or training program.
  - It is not well understood exactly how contact reduces stigma, and theories about this have not been adequately tested.<sup>80</sup>

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<sup>79</sup> Thornicroft, G. (2003). An evidence base for anti-discrimination actions. In *Reducing Stigma and Discrimination: What Works?* Conference Report from Rethink/Institute of Psychiatry conference on June 26, 2003 in England, 6.

<sup>80</sup> Penn, D.L., Couture, S.M. (2002). Strategies for reducing stigma toward persons with mental illness. *World Psychiatry*, 1(1), 20-21.