Stigma of Mood and Anxiety Disorders:
A Psychoeducational and Behavioural Modification Course

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Abstract

Objectives. To design a group-based, psychoeducational and behavioural modification course to help individuals with mood and anxiety disorders who are directly affected by mental health stigma. Second, to gather feedback on the course content and design using focus groups, then to finalize the course sessions.

Methods. Course development occurred in two phases. Phase I included content that was based on published research, including readings of personal experiences, and informal conversations with mental health service providers and mental health service consumers. In Phase II, three focus groups were conducted to gather feedback. Focus Group 1 included ten mental health service providers, Focus Group 2 included twelve mental health service consumers, and Focus Group 3 included three experts in the field of mental health stigma.

Results. All three groups had a positive reaction to the draft course and many suggestions were offered based upon focus group members’ personal experiences dealing with mental health stigma. All suggestions were taken into consideration and many were applied to refine the course content.

Conclusion. The revised anti-stigma course content is based on a compilation of research and suggestions taken from a wide variety of sources. This should ensure a comprehensive, feasible, and effective course. Development of this course is the first step towards a larger project aimed at reducing stigma directly experienced by those affected by mood and anxiety disorders in an effort to better their lives and encourage both resiliency and recovery.
Co-Authorship

Dr. Roumen Milev and Dr. Heather Stuart of the Department of Psychiatry at Queen’s University contributed to this study. Dr. Milev and Dr. Stuart contributed to study design and methodology.

Dr. Milev and Dr. Stuart also assisted with preparation of this document.
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Chapter 1: General Introduction

Many individuals with a mental illness state that the stigma associated with their mental illness is often more debilitating than the symptoms of the illness itself. Stigma is often applied to people who differ from social norms and includes a combination of stereotype, prejudice, and discrimination. In reference to mental health, stigma is manifested as both self-stigma and social (or public) stigma (Corrigan & Watson, 2002). Self-stigma occurs when negative stereotypes about mental illnesses are internalized and attributed to oneself, whereas social stigma occurs when the behaviour of others results in expressions of lack of knowledge, negative stereotypes, or social rejection of those with mental illnesses (Corrigan, Larson, & Rusch, 2009). This combination of social stigma and self-stigma can be detrimental to an individual’s overall well-being and pathway towards recovery (Corrigan, 2004; Sirey et al., 2001). The goal of this project is to reduce the self-stigma experienced by individuals with mental illness.

Individuals who are diagnosed with a mental illness often face a multitude of barriers directly stemming from the stigma associated with their illness. For example, individuals with mental illnesses are often perceived by society to be dangerous, violent, and capable of unpredictable behaviour. This, in turn, causes these individuals to be distrusted and avoided by others (Bathje & Pryor, 2011). This can have a direct effect on their well-being by causing challenges directly relating to their level of social support, housing opportunities, employment, and their mental health treatment (Overton & Medina, 2008). Stigma of mental illness can be all-encompassing, affecting multiple aspects of an individual’s life, and therefore has the potential to be dangerous and life limiting if not properly addressed.
Changing the deeply engrained, stigmatizing attitudes and behaviours of society is a difficult and long-term task. Although recent research has brought much-needed attention to the important issue of stigma, and a number of anti-stigma campaigns have been implemented, there is still much work left to be done. Most current anti-stigma campaigns focus largely on reducing public stigma associated with mental illnesses. Although this is an important issue to address in the overall effort to conquer stigma, it is also imperative to focus on the individuals who personally experience mental illnesses and who may have internalized stigmatized self-images. These individuals should be provided the opportunity to learn how to conquer the social stigma they are affected by on a daily basis, and given the tools to overcome the self-stigma that they are likely to have bestowed upon themselves.

This project is based on the premise that it is possible to conquer mental illness stigma through direct contact with stigmatized individuals. Research has shown that empowerment may be an important factor in the elimination of self-stigma experienced by those with a mental illness, and that empowerment may be effected if those who are stigmatized are able to involve themselves in a consumer peer-support group (Rusch, Angermeyer, & Corrigan, 2005). Therefore, the goal of this project was to design a group-based psychoeducational and behavioural modification course for individuals with mood and anxiety disorders to help them manage mental health stigma. The psychoeducation and behavioural modification course will provide group members with the opportunity to learn about stigma in mental health and to provide the tools necessary to overcome stigma. In the second part of this project, three focus groups of different people related to the field of mental health stigma were conducted to gather feedback on the draft course content and design. This should ensure a comprehensive, feasible, and effective course. Development of this course is the first step towards a larger project aimed
at reducing stigma directly experienced by those affected by mood and anxiety disorders in an effort to better their lives and encourage both resiliency and recovery.
Chapter 2: Literature Review

2.1 Mental Health

The World Health Organization (1946) defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”. This simple, yet all-encompassing definition was presented in 1946, and has not been amended since. The holistic nature of this definition serves as a reminder that health is not purely physical. According to this definition mental health also plays a vital role in maintaining an individual’s overall health and well-being.

Mental disorders are often characterized by an alteration in mood, behaviour, or cognition, and present a variety of symptoms associated with distress, disability, and decreased quality of life. According to Health Canada (2002), approximately one in five (or twenty percent) of Canadians will be diagnosed with a mental illness at some point in their lives. It is likely that the remaining four out of five will indirectly experience mental illnesses through a friend, colleague, or family member. These statistics highlight the fact that the topics of mental health and mental illness warrant much research and attention.

Mental illnesses can present in a variety of forms, and the amount of distress caused by these disorders can lie on a spectrum based on severity of the symptoms, characteristics of the affected individual, and the environment. Common types of mental disorders include (but are not limited to): mood disorders, anxiety disorders, psychotic disorders (such as schizophrenia), personality disorders, and eating disorders. This thesis focuses on mood and anxiety disorders because they are among the most common mental illnesses experienced by Canadians.

2.2 Mood and Anxiety Disorders
2.2.1 Mood Disorders - Definition

Mood disorders are characterized by extreme highs and lows of mood, which can lead to distress and impairment of functioning in every aspect of an individual’s life. Individuals with mood disorders generally experience extreme sadness and melancholy, or extreme happiness, excitability, and irritability. Mood disorders that are predominately characterized by low mood are depressive disorders, in which an individual often experiences intense feelings of sadness, melancholy, hopelessness, inappropriate guilt, loss of energy, and irritability. Mood disorders characterized by low mood alternating with high mood are bipolar disorders, in which an individual’s mood can alter between states of depression and mania. Two other categories of depressive disorders include dysthymia, and depressive disorder not otherwise specified. Other categories of bipolar disorders include bipolar II disorder, cyclothymia, and bipolar disorder not otherwise specified. More information on the diagnosis, etiology, and treatment of mood disorders, is contained in Appendix A.

2.2.2 Anxiety Disorders - Definition

Anxiety is part of the human natural response to stressful situations, and every person experiences anxiety at specific points in their lives. Individuals with an anxiety disorder experience extreme symptoms such as shortness of breath, fear, worry, and racing heart. These individuals often go out of their way to avoid potentially anxiety-provoking situations and often fixate on unhealthy coping strategies when they do find themselves in a stressful situation. Types of anxiety disorders include generalized anxiety disorder, panic disorder, phobia disorders, obsessive compulsive disorder, and post-traumatic stress disorder. Anxiety disorders can have a debilitating effect on an individual’s daily life and can lead to high levels of distress. More
information on the diagnosis, etiology, and treatment of anxiety disorders, is contained in Appendix A.

2.2.3 Burden of Mood and Anxiety Disorders

According to Health Canada (2002), approximately eight percent of Canadians will experience major depression at some point in their lives, while approximately one percent will experience bipolar disorder. The percentage of individuals experiencing dysthymia and bipolar spectrum disorders are thought to be higher. Health Canada (2002) has identified anxiety disorders as being the most common type of mental illness, with approximately twelve percent of Canadians experiencing an anxiety disorder over a one-year period, with approximately one percent experiencing generalized anxiety disorder, one percent experiencing panic disorder, two percent experiencing obsessive compulsive disorder, seven percent experiencing social phobia, and eight percent experiencing specific phobia. Symptoms of mood and anxiety disorders often appear first in adolescence or early adulthood, however mood disorders can affect individuals at all ages, and can onset at any point in an individual’s life. Studies have shown depression to be more common in females than males, with a ratio of approximately 2:1, whereas bipolar disorder seems to have an approximately equal female to male ratio of 1:1 (Culbertson, 1997). Women generally tend to report and to be diagnosed with anxiety disorders more often than men (Health Canada, 2002).

The WHO reports that unipolar depression is the number one cause of years lost to disability (YLD) for males and females, world-wide, among low, middle, and high income countries (World Health Organization [WHO], 2004). Using disability-adjusted life years (DALYs), which are calculated using a combination of years lost to disability (YLD) and years
of life lost (YLL) WHO estimates that unipolar depression is the third leading cause of disease burden world-wide. In middle and high income countries, it is the number one cause of burden of disease. The WHO predicts that unipolar depression will be the leading cause of disease burden worldwide by the year 2030.

Mental illnesses also carry a large economic burden. For example, a study based on the population-based Canadian Community Health Survey Cycle 2.1 estimated the economic burden of mental illnesses in Canada in 2003 to be $51 billion (Kim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008). Those with undiagnosed mental illnesses were also factored into this statistic, with most of the economic burden occurring in terms of lost health care and medical resources, and lost productivity.

Mental illnesses often cause difficulties in the workplace, with studies showing that mental illness leads to more days of lost work and impairment than many chronic physical health conditions, such as heart disease, asthma, and diabetes (National Alliance on Mental Illness [NAMI], 2010). Furthermore, mental health seems to be bi-directionally correlated with physical health, with individuals with mental illness more likely to develop physical illness, and individuals affected by physical illness more likely to develop problems with mental health (Canadian Institute for Health Information [CIHI], 2008).

2.3 Stigma in Mood and Anxiety Disorders

The Oxford Dictionary defines stigma as “a mark of disgrace associated with a particular circumstance, quality, or person”. Stigma results from perceptions, which may be correct or incorrect, about what is considered “normal” by society, and whether or not individuals conform to this normality (Goffman, 1963). There are many examples of stigma throughout history,
including stigma of ethnicity, sexual orientation, religion, criminality, physical disease, and mental illness, among others, in which members of society develop negative opinions of others based on certain attributes they possess.

Mental illnesses are feared and misunderstood and individuals who have experienced a mental illness have been stigmatized throughout history (Hayward & Bright, 1997). According to Corrigan and Watson (2002), stigma occurs through three avenues: stereotypes (in which negative beliefs are formed about a group or oneself), prejudice (in which there is a negative emotional reaction such as fear), and discrimination (in which there is a behavioural response). Stigma can be manifested as either social stigma, in which stereotypes, prejudices, and discrimination are expressed by the public to a stigmatized group, or as self-stigma, in which stereotypes are internalized and applied to oneself (Corrigan & Watson, 2002).

Although the general public’s reaction to those with mental illnesses has become slightly more accommodating throughout the last century, individuals diagnosed with mental illnesses are still highly stigmatized, and run the risk of being stereotyped as unpredictable, dangerous, strange, useless, emotionally weak, or lazy (Lai, Hong, & Chee, 2000). Research on value priorities in regards to stigma has shown that individuals generally prefer greater social distance towards people with mental illnesses due to the belief that they are more likely to engage in inappropriate social behaviour or to become dangerous (Norman, Sorrentino, Windell, & Manchanda, 2008). Another common belief is that individuals are responsible for their own mental illness, and are therefore blameworthy for possessing the inability to control their moods (Link & Phelan, 2001). The finding that individuals with mental illnesses are often held responsible for their condition is consistent with research that suggests that individuals who endorse the Protestant ethic, which stresses the necessity of hard work and responsibility in daily
life, are more likely to stigmatize those with mental illnesses (Rüsch, Todd, Bodenhausen, & Corrigan, 2010).

Many of these negative associations often stem from a lack of knowledge surrounding mental illness in combination with attitudinal and behavioural elements (Thornicroft, Rose, Kassam, & Sartorius, 2007). Six approaches to diminishing stigma have been identified as: protest, education, contact-based education, legislative reform, advocacy, and stigma self-management (Arboleda-Flórez & Stuart, 2012; Corrigan, 2004). It has been suggested that the most important steps in eliminating stigma are to protest inaccurate representations of mental illness, provide information so that the public can make informed decisions about mental illnesses, encourage people to maintain contact with individuals who have experienced a mental illnesses who are successful in holding down jobs and who are respectable members of society, develop improved protections of rights and freedoms for individuals with mental illnesses, increase priority of mental health on agendas of decision makers, and reduce personal impact of stigmatization through peer-supported and recovery-oriented self-learning.

Research surrounding programs developed to improve mental health literacy has shown that although educational workshops are often successful in reducing stigmatizing attitudes (Penn & Couture, 2002; Pinfold et al, 2003), behaviours often tend to remain the same, or even worsen (Angermeyer, Holzinger, & Matschinger, 2008). Therefore, it is important to place a large focus on discrimination in mental illness, and whether individuals actually show a change in behaviour following anti-stigma campaigns (Thornicroft, Rose, Kassam, & Sartorius, 2007).

Due to the social stigma attached to mental illness, many individuals who experience mental disorders often feel shame and embarrassment and do their best to conceal their illness from others. Erving Goffman (1963) defines stigma as “A process by which the reaction of
others spoils normal identity” (p.4), and mental health stigma is an excellent example of this concept, wherein for many people with a mental illness, their definition of themselves changes when they receive their diagnosis. Much of this change can be attributed to the “self-stigma” that individuals experience, which occurs when an individual is aware of the stigma surrounding their mental illness, agrees with the negative beliefs held by others, and therefore applies these negative beliefs to themselves (Corrigan, Larson, & Rusch, 2009). Although this process of self-stigma is often subconscious, it can lead to many negative consequences.

Research has shown that self-stigma can lead to lowered self-esteem, lowered self-efficacy, and lowered sense of hope (Corrigan, 1998). As a result, individuals may give up on many aspects of life because they believe they cannot succeed. Researcher Patrick Corrigan describes this phenomenon as the “why try” effect, in which self-stigma becomes self-fulfilling, and the acceptance of stigma directly translates into feelings of powerlessness and a lower quality of life (Corrigan, Larson, & Rusch, 2009). Furthermore, when self-stigma is present, shame and guilt are often felt, confidence and motivation are lost, avoidance tactics are used, and individuals often withdraw from others.

Stigma can be dangerous to individuals who experience mental disorders. Sometimes, people are so afraid of being labeled as “mentally ill” that they will avoid seeking professional treatment for their illness, therefore potentially encouraging symptoms to worsen (Corrigan, 2004). Often for people diagnosed with a mental illness, it is the stigma associated with their illness that brings upon the most distress, rather than the diagnosis itself. Once an individual is diagnosed with a mental illness, self stigma can play a part in disrupting opportunities for employment, housing, and education, along with disrupting social relationships, and potentially harming friendships and family dynamics. Therefore, stigma is often a major barrier to recovery.
The recovery paradigm that has recently emerged in the field of mental health emphasizes the importance of looking beyond symptom management to recovery, where recovery is defined as some combination of enhanced quality of life, improved functioning, and empowerment (Farkas, Gagne, Anthony, & Chamberlin, 2005). As stigma negatively affects many aspects of recovery, helping individuals with mental illnesses to overcome stigma is an important therapeutic aim.

2.3.1 Conquering Stigma

2.3.1.1 World-Wide Initiatives

Although stigma associated with mental illness has been an issue present throughout history, the problem has only become widely researched relatively recently, with world-wide organizations such as the World Health Organization (WHO), and World Psychiatric Association (WPA) recognizing stigma as a major challenge to public health. The World Psychiatric Association (WPA) became the first organization to initiate an international program to fight stigma and discrimination due to schizophrenia, when it assigned Alberta to become the pilot site for their Open-the-Doors program in 1996 (Stuart, 2008). The main goals of the Open-the-Doors pilot program were to evaluate approaches to stigma reduction and refine program development to be used by countries as part of the program. This program is considered to be the only existing world-wide anti-stigma effort, and it is currently active in approximately twenty countries (Stuart, 2005).

2.3.1.2 Canadian Initiatives
Anti-stigma efforts in Canada began in the mid 1950s, which makes Canada one of the longest-experienced countries in anti-stigma programming (Stuart, 2005). Although stigma-related research had been present in Canada for the past sixty years, it was not until 2009 that a national anti-stigma initiative was launched by the Mental Health Commission of Canada. Opening Minds is Canada’s largest-ever effort to reduce the stigma of mental illnesses (Mental Health Commission of Canada [MHCC], 2009). This initiative targets health care providers, youth, the workforce, and the media, with the initial goals of evaluating anti-stigma programs in order to be distributed nationally.

The Commission also works with other organizations such as the Canadian Mental Health Association, Mood Disorders Society of Canada, and Center for Addiction and Mental Health, among others, in order to provide support in stigma management research. Another largely publicized example of anti-stigma program in Canada is Bell Canada’s “Let’s Talk” initiative. This program has a main goal of supporting and promoting mental health in Canada, with a strong focus on promoting anti-stigma efforts (Bell Canada, 2012). Social media and popular communication outlets are used, as well as famous spokespeople who have personally dealt with a mental illness in order to raise money and awareness. All of these programs explicitly target public stigma. None directly address self-stigma.

2.3.1.3 An Example of a Local, Kingston Initiative

One important anti-stigma effort within the Kingston community, created by the Canadian Mental Health Association, the Centre for Addiction and Mental Health, and the Mood Disorders Association of Ontario is “Talking About Mental Illness” (TAMI). The TAMI program has been studied in several communities across Canada (including Kingston), and the
main goals of the project are to increase awareness about mental illness, encourage early intervention, and increase awareness of stigma surrounding mental illness. The basis of the program involves TAMI presenters sharing their personal experiences with mental illnesses in order to spread awareness and understanding throughout school groups and community organizations. Early reports on the project have shown TAMI to be successful in reducing stigma, and increasing knowledge surrounding mental illness (Talking About Mental Illness [TAMI], 2012).

Although local programs such as TAMI make important efforts in decreasing public stigma in society, it is also important to target self-stigma experienced directly by individuals with mental illnesses. Although there are currently no self-stigma focused groups in the Kingston area, local hospitals and health facilities do offer general mental illness support groups. For example, the Mood Disorders Support Group at Ongwanada Resource Centre is an unstructured group which allows patients who experience a mental illness to gather in a supportive environment to discuss the trials and tribulations of daily life with others who share similar experiences.

2.3.2 Importance of Self Management

To our knowledge, available anti-stigma efforts focus on removing negative public views of mental illness. Completely removing prejudices and changing social attitudes are difficult and long-term tasks. In the mean time, it is necessary for stigmatized individuals to learn to rise above stigmatizing conditions in order to live healthy and productive lives. Self-management strategies are useful as they provide the opportunity for individuals’ needs to be met quickly, appropriately, and without stigma (Schneider, 2006). Being more in control of one’s mental
health management not only leads to regaining self-respect and self-esteem, it also encourages recovery and empowerment (Wallcraft, 2005). Therefore, the development of programs catering specifically to individuals who experience mental health stigma is necessary in order to promote self-management. People who are diagnosed with a mental illness can then develop a deeper understanding of stigma and learn to diminish its negative personal consequences, with the ultimate goal of eventually overcoming stigma and achieving the highest level of personal recovery (Shih, 2004).

2.3.3 Psychoeducation and Behavioural Modification Programs

Psychoeducational programs typically offer a combination of information about mental illnesses, practical support, emotional support, development of problem solving skills, and crisis management. They have been shown to be effective in helping patients develop illness management skills and better cope with the consequences of their illness (Colom & Vieta, 2004). In a group setting targeted at reducing the stigma felt by those who experience mental illness, it is important that all of these points be addressed. This will ensure that every group member will develop a comfortable understanding of the topic and have opportunities to practice the skills necessary to make a change in their stigma experience.

Although many individuals who experience a mental illness are affected by deeply-rooted negative self-schemas, which may not be amenable to eradication in a short period of time, exercises rooted in behavioural modification therapy will provide group members with helpful tools that they can put into practice after the course has been completed. Not only will this serve to better their self-esteem and confidence, it may also lead to empowerment, and promote a positive path towards recovery. In order for individuals to take this proactive approach to
eliminating stigma, it is important that they are provided with the opportunity to develop the necessary knowledge, skills, and tools to use as a guide. The creation of a stigma-specific course for individuals with mood and anxiety disorders is necessary in order to provide the opportunity for individuals to be able to make a change in the way they cope with the stigma in their own lives, thus promoting a healthy path towards recovery. Therefore, the proposed stigma self-management course adopted a group psycho-educational approach to stigma management.
Chapter 3: Research Methods and Objectives

The primary objective of this research was to design a group-based, psychoeducational and behavioural modification course for people with mood and anxiety disorders to help manage self-stigma. The secondary objective was to gather feedback on the content and design of the course through focus groups, before finalizing the course sessions. Course development was divided into two phases.

3.1 Phase I

Phase I of course development included the basic design of a group-based, psychoeducational and behavioural modification course for people with mood and anxiety disorders to help manage self-stigma. This phase included content that was based on current research of published literature, in combination with readings of personal experiences, and informal conversations with mental health service providers, mental health service consumers, and researchers in the field of mental health stigma. These informal conversations took place at Providence Care Mental Health Services in Kingston, Ontario, and included discussions with psychiatrists, social workers, and members of the community treatment team. The proposed layout of the course, goals of the course, content of the course, and the proposed time-frame of the course were decided during Phase I of course development. Phase I of the course was developed by Ashley Beaudoin (author of current paper, MSc Candidate), with the guidance of Dr. Roumen Milev (MD, PhD, FRCPsych, FRCPsych) drawing on his knowledge of psychiatric disorders and treatments, and Dr. Heather Stuart (PhD), drawing on her expertise in the field of mental health stigma.
3.2 Phase II

Phase II of course development collected feedback on the content and design of the course through focus groups. Although the bulk of course content was developed in Phase I of project development, Phase II was helpful in refining the course to ensure optimal results. Three focus groups were conducted: one with mental health service providers, one with mental health service consumers, and one with experts in the field of mental health stigma research. A presentation of course material examples, as well as a set of questions was used within each focus group, in order to ensure a well-rounded discussion. The feedback was examined, and where deemed appropriate, used to refine the course material, with the goal of developing a course that would reach the highest efficacy and feasibility.

3.3 Focus Groups

Three focus groups were conducted over a period of approximately one month. Focus Group 1 consisted of ten mental health service providers, all of whom were a part of the Providence Care Mental Health Services Mood and Anxiety Disorders Team, in Kingston, Ontario. This team consisted of a combination of psychiatrists, social workers, and community health workers. Focus Group 2 consisted of twelve mental health service clients. All had experienced a mental illness for varying amounts of time, at varying levels of severity. They were all members of a drop-in support group that meets weekly at Providence Care Mental Health Services. Focus Group 3 consisted of three mental health stigma experts. The meeting took place at the fifth international Together Against Stigma conference, organized by the Mental Health Commission of Canada and the World Psychiatric Association Stigma and Mental Health Scientific Section, in Ottawa, Ontario. The focus group stigma experts consisted of
Heather Stuart (MA, PhD), Graham Thornicroft (MA, MSc, PhD, Psych, FacadMed), and Patrick Corrigan (PsyD), who were all keynote speakers at the conference, and are all extensive contributors to the published literature on the topic of mental health stigma.

At Focus Groups 1 and 2, myself, and another student attended. I gave a short presentation about the project, while the other student took notes about any feedback that was given throughout the duration of the meeting. The student assistant was not able to attend Focus Group 3 due to the location, so I did both the presentation, and the note taking. The presentation for each focus group consisted of a brief power point presentation, which included information on the project that had been developed as a result of Phase I. This included basic information on stigma in mental illness, information on project goals and objectives, potential group participants, course structure, session content, and examples of course content (including examples of group discussion topics, examples of role play, and examples of homework). This presentation was tweaked slightly depending on the focus group, with some presentations including more or less didactic information about the importance of researching stigma, depending on the existing knowledge of each focus group. Members of each focus group were encouraged to ask questions or to make comments throughout the duration of the presentation. Furthermore, at the end of the presentation, a set of questions was presented to focus group members. This list of questions is as follows:

1) Is the format of the course suitable for the proposed participants? Please comment on:
   a. Length of each session
   b. Number of sessions
   c. Breakdown of each session (i.e. time spent on each component)

2) Should sessions occur weekly, bi-weekly, or over some other time frame?
3) Please comment on course content (i.e. topic of each session of the course):
   a. Do all topics/sessions warrant this much attention?
   b. Do some topics/sessions require more attention?
   c. Are there any other topics/sessions that would be beneficial to add to the course?

4) Are there any suggestions for group activity exercises or homework ideas that have been useful in past experiences?

5) What do you believe will be the most beneficial aspect of this course to users?

Focus group members provided feedback on all of these questions, and often added helpful comments that were not associated with the above questions. All responses from focus group members were recorded, and taken into consideration when finalizing Phase II of the project.

3.4 Analysis of Focus Group Feedback

Once feedback was collected from focus groups, it was important to assess the feedback both within each individual focus group, as well as across all three focus groups. First, feedback from individual groups was taken into consideration. Following each focus group, the notes that were taken were analyzed in order to determine which suggestions were deemed valuable. These decisions were made following the discussion of focus group results with my thesis supervisor. All three of the focus groups suggested new ideas and many of these were deemed to be valuable contributions.

While some suggestions were taken into consideration and applied to the course development quite easily, there were some recommendations that took more careful consideration, as they held the potential to alter the course more dramatically. In these cases, it was important to assess whether or not any of these suggestions overlapped in the three separate
focus groups. Fortunately, most of the larger suggestions were consistent across all three groups. These larger suggestions included the addition of certain topics that were deemed by focus group members to be useful when discussing the overall concept of stigma. Had there been disagreement across the three focus groups about the addition of these topics, the problem would have been solved by putting more emphasis on the opinions of the members of Focus Group 2 (people with lived experience of stigma and mental disorders), as they are the group representing the individuals who were targeted for the course. If the acceptance of suggestions was still questionable, it would have been beneficial to gather further opinions of others, perhaps in the form of running an additional focus group.

Although all of the larger recommendations (which would change the course format and content) were consistent throughout all three focus groups, there were some inconsistencies across groups regarding other aspects of the course. These inconsistencies were all taken into consideration and have been recorded in the results section of this paper, however some of them have yet to be resolved. This is due to the fact that it will be necessary to actually run the course in order to make the best decisions on certain topics; therefore, it is best to wait until the pilot testing of the course begins in order to make these final decisions.
Chapter 4: Results

4.1 Phase I

4.1.1 Program Goals and Therapeutic Objectives

One of the first steps in Phase I of course development was to specify the main goals of the program, as well as the therapeutic objectives. This definition of goals and objectives was helpful in setting the tone for the rest of the course development, and allowed for a clear-cut description of our program’s aims. Goals were decided upon based on what the researchers considered were the most important take-home points. Therapeutic objectives were decided upon based on the measurable change that we aimed to see in clients after participating in our program.

The program has four main goals. It aims to help clients understand:

- The nature of depression and anxiety;
- The recovery process;
- The nature of stigma and discrimination and how it affects recovery; and
- Strategies for managing and overcoming stigmatizing experiences.

The specific therapeutic objectives of this program are to:

- Increase awareness of stigma and its consequences;
- Reduce the psychosocial impact of stigma;
- Improve feelings of self-efficacy and empowerment; and
- Promote recovery.
These overarching program goals and therapeutic objectives were referred to continuously throughout the development of the course in both Phase I and Phase II, in order to maintain the targeted purpose of this program and to accomplish the goal of ending with a program appropriately suited to the purpose of eliminating self-stigma in mood and anxiety disorders.

4.1.2 Course Structure and Content

The second main component of Phase I course development was the decision of how to structure the course, and of which content to include in the course. Research literature, as well as input from mental health service providers and clients, were used in order to determine the main troubling areas of a stigmatized individual’s daily life. These areas, as well as the components necessary to run a smooth program, contributed to the course breakdown.

Phase I of the course is organized into six closed two-hour sessions:

- Session 1: Orientation and introduction to stigma
- Session 2: Depression, anxiety, and recovery
- Session 3: Self-stigma
- Session 4: Stigma from family and friends
- Session 5: Stigma in the housing, education, and the workplace
- Session 6: Lessons learned and closing

In order to provide the highest opportunity for learning, information retention and overall comfort of the group members, most sessions are set to follow a relatively standard format:

- 30 minutes – Introduction: overview of goals and review of homework from last session
- 15 minutes – Didactic teaching and questions
- 15 minutes – Discussion of personal experiences
- 10 minutes – Break
- 20 minutes – Discussion of strategies pertaining to the session topic
- 20 minutes – Practice of strategies
- 10 minutes – Discussion of homework assignment for next week

Although this is the standard format of each session, it must be noted that this format is only suggested, and may vary depending on the session, or depending on the group of people partaking in the program, and future pilot testing. For example, some sessions may rely more heavily on didactic teaching in order to provide group members with the necessary information to understand strategies, whereas some sessions may have only a small focus on didactic teaching. This will occur in sessions where strategy practice is considered more useful in the overall stigma-reduction goals pertaining to the session. Furthermore, session format may vary depending on the group of participants. Some groups may be more talkative and enjoy openly discussing their experiences, while other groups may be more reticent, and therefore would require group facilitators to guide more of the discussion in an informative way that encourages group participation.

In addition to the course structure mentioned above, it was also tentatively decided in Phase I that sessions will occur on a weekly basis. This decision was made based on the idea that having a one week period between sessions will allow adequate time for homework and to reflect on the previous session, while not allowing too much of a time lapse which could encourage forgetfulness and lack of commitment to the group sessions.
Furthermore, it was decided that each program would require approximately 8-10 participants. This number was determined to be appropriate as this number of participants would form large enough groups to support vivid group discussion and promote learning from one another, but would be small enough to encourage intimate discussion. This number of participants would also provide an opportunity for each group member to receive adequate attention and would allow for any and all questions to be answered in a helpful and productive way. Furthermore, research has shown that 8-10 is considered to be the ideal number of participants for both focus groups, as well as group therapy (Gupta, 2005; McDaniel & Gates, 2005). In addition to the number of group members required, it is also required for group members to have a diagnosis of a mood or anxiety disorder, and to be relatively stable in their symptoms. This will serve to maintain consistency throughout the course (especially during the program testing phases), reliability of group member attendance, and maximize opportunities for learning.

The last important decision in the first part of Phase I course planning was to decide who would be in charge of conducting the program, and maintaining consistency from week to week. It was decided that there would be at least two group facilitators present at each session and that these facilitators should remain consistent throughout each session of the program. Ideally, one facilitator should be a regulated health professional with experience in facilitating psychoeducational and behavioural modification groups and, if possible, experience with a mental illness. The second facilitator may be a person with lived experience of a mental illness, research student, peer support worker, or other individual with special knowledge in mental illness, stigma, recovery, and with experience in group processes.
4.1.3 Program Manual and PowerPoint Slides

A large component of course design was to provide a set of information that could be used to distribute the program among multiple groups in a reliable and consistent way. In order to achieve this, a course manual for group facilitators, as well as powerpoint presentations of each session was provided. The course manual serves as a tool for the group facilitators to help guide their sessions and to ensure that all of the important points of the session are covered. Because only the group facilitators have access to the program manual, the manual contains supplementary information that will ensure smooth distribution of the program. For example, the manual contains reminders of when to encourage group discussion and when to pause and ask for questions, as well as examples that can be used in order to stimulate group discussion or provoke interaction in group role-play activities. Although much of the program is designed to be based on group discussion and sharing of personal experiences, the course manual is necessary as it will serve to provide consistency throughout the course. This is important so that each group involved with the program will follow the same general format and cover the same general information, regardless of the group facilitators. The powerpoint slides that are included for each session serve as a visual aid for the didactic teaching portion of the session. They also serve as a guide to ensure that all key questions leading into group discussions are asked, to ensure that each session stays on track in regards to timeline, and once again to help to provide consistency of the program.

4.2 Phase II

4.2.1 Focus Group Results
Insight received from focus groups was invaluable to the development of Phase II of this project. Members in all three of the focus groups contributed their ideas and opinions with great enthusiasm, and suggested many topics and changes that were not previously discussed during Phase I development. The examples of course material allowed members to develop an understanding of exactly what the course aimed to achieve, and the questions at the end of the presentation allowed for a consistent level of feedback from all three groups. Beyond the presentation and set list of questions, focus group members also asked many questions and provided comments.

4.2.1.1 Focus Group 1 – Mental Health Service Providers

Focus Group 1 consisted of mental health service providers, all of whom had experience dealing with patients with mental illnesses. One of the first important comments was that the efficacy of this program may depend largely on group members’ current point of diagnosis. In the experience of these focus group members, individuals with mental illnesses often varied in their response to certain group therapy efforts depending on how long they had been diagnosed with a mental illness. For example, it was suggested that the program may be more beneficial to group members who were recently diagnosed with a mental illness, but who were fairly stable in their symptoms. They thought that individuals with a longer standing diagnosis may feel as though they have already been exposed to stigma for a long period of time, and therefore have tried to combat it on their own.

Focus Group 1 members also emphasized the fact that group members may feel vulnerable in this type of group setting, and therefore may be less apt to participate in group activities. Therefore, it will be important for group facilitators to have examples of group
discussion topics ready in order to prompt the group for discussion, if necessary. They also thought that it would be difficult to change an individual’s core beliefs in such a short time, which is the main goal of some of the behavioural modification exercises. However, they also mentioned that there was no harm in trying, and that hopefully, even if these exercises failed to change core beliefs, they could succeed at eliminating some self-stigmatizing schemas.

When asked what other topics may be important to include in this course, Focus Group 1 members suggested a section on the stigma experienced from health care providers in medical settings, as many of their patients have had this experience. Focus group members also emphasized the importance of developing scripts to deal with certain anxiety-provoking situations. This would allow individuals to become more comfortable in dealing with potentially stigmatizing situations and would encourage productive and relaxed conversations with others.

Lastly, Focus Group 1 members made the important suggestion of changing the term “Homework” to “Home Practice”. They thought that many potential program members may have had negative experiences in school settings, and that it may be difficult for them to have a positive reaction to a self-help group that reminds them of this negative past association. Furthermore, all of the homework assignments throughout the course involve the direct practice of what was learned throughout the previous session, therefore, the term “Home Practice”, is a better description of the task. Focus Group 1 members believed that this course could be beneficial if offered to the appropriate set of participants.

4.2.1.2 Focus Group 2 – Mental Health Service Consumers

Focus Group 2 consisted of mental health service recipients who had all been directly affected by mental health related stigma in one way or another. One of the main goals of this
focus group was to develop a deeper understanding of exactly what mental health, and mental health stigma means to people with a mental illness. The focus group members were open about discussing how they are affected by mental health stigma, the areas of their lives that they are most affected, and the consequences of stigma in their day-to-day lives.

The response of focus group members to the course structure and content was highly positive. They emphasized that many groups they have belonged to in the past discussed stigma, but did not have such a strong, all-encompassing focus on the topic, and certainly did not have as much of a focus on the importance of eliminating self-stigma.

Group members also stressed their belief that the course could be useful for both newly diagnosed individuals as well as those that have been struggling with the symptoms of mental illness for many years. Focus Groups 2 members thought that, although individuals who have been living with a mental illness for many years have likely thought about stigma and been affected by stigma, it is unlikely that they have ever had the opportunity to experience such a well-rounded learning experience on the topic. They also emphasized the notion that life is constantly changing, as well as treatment and symptoms of an individual’s disorder, with new challenges being introduced throughout the years. Because of continuous change, focus group members thought that the program would be beneficial at any point in symptom management.

Although members of Focus Group 2 agreed with the course content and layout of Phase I, they also emphasized the problem of stigma in medical settings, whether in hospital, or in regular doctor appointments. They also discussed the issue of disclosure and how difficult it is to decide who to disclose to, and in what situations. They found this issue to be especially problematic in work environments and suggested that it may be helpful to include a session dedicated to this topic. Lastly, focus group members emphasized that they have found role-play
scenarios to be helpful in previous group experiences, and thought that script-writing would also be helpful to deal with difficult situations. Finally, Focus Group 2 members were intrigued by the project and were anxious for its launch so that they could experience it themselves.

4.1.2.3 Focus Group 3 – Mental Health Stigma Experts

Focus Group 3 consisted of mental health stigma experts who have contributed much of the research literature on the topic and were knowledgeable about best practices in stigma reduction. Focus Group 3 members had an opportunity to review course materials and to make comments and suggestions on Phase I of the course development. Their response was mainly positive and they also had some helpful suggestions. They, too, thought that adding a section on medical setting stigma and on disclosure would be helpful to potential course participants. Focus group members were able to provide some useful resources on both topics for potential inclusion into the course. Furthermore, they made the important suggestion of including a section at the end of the course that would provide group members with information on local group-centered resources that they could continue access after this course came to an end. This would be especially helpful to group members who reacted positively to the course so that they would be able to continue this positive journey of interaction with others who share similar experiences. Focus Group 3 members also encouraged the inclusion of as many scripts and role-playing exercises as possible in an effort to truly focus on the stigma reduction of future group participants.

One of the main suggestions of Focus Group 3 did not surround course content, but rather was based on the choice of potential group facilitators. In Phase I, it was suggested that one group facilitator be a mental health professional, and that one be a student, or mental health
service consumer. Focus Group 3 members suggested that many individuals with a mental illness affiliate with others and often learn best from others in a similar situation. This is why group-based therapy and discussion is often useful for diagnosed individuals. Focus Group 3 members suggested that instead of having a mental health professional who may not have personal experience with a mental illness as one of the course facilitators, it may be more useful to have someone who has experienced a mental illness and the stigma attached to it. They suggested that the other facilitator be a student, researcher, or another person with lived experience, and that mental health professionals may not be necessary at all in facilitation of the group.

4.3 Phase II Completion

All three of the focus groups conducted were invaluable in contributing to the development of this project. Although much of the groundwork of the course was completed during Phase I of project development, suggestions from the perspectives of the different focus groups brought many issues to the surface that would be necessary in tackling the topic of stigma in this group-based course. It was also interesting to compare and contrast the suggestions from mental health service providers and stigma experts, with those of the mental health service recipients. Although all three groups had similar suggestions in terms of course content, mental health service recipients seemed more willing to participate in all of the course sessions and activities than the other two groups had thought. Although all three of the focus groups had an overall positive response to the information presented and believed that the course would be beneficial, it was the mental health service recipient group that showed the most excitement for the potential opportunity to be a future member of this type of stigma-reduction group.
Based on the focus group feedback, the course content was modified to include a section on stigma in medical settings (included in Session 4, now titled *Session 4: Social Stigma Part I – Stigma in Family, Friends, and Medical Settings*). The title of Session 5 was changed to *Session 5: Social Stigma Part II – Stigma in Education, Housing, and the Workplace* in order to differentiate the two sections of social stigma that would be included; the first dealing with social stigma in a more immediate setting, the second dealing with social stigma in a more extended setting. A session on disclosure was also included as *Session 6: Disclosure*, placed before the concluding session, thus changing the format of this course to seven sessions, and therefore seven weeks. This session on disclosure was deemed necessary to add as an entire session near the end of the course as it was a topic of great importance to focus group members who had experienced a mental illness and one in which mental health service recipients expressed a need for education. A number of smaller changes were made to the course including changing the term “Homework” to “Home Practice” and adding information at the end of the course of additional resources for group members to continue their group-setting experience. The disagreement between Focus Group 1 and Focus Group 2 about which stage of diagnosis an individual should be to participate in the course has not been settled, as it was decided that this problem could be addressed in the future pilot phase of the program. Both newly diagnosed individuals and individuals with longer standing diagnoses should be invited to participate in the pilot testing phase of the program and further decisions regarding their participation will be determined based on feedback of the group members. Lastly, additional script-writing exercises were introduced into the course, as well as more opportunity for group discussion.

Finally, an important point to address is Focus Group 3 members’ suggestion of having a mental health service consumer as the primary group facilitator throughout the course. As this
course is focused largely on psychoeducation about both the topic of stigma and the topics of mood and anxiety disorders, it will be important for a mental health professional, or someone with extensive training on the topic of mental health to be present at all times in order to answer any questions that group members may have in regards to the didactic information presented. This is especially important throughout sessions one and two, where much of the technical information will be distributed to lay the groundwork of knowledge. It is important to note that mental health professionals may also have experienced a mental illness. Therefore, an ideal scenario would be to have the main facilitator be an individual who is both highly educated on the topic of mental health and also has direct personal experience in dealing with the stigma attached to mental illness. This will allow for group members to gain the necessary knowledge about the topics being discussed and will also allow them to be led by an individual that they can relate to, while also eliminating the potential for medical setting stigma. The secondary group facilitator in this case would be another person with lived experience, a student, or a researcher.
Chapter 5: Discussion

5.1 Course Content of Each Session

The decision of what to include in Phase I of each session in this program was based on a combination of published literature, readings of personal experiences, and discussions with mental health service consumers and providers. The decision of what to include after Phase II of the course was based on a variety of suggestions and opinions surrounding course content and layout collected after conducting three focus groups. The following provides a detailed breakdown of the contents of each session as they were modified after completion of Phase II, including why information was considered important to add, and how it will have a positive effect in providing the necessary tools for group members to practice stigma reduction in their day-to-day lives. For an example of course content in the form of PowerPoint, please see Appendix B, which outlines Session 4: Social Stigma Part I – Stigma in Friends, Family, and Medical Settings.

5.1.1 Session 1: Orientation and Introduction to Stigma

Session one is important in the overall development of the course as it sets the tone of the sessions to come. As an introduction and orientation session it will provide group members with a detailed understanding of what to expect throughout the course so that group members will have a comfortable and enjoyable program experience. It will be important to develop a sense of the group members’ personalities in the first session, note the way that group members interact with one another and the group facilitators, and develop a sense of the comfort level of group members in participating in group activities and discussions. Depending on the overall energy of
the group, the facilitators may decide to pay more attention to certain details in order to allow for
the most effective use of session time throughout the duration of the course.

The first order of business will be to ensure that each group member has a general idea of
the purpose of the program and what it aims to achieve. At this point, the program goals and
therapeutic orientations of the program will be introduced. Because the first session serves as a
foundation for the rest of the course, it will be imperative to develop a strong foundation of
comfort, trust, and openness. After the overview of program goals and therapeutic orientations is
discussed group members will engage in an ice-breaking activity. This activity will involve a
basic level of interaction with one another. Each group member will be paired up, asked to learn
about their partner, and then introduce their partner to the rest of the group. This will allow group
members to become comfortable with one another and their surroundings, and will encourage
easy interaction throughout the remainder of the program.

After the basic introductions to the course and to one another have been conducted, group
members will be provided with a detailed overview of the program. This will include a general
introduction of why it is important to use psychoeducational and behavioural modification
groups to tackle stigma, an overview of course structure, content, and session format, and
information on session routines and course expectations. Group members must understand the
importance of attending each session (barring exceptional circumstances) in order to experience
the greatest personal gain, but most importantly, they must understand that all discussions and
personal information shared within the group are to remain strictly confidential. Reviewing all
of the basic components of the course will ensure that group members develop realistic
expectations and are comfortable with the information that is to be discussed.
Once the detailed course introductions have been completed, it is time to delve into the heart of this program: the stigma of mental illness. As this session is meant to be introductory, it will be important to discuss the most basic aspects of stigma in a controlled group discussion with group facilitators prompting important points. The first order of business will be to suggest that, for many people with a mental illness, their definition of themselves changes when they receive their diagnosis. Then group members should be asked what stigma means to them, whether it be a definition, a feeling, or a specific example. Next, group members should be asked to recount personal experiences of how their self-conceptions may have changed when they found out they had a mental illness, and why they think that these changes occurred. At this time, one facilitator should use a flip chart or white board to keep a running tally of positive and negative changes that are reported. It is likely that few positive changes will be reported, however, if they are, they should be acknowledged and emphasized. Next, group members should be asked, if they are comfortable, to expand on their definitions of stigma provided earlier by sharing any personal experiences of stigma.

This preliminary discussion of the basics of mental health related stigma is intended to result in a sense of group cohesion, trust, and comfort. Beyond this, however, it is important at this time to draw a distinction between elements of self-stigma and social (or public) stigma. Specific examples of components of self-stigma and social stigma are provided to the group facilitators in the program manual; however, group members should be encouraged to provide personal or theoretical examples themselves. This distinction will be essential to recognize in the following sessions, when these varying types of stigma are discussed in more depth.

After the bulk of group discussion has come to a close, it will be important to discuss the negative and positive observations that have stemmed from the discussion. Examples of negative
observations may include “negative attitudes and experiences outweigh the positive for most people”, or “we are all socialized to have the same negative stereotypes about mental illnesses; these negative images become internalized at an early age and are reinforced through a variety of means (mass media, educational systems, family socialization, etc.)”. Positive observations may include “many people with mental illness recover and lead healthy and productive lives in spite of their symptoms”, or “many people learn to manage and overcome stigma”.

Understanding these very basic ideas will be important in order to develop strategies to manage stigma and promote recovery.

This introductory should end on a positive note with a discussion of individuals who have experienced and overcome both the symptoms and stigma attached to mental illness. Group members will be encouraged to share anecdotes of personal acquaintances, or to list any celebrities or famous individuals who have publicly disclosed their mental illness in an effort to promote stigma reduction. Group members will also be asked to identify some of the personal values that may support stigma management and promote recovery.

The home practice for this session will encourage reflection on the topics that have been discussed throughout the session. Group members will be asked to recount one personal example of self-stigma and one of social stigma. They will also be asked to indicate whether they have ever had a stigmatizing experience that they felt they handled particularly well, or if they have had an experience that they felt they handled particularly poorly. The goal will be to identify a preliminary list of general stigma coping strategies that group members have found useful, as well as strategies that have not been useful. These strategies will form the beginnings of a list of What Works and What Doesn’t. This list will be refined and enlarged throughout the progression of each session.
5.1.2 Session 2: Depression, Anxiety, and Recovery

As with every session throughout the remainder of the program, the first portion of this session will be dedicated to introductions and a review of the home practice from last session. This general review is important as it will serve as an avenue for group members to focus their attention and re-orient themselves to the topic of stigma. It will also allow group members to once again become comfortable with the atmosphere of group discussion. This time will be used to discuss and identify the preliminary list of general stigma coping strategies that group members have found useful, as well as the strategies that have not been useful. This will serve as the beginning of the list of What Works and What Doesn’t.

This session will consist of a larger didactic learning section than most, with one of the main goals being to provide psychoeducation on the topic of mood disorders, anxiety disorders, and recovery. Many individuals with mental illnesses are unaware of certain symptoms that may arise as part of their diagnosis, and are even more unaware of the symptoms involved in the illnesses if they are not personally affected. Therefore, the goals of this session are to provide group members with additional knowledge about their own disorders, as well as a broader awareness of other mood and anxiety disorders. The main goal is to educate group members so they will feel comfortable discussing these disorders and the stigma surrounding them throughout the remainder of the course.

The first step in providing this psychoeducation is to list the many variations of disorders falling under the general umbrella of “mood and anxiety disorders”. Although definitions of each disorder will not be provided automatically, group members will be encouraged to ask for a definition should there be any disorders listed that they don’t know.
Next, information regarding lifetime prevalence and gender differences of various disorders will be discussed. Facilitators will note that there is often a significant comorbidity found in depressive and anxiety disorders, making lifetime prevalence estimates more complicated than they seem (Kessler et al., 2005). It also should be noted that the lifetime prevalence may be higher than those reported due to the possibility of under-reporting. Likely reasons for under-reporting may include stigma (causing affected individuals to feel too uncomfortable to report) and the lack of participation in surveys to collect data on mental illness prevalence (due to the symptoms of their disorder). The potential debilitating nature of these illnesses will be emphasized by describing data from World Health Organization research which describes depressive disorders as one of the leading causes of disability, worldwide (WHO, 2004).

Next, symptoms of depression and general symptoms of anxiety disorders will be discussed. Although not every spectrum mood and anxiety disorder is discussed, it will be important to provide more detailed information on the most prevalent disorders, which many of the group members may personally experience.

Another issue to address is the biological basis of mood and anxiety disorders. A common misconception of mental illnesses is that they stem from a person’s moral weakness; that an individual should be able to ‘snap out’ of their disorder, if only they had a stronger determination to get better. This concept is deeply rooted in the stigma attached to mental illnesses and is largely influenced by lack of knowledge. Facilitators will ensure that members understand that mental illnesses (including both depressive and anxiety disorders) have a strong biological basis, which can predispose an individual to become more or less prone to developing these disorders. A brief description of the biological etiology of these disorders will be discussed
to emphasize the physical components of mental illnesses. This knowledge will help to reduce self-stigma as individuals often feel that they should be able to just “decide” to get better, and when they can’t, they must be lacking some important emotional quality or trait. Following this there will be a brief discussion on the varying treatment methods for mood and anxiety disorders.

Another topic that will be important to introduce in this session is recovery. Group members will first be asked what the term “recovery” means to them. Next, they will be given a more formal definition of recovery (based on a recovery model), which promotes the importance of looking beyond symptom management to recovery, where recovery is defined as a combination of improved functioning, enhanced quality of life, and empowerment. Core elements of the recovery model will be provided (Farkas, Gagne, Anthony, & Chamberlin, 2005), and should lead into a discussion about the ways in which stigma can have an effect on the recovery of an individual with a mood or anxiety disorder.

If there is time remaining, group facilitators will take an opportunity to promote further group discussion by depicting various case studies describing mental illnesses. Coping strategies will be discussed keeping the recovery model in mind. This exercise should segue smoothly into the assignment of home practice for this session. Group members will be asked to choose a mental illness (preferably one that they know the least about or are not personally affected by), and asked to research a brief background on the disorder (including prevalence, symptoms, and etiology). They will then brainstorm any negative connotations or stigmatized ideas that may be attached to the disorder and ways that may be acceptable to cope with this stigma.

5.1.3 Session 3: Self-Stigma
The first portion of this session will be dedicated to the review of home practice. Each group member will be given the opportunity to share, briefly, what they have learned about the mental illness they have researched. Discussion will be focused on identifying stigmatizing ideas that are attached to the mental illnesses, as well as identifying coping strategies that would be useful to conquer the stigma. As part of this review it will be important to provoke group members to imagine how the social stigma surrounding these disorders would personally affect a person diagnosed with the disorder. Group members will then discuss how they think that the social stigma surrounding their own mental illness has affected their own self-image. This discussion will lead into the introduction of self-stigma.

Self-stigma will be presented as an important topic in the grand scheme of mental health related stigma because it can be debilitating, and consists of deeply rooted, negative schemas directed toward oneself as a result of the social stigma experienced due to one’s mental illness. Group members will be told that, although self-stigma may be difficult to eliminate completely, it is unique in the fact that it belongs to the individual who is stigmatized; therefore, given the right tools for change, an individual who self-stigmatizes may be able to overcome this aspect of stigma in a more immediate sense than they would in comparison to social stigma. Therefore, the goals of this session are to introduce didactic information about self-stigma, to identify challenges and coping strategies for minimizing self-stigma, and to practice modification of self-stigmatizing beliefs.

The first step in introducing didactic information about self-stigma to group members is to define exactly what the term “self-stigma” means, and to compare and contrast this definition to the definition of social stigma. Although both of these definitions were already touched upon during the introduction and orientation session (session one), they are most important to reiterate.
now, as the topic of this session will be rooted within these definitions. It will be essential for group members to understand that self-stigma concerns the stereotype, prejudice and discrimination of mental illnesses being turned inwardly to oneself (Corrigan & Watson, 2002). Furthermore, it will be important to understand that self-stigma is manifested when an individual is aware of the stigma surrounding their mental illness, agrees with the negative beliefs held by others, and therefore applies these negative beliefs to oneself (Corrigan, Larson, & Rusch, 2009).

Group members will learn that the consequences of self-stigma can be quite debilitating in terms of lowering self-esteem, self-efficacy, and sense of hope for the future. It will be important to discuss these consequences so that group members can be made aware of the importance of attempting to conquer self-stigma. Self-esteem and self-efficacy also will be defined to ensure a full understanding of the terms and their importance for an individual’s well-being.

After the main three consequences of self-stigma have been defined, group members will be asked to brainstorm other ways that self-stigma may be harmful to an individual’s well-being. These may include, but are not limited to, feeling shame and guilt, a loss of confidence and motivation, and the use of avoidance tactics. Group members will also brainstorm common negative statements about the self, which may reflect self-stigma. These may include examples such as, “I am weak and unable to take care of myself”, “People like me are unable to accomplish most of their goals”, and “I am unworthy of happiness”. Group members will be asked to share personal experiences about these thoughts or feelings. In response to this discussion, group members will brainstorm ways they can personally challenge these feelings and the self-stigma that they reflect.
Group members will be introduced to the six approaches that have been identified to diminish stigma: protest, education, and contact-based education, legislative reform, advocacy, and stigma self-management (Arboleda-Flórez & Stuart, 2012; Corrigan, 2004). Group members will be encouraged to provide examples of what one could do to put each approach into action. Group members will be asked to identify more specific ways to challenge self-stigma, including those they may have personally used in the past.

At this point, it will be reiterated that the first step to reducing stigma is to eliminate it within oneself because if one feels negative about oneself, it will be virtually impossible to prove their value to others. An example of an attitude to work towards is: “Although I have some difficulties, I am still able to achieve most of my goals in life, just like other adults who face similar obstacles”. It will be helpful at this point to stress the fact that every person in the world faces adversity at some point in their lives, and that they are just as worthy of living full and meaningful lives, without having to face the loss of opportunity that stems from stigma and discrimination.

The behavioural modification and home practice of this session will follow the same basic format with the main goal being to challenge any deep-rooted, self-stigmatizing beliefs that individuals hold. Group members will be asked to identify a negative, self-stigmatizing belief that they have been holding about themselves in relation to their mental illness (i.e. this illness makes me a bad parent/friend/son/daughter, this illness makes me unable to work, this illness makes me unworthy of general success in life). Group members will be encouraged to create a list of identifiers such as worthy/unworthy, able/unable, good/bad, depending on the belief they have chosen. Group members will be asked to collect evidence against the negative belief they hold (with the opportunity to ask for help/opinions from those who are closest to them, if
necessary). This will assist group members to develop more realistic perceptions of their general abilities.

5.1.4 Session 4: Social Stigma Part I – Stigma in Family, Friends, and Medical Settings

Please see Appendix B to view the PowerPoint information for this session.

The first portion of this session will be dedicated to the review of home practice from the last session. Group members will be asked to share the evidence they have collected against the negative, self-stigmatizing beliefs they have held. Group members will be asked to describe if and how their perceptions have changed as a result of this activity, and if it has made them more aware of the self-stigmatizing beliefs that they hold. They will be encouraged to keep trying to challenge these self-stigmatizing thoughts in their day-to-day lives, in order to obtain a more positive outlook.

The focus of this session will now switch from self-stigma to stigma that has been experienced by group members from people in society (social stigma). This is an important and potentially sensitive topic to discuss. Although the goal is to educate members on the stigma that is present in society, it will be important not to dwell on the negative any more than is necessary to elicit the point because a key goal of this course is to empower group members. Therefore although negative aspects of stigma must be discussed to address the problem, the main focus should be to explore what can be done to create a positive change. This is especially important as family members, friends, and medical providers often contribute largely to the support system of group members. Therefore, maintaining healthy relationships with these people should be beneficial to the overall recovery of group members.
The first point that is important in discussing the topic of stigma within family and friends is that there are two different ways to view the topic. First of all, family and friends may direct stigma towards a mentally ill individual after learning about their illness, and secondly, family members and friends may face stigma and discrimination from others for associating with a person who has a mental illness. Although it is necessary to acknowledge the different ways family members and friends can be associated with stigma, it is important to focus more on the stigma that family members and friends associate with the group members, as this is something that group members can learn to positively change.

Once the topic of stigma within family members and friends is introduced, it is necessary to include some statistics about the topic to show group members that this is a common problem experienced by those with a mental illness. Example statistics from the 8th Annual National Report Card on Health Care state that although 58 percent of Canadians indicate that they would socialize with a friend who has a mental illness, approximately 42 percent are less certain that they would do so, and that only 50 percent of individuals would tell other friends or coworkers that they have a family member who is affected by mental illness (Canadian Medical Association [CMA], 2008). These statistics show that stigma in society can effect even those who are meant to be the most influential support group for individuals with a mental illness.

After providing group members with this statistical information, the floor for discussion will be opened by asking if anyone has found that family members and friends have treated them differently since being diagnosed with a mental illness. This question will be used to lead into an in-depth discussion of the ways that group members’ relationships have changed since being diagnosed. Some examples may include distancing relationships, family and friends “walking on eggshells”, patronizing behaviour, avoiding or over-emphasizing the topic of mental health, or
completely avoiding the individual. Group members will then be asked what they have done in the past in order to overcome these adversities. Group facilitators will make a list of these changes and coping mechanisms to add to the *What Works and What Doesn’t* list.

Once challenges and coping mechanisms to manage the stigma from friends and family members have been discussed, it will be time to put these management skills into practice in a behavioural modification exercise. Group members will be divided into two groups, one as family members and friends, and one as the person with the mental illness and stigma. The family and friend group will brainstorm several stigma-inducing scenarios that occur commonly in the household or among friends, and will present these to the second group, who will then brainstorm ideas about how to cope with the stigma. This will end the discussion on a positive, stigma-free note. After completing this exercise, the groups will switch, and the exercise will be completed a second time so that each group member gets the opportunity to practice and experience the give-and-take of relationships that is imperative to healthy, stigma-free communication.

Now that the topic of family and friends stigma has been discussed and coping mechanisms have been practiced, it is important to discuss the topic of stigma in medical settings. Although medical doctors and those working in medical settings are some of the most educated about mental illnesses, many patients find that this is often where stigma is the worst. Group members will be introduced to research that suggests that medical students often hold the view that people with mental illnesses are dangerous, violent, “not easy to like”, and are unlikely to recover (Kassam, Glozier, Leese, Loughran, & Thornicroft, 2011). Thus, patients may find that doctors do not take their symptoms seriously and do not ask the questions necessary to understand exactly what the patient is experiencing. At this point, group members will be asked
if they have experienced stigma in medical settings and what effect it has had on their personal path towards recovery. It will be helpful to also ask group members if they have had any experiences where they felt they dealt with this stigma positively and these coping mechanisms will be added to the list of *What Works and What Doesn’t*. Group members may also be given a chance to discuss personal experiences they have had with doctors in the community, in order to give others a sense of which doctors are more accommodating in discussing mental health.

Because research suggests that one of the most helpful things that patients can do to personally cope with stigma in medical settings is to take a more active role in appointments group members will be asked to create a script and a list of goals of what they wish to see out of an appointment. This will promote shared decision-making and ensure that everything is covered in an organized fashion without leaving any important points out (Drake, Deegan, & Rapp, 2010). Although it may be difficult for stigmatized individuals to completely overcome the stigma from health providers, there are some tools that may improve experiences with difficult doctors. For example, researcher Patricia Deegan has developed a “Commonground” program which helps patients prepare for meetings with psychiatrists in order to arrive at the best decisions for treatment and recovery (Deegan, 2010). Developing scripts such as the ones found in this program can be helpful in order to show that an individual possesses the ability to take an active role in their treatment and recovery. This will enable individuals to feel more comfortable in their meetings with mental health professionals, and will promote a smoother path towards recovery.

Stigma experiences and their impact may vary by individual. Therefore, group members will be given a choice of topics for their home practice. If they choose the family and friends option, they will be asked to keep track of any stigmatizing experiences that have stemmed from
interactions with family and friends. They should be encouraged to use some of the coping mechanisms that were previously discussed, and to keep track of what was most helpful in dealing with the situation as positively as possible. These results will be discussed at the opening of the next session. If they chose the medical setting topic, group members will be asked to develop a script and list of goals that they would like to use for their next appointment. They discuss how they think this script will be helpful in combating the stigma that they often experience within medical settings.

5.1.5 Session 5: Social Stigma Part II – Stigma in Education, Housing, and the Workplace

This session will begin with a review of the home practice from last session. Group members will be given the opportunity to discuss experiences of family and friend stigma over the past week, and/or their experiences of script writing for future medical appointments. The discussion will be based on what coping mechanisms group members have found helpful, and how they think that these coping mechanisms and scripts can be useful in other stigmatizing situations experienced within day-to-day life.

This discussion will be used to lead into the topic of the current session, which deals with social stigma on a wider scale and its potential effect on the less immediate aspects of one’s life, such as education, housing, and workplace experiences. These are areas in which most people experience at some point in their lives, and which, if stigma is present, can have a debilitating effect on one’s overall well-being. Although this session will touch upon the stigma experienced in housing and school, the focus will be on stigma experienced within the workplace.

Although many of the group members in these sessions may have completed their education, there may still be high school or college-aged members, or mature students pursuing
further education. Regardless of whether or not group members are currently enrolled at an educational institution, every individual is likely to have been exposed to a school environment at some point in their lives, which is why it is importance to touch on this topic in regards to stigma presented in society.

When discussing stigma in education systems, it is important to note that schools are a unique situation. School systems can have the power to promote stigma as students often go with the trend of their peers. If their peers promote negative beliefs about mental illnesses, it is likely that this mindset will extend to others who have yet to form their own (educated) opinion on mental illness. Keeping this in mind, it is also important to note that school systems can be a powerful outlet in reducing the stigma surrounding mental illnesses. At this point in the session, group members will be asked to share and personal experiences of stigma within education systems and any coping strategies that they found particularly useful in combating this stigma.

Housing is another area in which individuals with a mental illness may be stigmatized, though not all group members may have been personally affected. Group members will be presented with research showing that landlords are less likely to consider renting to individuals who reveal that they have received mental health treatment in the past, especially if it was inpatient treatment (Corrigan et al., 2003). This is an important point to raise, as it can contribute to the vicious cycle of mental health stigma and discrimination. For example, individuals who are unable to rent from landlords may face a higher possibility of ending up homeless, which serves to further perpetuate the stigma targeted at individuals with mental illness. At this point in the session, group members should be asked if they have ever experienced any type of stigma in regards to housing. If so, they should be asked to share what types of coping strategies were used, and which were most effective.
Stigma in the workplace is particularly important to discuss, as it is an immediate reality for many individuals with a mental illness. It is important to note that workplace stigma can be experienced in two ways: stigma in terms of unemployment, and stigma in terms of discrimination within the office/workplace. Although it may be true that mental illnesses can have an effect on an individual’s ability to function at the level of other employees in the workplace, treatment and good symptom management can often allow for a successful level of functioning in the workplace.

At this point in the didactic lecture, it is important to share statistics about stigma in the workplace and about unemployment in those affected by mental illnesses. These statistics are not meant to discourage group members, but rather to show the severity of stigma and discrimination often applied to individuals with mental illness and how it can affect their daily lives. An example statistic about stigma in the workplace is that only 49 percent of Canadians would socialize with a colleague with a mental illness (CMA, 2008). Furthermore, research has shown that although most individuals with mental illnesses are willing and able to work, the unemployment rate of individuals with mental illness is approximately three to five times higher than in those who are mentally healthy (Stuart, 2006). This statistic highlights a very large disconnect between the abilities of individuals who experience mental illnesses, and the way that they are viewed by employers.

The workplace can be an important area for addressing mental health issues. Researchers have identified four specific areas where organizations can take action. These include focusing on education and communication to reduce fear, stigma, and discrimination in the workplace, ensuring the organizational culture is supportive of employee mental health, encouraging senior executives to show mental health leadership, and building managers’ capability to support
employees by providing mental health tools and training (Thorpe & Chénie, 2011). Although there have been many specific ways identified that management can help to reduce the impact of mental health stigma in the workplace, it may be more difficult for individuals to make an immediate positive change. Group members will be encouraged to take small steps such as correcting individuals who use stigmatizing comments, and only disclosing information about their mental illness to individuals who are known to be trustworthy and open-minded.

A large problem that many individuals with mood and anxiety disorders face in the workplace is the gaps they may have in their resume due to sick leave. The stigma surrounding mental illness can be prevalent in this case and may cause prospective employers to be unsympathetic concerning time off. For example, an individual who undergoes heart surgery and takes time off of work to recover would likely be given a large window of time to recuperate from their employers. However employers may be less likely to understand why an individual with a mental illness would need to take time off of work, since symptoms of mental illness may not be as obvious as physical symptoms. Consumer focus group members found this notion of employers being unsympathetic to time taken off work to be anxiety-provoking and often found that it made the transition back to the work force even more difficult. If this is the case for group members when planning a return to the workforce, it is important for them to plan what they would like to say to their employer and colleagues to help them understand.

Creating a script is a helpful way to ensure that the individual does not forget anything important. In this script, it will be important for the individual to focus on their strengths, rather than their weaknesses. However, it is also necessary to identify limitations caused by one’s mental illness, and to suggest potential accommodations that could be made in order to support a smooth transition back into the workforce. It is always important to end the conversation on a
high note, and to maintain a positive outlook throughout the conversation, for one to show their employer that they are ready for a successful new beginning within the workforce. Although using this type of a tool does not guarantee successful hiring of an individual or acceptance after time off, it will help individuals feel more comfortable with the confrontation and may also help employers gain a better understanding of their employees’ needs.

The home practice portion of this session will encourage group members to create a script that would be useful in explaining any time off from a current job, or resume gaps when applying to a new job. As every group member’s employment situation will be different, all of their scripts should be catered towards their current employment area/position, or their future employment area/position. Group members will be given a flexible template to use to create their script to ensure that nothing important is left out, but will be given the freedom to personalize their script based on their own criteria. Group members also will be encouraged to write a script to present to those people in the workplace who they have chosen not to disclose. The script-writing process and results of the script-writing will be discussed at the opening of the next session.

5.1.6 Session 6: Disclosure

This session will open with a discussion of the home practice from last session. Group members will be encouraged to share the scripts that they have created to deal with potentially stigmatizing situations in the workplace, and group facilitators will promote discussion of whether group members think that these scripts will be useful in the future. Group members will be encouraged to take notes of what other people may have done differently in their scripts, and to alter their own scripts, if necessary, based on any new ideas they may have gathered from hearing the scripts of others.
Up until this point in the course the goal has been to provide group members with as much knowledge as possible on the topic of stigma of mood and anxiety disorders. Psychoeducation has been provided about the disorders and the ways in which stigma is most often experienced, and group members have been provided with the tools necessary to take what they have learned and apply it to real-life situations in a way that will promote positive relationships and a smoother path towards recovery.

Now that group members have a better understanding of both social stigma and self-stigma, it is important to discuss the relevance of disclosure. Group members will vary in their level of disclosure, with some group members falling on the complete secrecy end of the spectrum, and some falling on the full disclosure end. Regardless of group members’ positions on this spectrum, it is important to discuss the effects of disclosure to ensure that group members are educated on the topic to make sound future decisions.

The first step in discussing the subject of disclosure in the group setting will be to acquire an understanding of the level of disclosure that each group member has personally experienced at this point in their lives. Group members will be asked to discuss who in their lives knows about their mental illness, and why these people know, as opposed to others who may not know. This discussion will provide group facilitators with a better understanding of where each group member lies on the continuum of disclosure, and will provide the opportunity for open discussion about the topic.

Now that group members have had the opportunity to consider their own personal levels of disclosure, it is important to gain their feedback on what they believe the pros and cons of disclosure to be. For example, some possible benefits of disclosure may include psychological well-being, increased self-esteem, decreased distress, and enhanced relations with key
institutions such as work, while possible detriments may include social avoidance by others, social disapproval, isolation from others, self consciousness, and self-fulfilling prophecies (Corrigan & Matthews, 2003).

Now that the possible benefits and detriments of disclosure have been discussed, it is important to provide group members with information on the different types of disclosure that have been recognized. Corrigan and Lundin have identified a hierarchy of strategies, including social avoidance, secrecy, selective disclosure, indiscriminate disclosure, and broadcast (Corrigan & Lundin, 2001). According to their definitions, social avoidance occurs when an individual affected by mental illness avoids others so that they do not allow others the opportunity to get to know them – let alone stigmatize them. Although this strategy allows the individual to completely avoid stigma in relation to mental illness, it may also prevent them from living a healthy, social, and fulfilling life. Individuals who prefer the secrecy method tend to live their lives as normal, but do not tell anyone about their mental illness. Although this strategy allows for a regular lifestyle (individuals are able to go to work, see friends and family, etc.), it also denies the individual of any support that others may be able to provide, if they were aware. Selective disclosure is used when an individual decides who to disclose to, depending on how they think individuals will react. For example, a person using this disclosure method may tell a person who is known to be open-minded and accepting, rather than a person who is known to be closed-minded. This method is useful as the person with a mental illness will have the opportunity to gain support, with a low likelihood of discrimination. However, these individuals will still hold the burden of secret-keeping from those who they have not disclosed to, as well as the burden of deciding who-and-who-not to tell. Individuals who use the indiscriminate disclosure strategy do not hide their mental illness. They do not deny having a mental illness,
and most people in their life are aware of the fact. This strategy allows for a large support system, as well as the openness and relaxation of not having to keep a secret. It may, however, allow for people to discriminate against the disclosing individual. Finally, those who use the broadcast strategy are proud to discuss their mental illness. They are not afraid to let anyone know about it, and are very comfortable discussing the topic. The advantage of this strategy is that is can be empowering for an individual, and would most certainly provide a strong support system. It may also encourage others to open up about their mental illnesses, and could eventually reduce much of the stigma associated with mental illness by encouraging informed discussion. However, a person who uses the broadcast strategy may run the risk of being discriminated against.

Now that the possible benefits and detriments of various disclosure methods have been discussed, it is important to consider how one should go about deciding which disclosure method to choose for their personal experience with mental illness. Some ideas to take into consideration when choosing a disclosure method may include, but are not limited to, personal preference (i.e. a person’s personality or level of comfort with social interaction), one’s perceived level of social support, one’s stage of dealing with mental illness, or the situation in which disclosure could have an effect (i.e. workplace versus home life). Together, at this point in the session, group members and group facilitators will work to create decision trees that may help an individual to determine whether or not they wish to disclose in a certain situation. Group facilitators will be provided with sample templates of such decision trees in order to guide the discussion, however it is important for group members to play a large role in discussing what they believe to be the most important factors of making the decision to disclose.
After the different ways to go about deciding on disclosure methods have been explored, it will be important to provide group members with some insight into empowerment. Patrick Corrigan, who is one of the leading researchers on stigma in mental health, and a part of the stigma expert focus group, describes the importance of empowerment in the reduction of the stigma and self-stigma of mental illness. According to Corrigan, personal empowerment, which some people acquire by using full disclosure methods, is associated with higher self-esteem, better quality of life, and increased social support (Corrigan & Rao, in press). Therefore, the encouragement of empowerment may be helpful in reducing the overall stigma of mental illness.

While explaining this information to group members, it is important to keep in mind that although this information about the empowerment of full disclosure is being supplied to them, the decision of disclosure method is their choice. The information is being provided in order to allow group members to gain full knowledge about all costs and benefits of disclosure, not to put any pressure on group members to fully disclose.

Throughout this session, the possible pros and cons of different methods of disclosure have been discussed in broad terms; however, it is important to realize that disclosure is a personal decision. Therefore, the home practice portion of this session will require group members to take the time to weigh the pros and cons of disclosure in relation to their own lives. If group members have fully disclosed, they will be asked to reflect on the effects of this disclosure, and of any direct positive or negative associations they have had in regards to this disclosure. If group members have not disclosed, they will be asked to reflect on why this is the case, and whether learning more about disclosure has changed their opinions.

5.1.7 Session 7: Conclusion
This session will begin with a review of home practice from the previous session. The topic of disclosure will be discussed and group members will be given the opportunity to express their feelings regarding the reflections they have considered regarding their current level of disclosure. Group members will be encouraged to ask any questions regarding disclosure, and will be encouraged to ask one another for opinions about disclosing to certain people that they have not yet disclosed to, but may want to in the future.

After the discussion of home practice has come to a close, it will be important to let group members know that this session will be dedicated to reviewing everything that has been discussed thus far. The concluding session will provide an overview of all of the material that has been covered and will provide an opportunity for group members to ask any questions that have yet to be resolved. It will also allow group members to reflect on their progress throughout the duration of the course and to determine how their opinions about stigma have changed.

The first goal of the concluding session is to provide a brief overview of each session of the course, while ensuring that all important points are reiterated. There should be time allotted to questions and comments after the review of each session, to ensure that group members have the chance to have all questions answered and all opinions heard.

After all of the sessions have been reviewed, it will be important to return to the list of What Works and What Doesn’t. Group facilitators will have updated this list, with the help of group members, throughout the duration of the program. They will prepare a compiled list in a document for this concluding session, for group members to take home. Group members will be given an opportunity to discuss the contents of the list, and to add any last thoughts to the list, if necessary.
Next, group members will be asked to provide feedback on the course. A quick survey will be given, with questions aimed at determining group members’ thoughts on course content, course duration, course layout, and overall efficacy and enjoyment of the course. This information will be valuable in order to determine whether or not changes should be made in the future to provide a more helpful program to potential group members.

Finally, the session will close with a brief chat about lessons learned and closing. Group members will be asked what they believe the most important take-home messages of the program to be, and how they think they will be able to apply these to their everyday lives. Group members will also be given the chance to ask any remaining questions. Finally, group members will be provided with information regarding other group-based programs in the area that provide the opportunity for individuals with a mental illness to gather and to discuss their experiences. This information is important as it will give group members an opportunity to continue this type of group interaction on the subject, if they have found it particularly useful throughout the duration of this program. Group members will also be encouraged to share personal contact information with one another, if comfortable, in order to meet together as an informal support group following the conclusion of this program.

5.2 Future Directions

This research and course development is the first step of a larger project that will involve pilot testing, and controlled trials to determine the efficacy of the program in eliminating the stigma experienced by individuals with mood and anxiety disorders. Pilot testing will involve running the full course with the targeted population, in order to determine feasibility, and to make any changes to the finalized course depending on the reaction of participants. Controlled
testing will determine the efficacy of the course in reducing stigma, by comparing the attitudes of individuals who have taken the course, to those who have not. If successful, the long-term goal of this project is that this course may be used in many different sites throughout Canada, and internationally, in order to help as many people as possible to cope with the stigma surrounding their mental illness, thus promoting a more pleasant, smooth, and manageable road to recovery.
Chapter 6: Conclusions

The stigma surrounding mental illness must be eliminated in order for individuals who are diagnosed with a mental illness to experience a healthy and supportive road to recovery. Several anti-stigma campaigns and initiatives have been implemented recently both world-wide, and within Canada. Although these anti-stigma campaigns are important to reducing public stigma, it is important to note that completely eliminating prejudices and changing stigmatizing behaviours are difficult and long-term tasks. Furthermore, most current anti-stigma campaigns focus on reducing the social stigma of mental illness, rather than the self-stigma directly experienced by those diagnosed with mental illnesses. It is important for stigmatized individuals to be provided the opportunity to learn how to rise above stigmatizing conditions in day-to-day life in order to live healthily and productively. The creation of a stigma-specific course for individuals with mood and anxiety disorders is necessary in order to provide the opportunity for individuals to learn to overcome self-stigma and manage social stigma in positive and self-affirming ways.

The objective of this research was to develop a psychoeducational and behavioural modification group-based course to reduce the stigma of individuals with mood and anxiety disorders. Two phases of program development occurred in order to obtain as much feedback as possible prior to program implementation. The decision of what to include in Phase I of each session in this program was based on a combination of published literature, readings of personal experiences, and discussions with mental health service consumers and providers. The decision of what to include after Phase II of the course was based on a variety of suggestions and opinions surrounding course content and layout collected after conducting three focus groups. The resulting content of the course is a compilation of the ideas, feedback, and opinions of many
varying groups of people, from mental health service consumers to mental health stigma experts. It is expected that this course will offer a well-rounded experience for future participants and will be an effective tool in eliminating the personal impact of stigma experienced by individuals with mood and anxiety disorders.

Although it is expected that this program will be successful, several limitations should be considered. One limitation is that, although some candid conversations with mental health service recipients took place throughout the duration of course development, it would have been useful to include people with a mental illness from the beginning of Phase I. This would have ensured that people who experience stigma had an opportunity to provide feedback on every aspect of course development. In addition, it would have been beneficial to include more focus groups involving people who have a mental illness in order to obtain additional feedback from the individuals directly affected by stigma.

Although the development of this course was only the first step towards a much larger project, the end goal will always remain the same: to reduce the stigma experienced by those with mood and anxiety disorders. Stigma is an unnecessary by-product of many years of ignorance and misunderstanding about mental illnesses. This resulting stigma has created a large obstacle in the recovery of many individuals, who not only have to conquer the stigma presented by society, but also their self-stigma. This course was designed with the overarching goal of being able to provide information and tools to those suffering from the stigma of mental illness, in order to improve their lives, promote resiliency to stigma in the future, and to encourage a healthy road to recovery.
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Appendix A

Depressive Disorders

According to the Diagnostic and Statistical Manual of Mental Disorders [DSM-IV-TR] (2000), in order to be diagnosed with Major Depressive Disorder (MDD) (otherwise known as major depression), an individual must experience symptoms of depressed mood or loss of interest, as well as at least four other depressive symptoms for a period of at least two weeks. This period of at least two weeks of continuous depressive symptoms would be considered a single episode of major depression, and would warrant a diagnosis of major depressive disorder (DSM-IV-TR, 2000). If an individual experiences more than one episode, they would be diagnosed with Major Depressive Disorder (Recurrent). Subsets of MDD include, but are not limited to, seasonal affective disorder (SAD), which is characterized by depressive episodes occurring predominately in winter months, and post-partum depression (PPD), which consists of depressive episodes occurring in the months after a new mother gives birth.

Two other categories of mood disorders include Dysthymia, and Depressive Disorder Not Otherwise Specified (DD-NOS). Dysthymia is characterized by a chronic low mood of at least two years. This low mood is generally less severe than the low mood experienced in major depressive disorder, however those with dysthymia run the risk of experiencing a major depressive episode within their dysthymic state, thus resulting in an experience of “double depression”. Depressive disorder not otherwise specified is diagnosed when the presentation of depressive symptoms does not meet the criteria for any specific disorder (DSM-IV-TR, 2000).

Bipolar Disorders
According to the DSM-IV-TR (2000), bipolar I disorder can be diagnosed when an individual experiences one or more manic or mixed episodes, with or without the experience of a depressive episode. Although individuals diagnosed with bipolar I disorder are not required to experience a depressive episode in order to be diagnosed, it is common that individuals experience depression directly before a manic episode, directly after a manic episode, or at the same time as a manic episode, known as a “mixed state” (Basco, 2005).

Within the umbrella definition of bipolar disorder, there also lies bipolar II disorder, cyclothymia, and bipolar disorder not otherwise specified (BD-NOS). Bipolar II disorder is diagnosed when an individual experiences a combination of recurrent hypomanic (mania to a lesser degree) episodes, with depressive or mixed episodes, whereas cyclothymia is diagnosed when an individual experiences a combination of hypomanic and dysthymic episodes, thus never fully experiencing any full manic or depressive episodes. BD-NOS is diagnosed when an individual experiences symptoms of bipolar disorder, but does not fall into a diagnostic category of any of the formal bipolar disorder diagnoses (DSM-IV-TR, 2000).

Anxiety Disorders

Generalized anxiety disorder (GAD) is characterized by excessive anxiety and worry about a number of events or activities in one’s daily life. According to the DSM-IV-TR (2000) criteria for diagnosis, GAD is diagnosed when an individual is significantly affected by their excessive worry more days than not, for a period of at least six months. The DSM-IV-TR also requires an individual to be affected by at least three of the following symptoms in order to be diagnosed: restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and/or sleep disturbance.
Panic disorders occur when an individual experiences frequent panic attacks of intense anxiety and terror, often accompanied by such physical symptoms as sweating, trembling, and palpitations. According to the DSM-IV-TR (2000), these panic attacks must be recurrent and unexpected, with the individual experiencing either concern about having additional panic attacks, the implication of attacks and their consequences, or experiencing a significant change in their behaviour in relation to the attacks. Panic disorders may also be associated with agoraphobia, in which an individual avoids social situations due to the fear of embarrassment, should a panic attack occur (Health Canada, 2002).

Phobia disorders occur when an individual is possessed by irrational fear and anxiety of certain objects, experiences, or situations. Specific phobia occurs when an individual experiences intense anxiety about concrete objects or experiences such as spiders, flights, or heights, without this anxiety translating to other aspects of their life. The fear must be excessive or unreasonable, may trigger a panic attack, must cause an individual to avoid situations in which they may endure their fear (or endure it with much anxiety), and the distress associated with the phobia must interfere with the individual’s daily routine (DSM-IV-TR, 2000). Social phobia occurs when an individual experiences excessive or unreasonable fear in social or performance situations. This fear may present in the form of a panic attack, the individual will avoid social situations (or experience them with great distress), and the avoidance and fear of these situations and potential anxiety must interfere with the individual’s daily functioning (DSM-IV-TR, 2000).

Obsessive-compulsive disorder (OCD) is experienced when an individual develops obsessions or compulsions that are excessive or unreasonable. Obsessions are characterized by intrusive and inappropriate persistent thoughts or images that are anxiety provoking and stressful, and are not simple worries about regular life problems (DSM-IV-TR, 2000).
Compulsions such as cleaning, hand-washing, and counting, are developed as regular behaviours that a person feels compelled to perform in response to their obsession, however these compulsions are often not logically connected to their obsessions, or are excessive (DSM-IV-TR, 2000). These obsessions and compulsions must cause marked distress, and must interfere significantly with an individual’s daily routine.

Post-traumatic stress disorder occurs when an individual experiences extreme anxiety and fear after experiencing a traumatic event, such as combat, a serious accident, or sexual abuse. The individual must experience recurrent and distressing recollections of the events of the incident, distressing dreams recounting the incident, or intense flashbacks about the incident, in which the individual feels as though they are reliving the experience (DSM-IV-TR, 2000). The individual must avoid situations which trigger memories of the experience, may have difficulty remembering aspects of the experience, may experience diminished interest in everyday activities, and may feel detachment from others, as well as other physical symptoms such as difficulties sleeping, hypervigilance, outbursts of anger, and difficulty concentrating. All of these symptoms and experiences in relation to the traumatic experience must significantly interfere with the individual’s daily routine (DSM-IV-TR, 2000).

Etiology of Mood and Anxiety Disorders

It is important to view the etiology of mood and anxiety disorders from a biopsychosocial perspective, thus accepting that a variety of factors from an individual’s biology, psychology, and environment can contribute to the development of a mood or anxiety disorder (Alvarez, Pagani, & Meucci, 2012). For example, an individual with a family history of depression, bipolar, or anxiety disorder may inherit a predisposition to the disorder, thus increasing their
likelihood of eventually developing the disorder. However, it may take a particularly stressful life event in order to trigger the disorder, if it is even triggered at all. This theory of genetic factors being dependant on environmental factors is known as the diathesis-stress model, and is very useful in understanding the etiology of mood and anxiety disorders specifically, as well as the full spectrum of mental illnesses (Monroe & Simons, 1991).

Other proposed causes of mood and anxiety disorders are largely based on biological and neurochemical factors. For example, a meta-analysis of studies has shown that major depression is associated with such brain abnormalities as smaller volumes of the basal ganglia, thalamus, hippocampus, frontal lobe, and orbitofrontal cortex, compared with healthy volunteers (Kempton et al., 2011). Furthermore, this study has shown that both major depression and bipolar disorder are associated with increased lateral ventricle volume and rates of subcortical gray matter (Kempton et al., 2011). Studies have also shown that the amygdala play an important role in the processing of fear and anxiety, and may be altered in those affected by mood and anxiety disorders (Etkin & Wagner, 2007). Varying levels of activity of certain neurotransmitters such as serotonin, dopamine, norepinephrine, and gamma-aminobutyric acid (GABA) are also known to play a part in the etiology of mood and anxiety disorders (Kalueff & Nutt, 2006; Nutt, 2008).

**Treatment of Mood and Anxiety Disorders**

There are a variety of treatments available for mood and anxiety disorders, many of which are used in combination in order to develop the most effective strategy for recovery. Treatment strategy may also depend on the severity of the disorder, how long the individual has been affected by the disorder, and the general preferences of the individual.

Psychotherapy is often one of the first efforts to treat mood and anxiety disorders, and includes such treatments as cognitive behavioural therapy and interpersonal therapy which are
often combined with psychoeducation and behavioural modification in order to positively alter any skewed mental processes occurring within the individual. Research has shown psychotherapy to be especially effective in treating mild, moderate, and severe depression, as well as anxiety disorders (Hofmann & Smits, 2008; Jorgensen, Dam, & Bolwig, 1998; Schulberg, Raue, & Rollman, 2002).

Pharmacotherapy is another common method of treatment for mood and anxiety disorders. Antidepressants such as selective-serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), monoamine oxidase inhibitors (MAOIs), and tricyclic antidepressants are often used for treatment of depressive symptoms and anxiety symptoms, and research has shown most to be effective in comparison to placebo in controlled clinical trials (Anderson, 2000; Papakostas, Thase, Maurizio, Nelson, & Shelton, 2007; Thase, 2003). Mood stabilizers such as lithium carbonate, and anticonvulsants such as sodium valproate have been effective in reducing the manic episodes present in bipolar disorder (MacRitchie et al., 2003; Poolsup, Li Wan, & De Oliveira, 2000). Benzodiazepines and atypical antipsychotics may also be used in the treatment of mood and anxiety disorders, depending on the symptoms experienced by the individual (Llorca, Spadone, & Sol, 2000; Westenberg, 1999).

Alternative treatment options for mood and anxiety disorders include acupuncture, sleep therapy, exercise therapy, music therapy, and natural medications such as Saint John’s Wort. Another common treatment for depression is light therapy, in which the affected individual is exposed to bright light for a period of time during the day. This form of treatment is particularly effective for individuals affected by seasonal depression (Golden, Gaynes, & Ekstrom, 2005).

For more severe cases of mood and anxiety disorders, or for those who are resistant to the more traditional forms of treatment, there are slightly more invasive options available. Examples
of these treatments include electroconvulsive therapy (ECT), which relies on the application of brief electrical pulses to the scalp to induce controlled brain seizures, and repetitive transcranial magnetic stimulation (rTMS), which relies on the application of focal magnetic stimulation to the scalp, inducing electrical stimulation in cortical tissue (Ressler & Mayberg, 2007). Another method that may be effective in treating treatment-resistant depression is deep brain stimulation (DBS), in which a device called a “brain pacemaker” is surgically implanted into the brain, in order to send electrical pulses throughout on a regular basis (Perlmutter & Mink, 2006).

Although there are a wide variety of treatments available for mood disorders, it is important to note that different people are affected by treatments in a variety of ways. Therefore, what works for one person may not work for another, and it is often difficult to find an effective method of treatment for an affected individual.
During our last session, our main focus was how to avoid the common problem of internalizing stigma to produce the phenomenon of “self-stigma”. The first step to conquering feelings of stigma is to identify them in yourself, change this thinking/behaviour into a positive reaction, and therefore eliminate any negative feelings that you previously felt. Now that we have explored and identified ways in which you can aim to reduce feelings of stigma within yourself, we can more outward into the bigger picture: stigma and discrimination in society.

Just to refresh your memories from last session, there are a few key differences to keep in mind when comparing social stigma to self stigma.
The sad reality of the stigma and discrimination presented in society, is that it can sometimes expand to not only influence us personally, it can also influence the people we love the most, and our most important support group: our family and friends.

It is important to note that there are two different ways to view the topic of stigma with family and friends.

The 8th Annual National Report Card on Health Care, which surveyed over 2200 Canadians in 2008 about mental health issues, found some very interesting statistics regarding stigma in family members and friends.

Open up the group for an in-depth discussion with this question. Have one of the group facilitators make a list of all of the ways that their family members and friends have treated them differently, and of the ways that their relationships have sub sequentially changed.
**Slide 6**

Examples of Change within Relationships

- Distancing friendships or relationships
- Family/friends "walking on eggshells" out of fear of upsetting you
- Family/friends may patronize you or act as if you are unable to do certain things for yourselves
- They may avoid the topic of your mental health completely as if it is a tainted topic
- They may put too much emphasis on the topic of mental health, as if it is the only thing that defines you

**Slide 7**

What have you done to manage these adversities in your relationships?

What do you think would be helpful in order to make your relationships as seamless, comfortable, and supportive as possible?

**Slide 8**

Two Main Types of Family/Friend Stigma

- Stigma in terms of distancing relationships:
  - Spending less time with you
  - Avoiding you
  - Not wanting to associate with you
  - Not acknowledging your mental illness
- Stigma in terms of being overbearing:
  - Patronizing you
  - Not believing in your abilities
  - Letting your mental illness define you

Add to the discussion by mentioning these changes, if they have not already been identified by group members.

Now that we have identified the ways in which our group members’ relationships with family and friends have been affected since being diagnosed with a mental illness, we can start to identify ways that we can make positive changes in these relationships.

At this point, it may be useful to divide the discussion into these two sections to make sure that all areas are covered (with every group member participating in both sections).
At this point, role play will be conducted between group members in order to practice the give-and-take relationship between family members and friends in order to eliminate stigma-inducing scenarios.

Stigma in medical settings is an issue in which many individuals with mental illnesses are bothered.

Open the floor for discussion by asking group members’ about their own personal experiences dealing with medical setting stigma.
Medical Stigma Coping Strategies

- Individuals should take a more active role in their own medical appointments
- Before an appointment, individuals should:
  - Create a list of goals of what they wish to accomplish during the appointment
  - Come up with a script to describe their current problems or worries
  - This will ensure that nothing is forgotten, and all important points are covered, leading to a smoother road to recovery

Discuss strategies for coping with medical setting stigma. Stress the importance of script-writing in order to prepare for appointments, and discuss possible templates for script-writing. Mention Pat Deegan’s web-based application “CommonGround”.

Home Practice

- Keep track of any stigmatizing experiences that have stemmed from interactions with family and friends. Use coping mechanisms that were discussed, and keep track of what was most helpful in dealing with the situation

OR

- Develop a script and list of goals you would like to use for your next appointment. Take note of how this script will be helpful in combating the medical stigma often experienced

Group members have two options for home practice this week, depending on which aspect of this session they are most personally affected. Be sure to mention that group members are more than welcome to complete both home practice tasks, if they feel inclined.