THE STIGMATIZATION OF MENTAL ILLNESS: A MIXED METHOD STUDY

by

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Abstract

Current research regarding the stigmatization of mental illnesses focuses mainly on quantitative data. There is insufficient data regarding the thoughts, feelings, and experiences of people with mood disorders. This thesis aims to understand the extent of stigmatization that people with mood disorders have experienced. A total of 212 participants with depression and bipolar disorder took part in this study. The Inventory of Stigmatizing Experiences (ISE), a 36-item questionnaire evaluated experiences with stigma. 16 open-ended questions emerged with responses suitable for coding. Responses were deconstructed sentence by sentence to identify themes. A total of 18 themes and 17 sub-themes emerged. When asked to elaborate on their experiences, responses rates were minimal, between 10-30%. Question 18 asked for an example of ‘stigma that had occurred in the past year’ and response rates averaged 40%, the most common theme was ‘stigmatizing experiences.’ This indicates that the stigma of mental illness is still prevalent. Question 27 asked ‘how do you cope with stigma,’ and response rates hovered around 55%. Coping techniques tended to be positive with themes such as ‘education,’ ‘humour,’ and ‘exercise.’ The data was re-arranged by gender, age, diagnosis, age of first symptoms and education to search for similarities and differences. When comparing genders, Question 18 resulted in women discussing the theme of positive experiences 19% compared to 31% of men. Non-parametric T-tests searched for statistically significant differences between groups. Significance was met in question 18, under the theme ‘positive experiences’ (p = .044) and ‘stigmatizing experiences’ (p = .001). In Question 22 when the data was rearranged by education, university learners reported the most stigmatization (51%), compared to college
(38%), and high school (45%). When asked in Question 35, ‘what causes stigma,’ response rates averaged 70%. The theme of ‘ignorance’ was most common.

This data could be useful to further anti-stigma campaigns by reminding people that mental illness affects diverse types of people. This study indicates that mental illness stigma is still a barrier that needs to be overcome. By lowering the stigma associated with mental illness, we could expect higher treatment adherence and remission rates.
Co-Authorship

I hereby declare that this thesis incorporates material that is result of joint research, as follows: Chapter 4 of this thesis was co-authored with L. Lazowski and M. Koller under the supervision of Dr. Stuart and Dr. Milev. In all cases, the key ideas, primary contributions, experimental designs, data analysis and interpretation, and writing were performed by the author, and the contribution of co-authors was primarily through the provision of the pilot study. L. Lazowski and M. Koller contributed to the creation of the ISE, recruitment of participants and preliminary data collection. I certify that, with the above qualification, this thesis, and the research to which it refers, is the product of my own work.
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List of Abbreviations

AIDS  Acquired Immune Deficiency Syndrome
ART  Antiretroviral Therapy
CBT  Cognitive Behavioural Therapy
CDS  Canadian Depression Study
DMDA  Depression and Manic Depression Association
GAD  Generalized Anxiety Disorder
HIV  Human Immunodeficiency Virus
ISE  Inventory of Stigmatizing Experiences
MAOI  Monoamine Oxidase Inhibitors
NLEP  National Leprosy Elimination Program
PTSD  Post-Traumatic Stress Disorder
SES  Stigma Experiences Scale
SIS  Stigma Impact Scale
SSDS  Self Stigma Depression Scale
SSRI  Selective Serotonin Reuptake Inhibitor
TCA  Tricyclic Antidepressant
WHO  World Health Organization
WPA  World Psychiatric Association
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Chapter 1

Introduction

1.1.1 Stigma in Mental Illness

Stigma, a set of negative beliefs, often unfair, that a group or society has about a particular issue (Goffman, 1963). There are many different types of stigma that have occurred throughout the years, including but not limited to, stigma against leprosy, HIV/AIDS and more recently, stigma in mental illness. One of the biggest issues with any kind of stigma is shame, which can result in low self-esteem, poor adherence to treatment and most frighteningly of all suicide (Cook & Wang, 2010). The majority of information being collected on the stigma of mental illness focuses on quantitative data, which often belies the actual experience. Quantitative data is vital to understanding the thoughts and feelings of those that have been victim of the stigma of mental illness. Understanding stigma and the underlying causes is vital if it is to be minimized and eventually eradicated.

1.1.2 Depression

Depression can be described as a mental state with feelings of sadness that can affect a person’s overall sense of wellbeing (American Psychiatric Association, 2000). Sadness, anxiety, hopelessness, guilt, irritability and restlessness are all common feelings (APA, 2000). Issues with concentration, losing interest in once pleasurable activities, changes in appetite, as well as more serious thoughts of suicide can also be present (APA, 2000). Symptoms of depression can also show up as somatic, including but not limited to headaches, back pain, muscle aches, exhaustion,

1.1.3 Bipolar Disorder

Bipolar disorder has many names including bipolar affective disorder, manic-depressive disorder and manic depression (APA, 2000). There are two types of bipolar disorders. Bipolar I is classified as one or more major depressive episodes, and one or more manic episodes (APA, 2000). A manic episode involves an abnormally and consistently elevated mood for over a week in time, with feelings of elation, impulsiveness, hyperactivity, grandiosity and distractibility (APA, 2000). Hospitalization sometimes occurs during a manic phase. Bipolar II disorder is similar; however, it does not lead to such severe manic episodes as bipolar I, and usually involves mild to moderate mood levels known as hypomania (APA, 2000). Common feelings include hopelessness, despair, guilt, anxiety, lethargy and suicidal ideation (APA, 2000). A mixed state is when a person experiences both mania and depression simultaneously or in rapid succession (APA, 2000).

1.1.4 Anxiety

Anxiety disorders are a type of mood disorder that can be characterized by feelings of anxiety, fear or worry (APA, 2000). Generalized anxiety disorder (GAD) is defined as six or more months of excessive worry and at least three or more symptoms such as lack of concentration, irritability, restlessness, fatigue, muscle tension and sleep disturbances (APA, 2000). Other common anxiety disorders include panic disorder, a specific phobia, social anxiety disorder and separation anxiety disorder (APA, 2000). Anxiety disorders are often comorbid with
other disorders including depression, bipolar, personality and eating disorders (Batterham, Griffiths, Barney & Parsons, 2012; Szkodny, Newman & Goldfried, 2013).

1.2 Stigma: History

Stigma is considered a discredited attribute that reduces a person’s status within society (Hong et al., 2008). Link et al. (2001) define stigma as five inter-related components; labeling, stereotyping, discrimination, status loss and separation. The loss of status implies a process of devaluation and discrimination against a specific individual or group (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001).

An important universal expression of stigma is fear, fear of the illness, fear of potential contagion, and fear of death all add to this emotion (Hong et al., 2008). Denial, prejudice and silence are also forms of stigma (Hong et al., 2008; Link et al., 2001). Stigma occurs not only in part to a specific illness or disease, but through association with particular groups that are marginalized by society (Hong et al., 2008).

1.2.1 Leprosy

Leprosy, also known as Hansen’s disease, is a contagious disease that affects the skin, mucous membranes and nerves (Nevon, 1998). It can cause lumps, disfigurement, discoloration of the skin, and deformities although only 30% of untreated cases suffer from these deformities (Nevon, 1998). Leprosy is believed to be spread through respiratory droplets such as a cough or fluid from the nose (Nevon, 1998). A cure for leprosy was discovered in the 1940’s (Nevon, 1998). Leprosy has been discussed in ancient texts from India as far back as 2000 BCE (Jacob & Franco-Paredes, 2008). Biblical teachings by missionaries perpetuated myths that leprosy was
associated with sin and uncleanness (Kazeem & Adegun, 2011). The laws in India punished those who married into families with leprosy and contact with people with leprosy was prohibited (Jacob & Franco-Paredes, 2008). Due to fear of contagion, it’s chronic and disfiguring nature, and ineffective therapies, those with leprosy were, and still are, ostracized and stigmatized (Kazeem & Adegun, 2011; Jacob & Franco-Paredes, 2008).

The Leprosy Act of 1898 made it legal to institutionalize people with leprosy, gender segregation was utilized to try and prevent those with leprosy from reproducing (Jacob & Franco-Paredes, 2008). In 1991, the British government created the Leprosy Commission and concluded that “the amount of contagion which exists is so small that it may be disregarded” (Jacob & Franco-Paredes, 2008). Nonetheless, cultural beliefs such as traditional medicines and stigma are still major factors that need to be addressed. Leprosy is still being stigmatized in part due to the now abolished, but deeply ingrained, caste system (Nevon, 1998; Jacob & Franco-Paredes, 2008). Lack of knowledge mainly through high illiteracy rates and misinformation about the disease are still prevalent (Kazeem & Adegun, 2011).

1.2.2 HIV/AIDS Stigmatization

Another highly stigmatized group of individuals are people living with, or associated with Human Immunodeficiency Virus (HIV)/ Acquired Immunodeficiency Syndrome (AIDS). HIV is a virus that attacks the immune system (Hong et al., 2008). AIDS is a condition that develops when HIV causes severe damage to the immune system (Hong et al., 2008). Symptoms of AIDS are related to infections developed as a result of a damaged immune system such as tuberculosis, types of cancer, pneumonia and other infections (Florom-Smith & De Santis, 2012). HIV is transmitted through exchanged bodily fluids, most commonly through unprotected sex,
contaminated needles, blood transfusions and from mother to child (Florom-Smith & De Santis, 2012). While there is no cure for HIV, advancements in modern medicines allow individuals affected with HIV to live many healthy years and may never actually develop AIDS (Hong et al., 2008).

People living with HIV/AIDS are often stigmatized, not only for having an infectious disease, but also due to it’s prevalence among high-risk groups such as drug users, sex workers, and homosexuals (Hong et al., 2008). Stigmatizing attitudes can delay treatment and partner notification (Adam et al., 2011; Hong et al., 2008). HIV-related stigma has been shown to negatively impact those affected through increased chances of depression and altered self-perception which can negatively impact employment, social interactions and access to health services (Palmer et al., 2011).

1.3 Mental Illness Stigma

Goffman described three general types of stigma: abominations of the body, such as deformities, tribal stigma, such as race and religion, and flaws in moral character, such as mental illness and drug addiction (Goffman, 1963). Studies have shown that people are just as concerned with distancing themselves from people with mental illness as much as those who have been incarcerated or addicted to drugs (Link & Phelan, 1998). The burden of stigmatization is an additional stressor to cope with in addition to symptoms and side effects of treatment (Ilic et al., 2012).
1.3.1 Self-Stigma

When negative public attitudes become internalized this can result in self-stigma. Self-stigma is “the stigmatizing beliefs and responses of the stigmatized individual themselves” (Barney et al., 2010). Self-stigma includes feelings of shame, social withdrawal and lowered self-esteem (Stuart et al., 2005). Concealment of the illness, non-acceptance, diminished quality of life and non-adherence to treatment are common issues for those affected by self-stigma (Stuart et al., 2005).

1.3.2 Family Stigma

Goffman (1963) described courtesy stigma, shared by people who are associated or connected to stigmatized individuals, through social structure associations and by choice. People stigmatized by association with another stigmatized group, in this case family members and spouses, is known as associative stigma (Phelan, Bromet, & Link, 1998). Feelings of rejection and concealment, are common among those living with someone affected by mental illness (Phelan, Bromet, & Link, 1998).

1.3.3 Stigma in the Workplace

People in the workforce face many types of discrimination, through gender, race, or age; however, stigma in the workplace is garnering more attention (Stromwall, Holley, & Bashor, 2011). Goffman (1963) describes this as being metaphorically “in the closet.” There is an additional stressor for those who do not to disclose their illness of being ‘found out’ and subsequently stigmatized (Joyce, McMillan, & Hazelton, 2009). Compared to the general labour
force, those with mental health disabilities face unemployment rates as high as 60% compared to only 20% in the general population (Stuart, 2006).

1.4 Inventory of Stigmatizing Experiences (ISE)

Measuring stigma has been met with a lack of psychometrically tested instruments to quantify the stigma that people living with mental illness experience (Stuart, Milev, & Koller, 2005). Current literature has two key short-comings, an overemphasis on psychological research methods that derive from individual attributes and a lack of research on the lived experiences of people that struggle with stigma daily (Jenkins & Carpenter-Song, 2009). These studies focus on measuring the expectation of stigma, describing past experiences and quantifying the extent to which people with mental illnesses apply stereotypes. Few if any have addressed the extent of stigmatizing experiences or psychosocial impact (Stuart et al., 2005).

The ISE was created to assess the stigmatizing experiences of those with mood disorders (Stuart et al., 2005). The ISE includes both a frequency and intensity scale to capture a full range of experiences (Stuart et al., 2005). The SES measures the prevalence and frequency of stigma experiences and the SIS assesses the intensity of the psychosocial impact of stigma such as quality of life, relationships with friends, family, society, and self-esteem (Stuart et al., 2005).

The goal of this thesis is to determine and characterize the extent of stigmatization on those with mood disorders using the ISE. By focusing on open ended questions and using a qualitative approach, the objective is to understand the impact of stigma by understanding the thoughts, feelings and experiences of those individuals with depression or bipolar disorder. This
data will provide helpful information to further future campaigns aimed at educating the public on mental illness and the associated stigma.

The following literature review presents an overview of mood disorder prevalence rates, significance and treatment, stigma prevalence and finally the usefulness of qualitative research methods and approaches.
Chapter 2

Literature Review

2.1.1 Depression

The World Health Organization (WHO) conducted a cross-national Global Burden of Disease study and concluded that depression is poised to be one of the major diseases in the twenty-first century and one of the most debilitating health problems (Han, Chen, Hwang & Wei, 2006). In 1990, it was estimated that major depression caused more disability than ischemic heart disease and cerebrovascular disease combined (Saver, Van-Nguyen, Keppel & Doescher, 2007). In 2002, the prevalence rate for major depression in Canada was 4.8% and 6.8% in the United States (Cook & Wang, 2010; Saver et al., 2007). It has been predicted that by 2020, depression could account for nearly 15% of the disease burden of non-communicable diseases (Han et al., 2006).

Those diagnosed with depression not only have to deal with the psychological implications of being diagnosed, but there is evidence that the diagnosis itself can also lead to feelings of shame, embarrassment and guilt (Barney, Griffiths, Christensen & Jorm, 2010). It has been estimated that nearly 50% of people with depression do not consult with doctors, psychologists or psychiatrists (Hogg, 2011; Saver et al., 2007). The inability to detect and recognize symptoms of depression is still problematic, this is particularly concerning given the high mortality rate, 15-20%, of those with untreated mood disorders (Lewis, 2000). The intervention of depression can be difficult due to their reluctance to seek professional help. Han
et al. (2006) noted that only 12% of depressed people sought help from psychologists and psychiatrists.

Common treatment options for depression are typically antidepressants, therapy, or a combination of both. Selective Serotonin Reuptake Inhibitors (SSRIs) are a class of drugs that are the most common type of antidepressant medication prescribed for depression (Myette, 2008). Other types of antidepressants include but are not limited to: Serotonin-norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MOAIs) (Myette, 2008). Common side effects of antidepressants include: nausea, weight gain, loss of sexual desire/dysfunction, fatigue, drowsiness, insomnia, dry mouth and dizziness (Kanter et al., 2008).

Antidepressants can be prescribed by a psychiatrist or a family doctor. Women have been found to seek advice from their primary care physician more often (Menke & Flynn, 2009). Prescriptions for antidepressants have tripled in the past decade (Blumner & Marcus, 2009). In 2007, antidepressants were the most common type of medication prescribed (Hogg, 2011). Saver et al. (2007) found that nearly 75% of depressed individuals sought help from a primary care physician. The majority though, felt that they did not receive enough information about depression and its treatment options (Saver et al., 2007). This could explain why medication adherence issues are common, with only 69% reportedly take their medication as instructed (Lewis, 2000).

One issue with taking antidepressants is the stigmatizing attitude that taking medication is palliative and that the person is unable to deal with ‘life’ or the root cause of ‘emotional distress’ (Hogg, 2011). In fact, one quarter of an Australian sample of 999 people felt that medication
could potentially be dangerous to someone depressed or suicidal (Hogg, 2011). A study by Kanter, Rüsch & Brondino (2008) noted that stigma was not related to therapy but was related to antidepressants. Those who had taken antidepressants reported higher levels of treatment stigma (Kanter et al., 2008).

Therapy is another common treatment option, which can take place with a psychologist, psychiatrist or in a group setting (Rüsch, Kanter, Angelone & Ridley, 2008; Lewis, 2000). A popular type of therapy is cognitive behaviour therapy (CBT), a therapeutic approach aimed at addressing dysfunctional emotions, maladaptive behaviours and cognitive processes (Bradford & Rickwood, 2012). The purpose is to challenge how an individual thinks and reacts while learning more adaptive coping skills (Bradford & Rickwood, 2012). Therapy sessions are more personal trusting environments, body language is readable and feedback is more customized. It provides positive human contact for those that lack interaction. (Bradford & Rickwood, 2012).

In the US, only 12% of depressed individuals sought help from a mental health professional (Han et al., 2006). Peer support groups are another positive option to help with mood disorder. Lewis (2000) found that in a study of nearly 5000 individuals, nearly 95% described their Depressive and Manic-Depressive Association (DMDA) group as ‘helping to some extent.’ Rüsch et al. (2008) noted that 44% of their participants would be embarrassed to see a psychiatrist and 38% embarrassed to see a psychologist. Stigmatized groups or those of low-status, who hold their group in a positive light are associated with better mental health (Illic et al., 2011). These groups can improve self-efficacy and are more cost effective compared to therapy (Morriss et al., 2011).
Psycho-education is another method used by therapists; however, not everyone who works with psycho-education is a trained therapist (Colom, 2011). The aim is to assist by promoting awareness, knowledge and tools on how to cope with their condition and symptoms (Colom, 2011). Psycho-education has shown to have positive efficacy and effectiveness in a variety of illnesses with varying degrees of severity (Colom, 2011).

Treatment efficacy, regardless of which type of treatment is chosen, is one of the key issues regarding the remission of mood disorder symptoms. Of those that sought treatment, delay of treatment and early withdrawal were common issues (Henshaw, 2014). The Canadian Depression Study (CDS) found that only one quarter of respondents found close to complete alleviation of depression (Myette, 2008). Reframing treatment as a source of prevention and relief can help change the perception of treatment (Henshaw, 2014).

2.1.2 Bipolar

Bipolar disorder affects approximately 0.3-1.5% of the population and the bipolar spectrum is prevalent in up to 8% of people (Sanchez-Moreno, 2008). According to WHO, bipolar disorder is the sixth leading cause of disability worldwide for those aged 15-44 years (Lewis, 2000; Michalak, Yatham, Maxwell, Hale & Lam, 2007). In the US, 45 billion dollars was spent on the direct and indirect costs related to bipolar disorder (Michalak et al., 2007).

The peak onset for bipolar disorder is between 15-19 years of age (Lish, Dime-Meenan, Whybrow, Price & Hirschfeld, 1994). Lish et al. (1994) reported that 59% of 500 respondents had their first symptoms during childhood or early adolescence. It has been estimated that from the onset of diagnosis, patients with bipolar disorder spend about 20% of their lifetime in
episodes, with some lasting anywhere from 2-7 months (Crowe et al., 2011). Recurrence rates for both mania and depression are high. In the first year, recurrence rates are over 50% and up to 70% within four years (Morriss et al., 2011). Females, early onset and those who had prominent mania before age 30, have all reported more frequent recurrence (Lish et al., 1994).

Treatment costs for bipolar disorder have been estimated at approximately 7 billion dollars (Michalak et al., 2007). Bipolar disorder can be costly to treat, nearly twice the cost of depression (Laxman, Lovibond & Hassan, 2008). Medication is generally the first treatment option. Medications can include mood stabilizers, antidepressants, anticonvulsants, antipsychotics and benzodiazepines though it’s usually a combination depending on symptoms. (Lish et al., 1994).

Lithium, a mood stabilizer, is a common first line of defense (Lish et al., 1994). Lithium side effects include, nausea, dizziness, diarrhea, fatigue, feeling dazed and tremors (Michalak et al., 2007). Unwanted side effects often improve with continued use. When a manic period precedes the onset of depression, this is a good indicator of lithium response, if however, a mixed state occurs, this can be an indicator of lithium resistance (Lish et al., 1994). Due to the severity of symptoms, one medication is not always effective enough. In a study of nearly 3000 African Americans and Caucasians, at least one third of participants were taking a minimum of three kinds of psychotropic medications (Kupfer et al., 2005). Kanter et al. (2008) noted that those who had taken medication reported higher levels of treatment stigma while there was no relation between psychotherapy and stigma. In ethnic minorities, taking medication can be stigmatized harshly. Latinos, in particular, interpreted medication use as a sign of being ‘crazy’ or ‘weak’ (Interian et al., 2010).
For bipolar disorder, CBT is considered to have good efficacy but less effectiveness (Colom, 2011). When Power et al. (1990) conducted their study, they found that a combination of diazepam and CBT was most effective. CBT with or without medication was the only treatment showing the least incidence of treatment six months later. One major issue is the lack of access to trained psychologists which can be especially limited for those with severe and persistent problems (Marsh & Johnson, 1997; Myette, 2008).

Group psychoeducation in addition to medication, has also been shown to be effective in treating bipolar disorder (Morriss et al., 2011). Another form of treatment is peer support groups which can help improve self-efficacy, medication adherence and cost effectiveness (Morriss et al., 2011). Over 45% of respondents felt that the group helped the most with taking their medication and coping with side effects (Lewis, 2000). Treatment for bipolar disorder can be slow and difficult. It has been estimated that less than 50% of individuals are being successfully treated for bipolar disorder (Lewis, 2000). Psychoeducation has increased functioning, time to relapse and reduced hospitalization (Morriss et al., 2011). Fragmented services and inadequate funding for community based programs are common issues (Marsh & Johnson, 1997).

One of the significant issues with bipolar disorder is receiving a diagnosis, with over one third of patients taking at least 10 years to receive a diagnosis (Mantere et al., 2004; Sanchez-Moreno et al., 2008). Misdiagnosis is also a common issue for those with bipolar disorder. Ethnic minorities are commonly misdiagnosed as schizophrenic (Kupfer, Frank, Grochocinski, Houck & Brown, 2005). African-Americans and Hispanic people have the highest risk of misdiagnosis (Kupfer et al., 2005). Recovery from bipolar usually occurs slowly. Approximately
40% of people can maintain a full functional recovery, 25-35% experience partial impairment and as many have 25-35% have severe deficits (Crowe et al., 2000).

The internet is a useful source for gaining knowledge with 4.5% of internet searches pertaining to health and medical information (Hansell et al., 2011). It can assist by verifying information, extend effectiveness of clinical suggestions and reduce stigma (Hansell et al., 2011). Furthermore, therapy can take place online, either privately or in online group discussions (Bradford & Rickwood, 2014). Online service provisions are expected to rise as young people prefer to access services thanks to the anonymity of the internet, the easily accessible information and the ability to engage with people who have been through similar situations (Bradford & Rickwood, 2014). In one study, as many as 68.5% of anxiety patients researched information online (Hansell et al., 2011). It is vital that leading mental health organizations ensure their websites are up to date as quality of information can vary.

2.1.3 Anxiety

Anxiety disorders are some of the most expensive to treat due to their early age of onset and chronic nature (Coles & Coleman, 2010). Onset can occur as early as 8 or 9 years of age (Masi et al., 2013). The US Department of Health noted that anxiety disorders represent the single largest mental health problem in the US, with over 18% of the adult population affected each year, and a prevalence rate of 28% during a person’s lifetime (Coles & Coleman, 2010). Prevalence rates for GAD are between 1.2-1.9% with a lifetime prevalence of 4.3-5.9% (Cuijpers et al., 2014). Due to the chronic nature of anxiety disorders, many patients are still affected 6 to 12 years later making it one of the most expensive disorders to treat resulting in over 31% of mental health care costs (Coles & Coleman, 2010; Cuijpers et al., 2014).
Masi et al. (2013) found that over 90% of their 388 patients had a co-morbid mental disorder with 48% co-morbid with depression. It is estimated that between 25-42.5% of individuals with anxiety issues seek professional treatment with a psychologist or doctor (Coles & Coleman, 2010; Griffiths, Batterham, Barney & Parsons, 2011). Only a small minority, approximately 2%, of those with anxiety disorders, are hospitalized (Griffiths et al., 2010). A major issue with anxiety disorders is the delay in treatment. In one study, 40% of people with mood disorders sought treatment within the first year of onset whereas anxiety disorders are associated with average delays exceeding 10 years (Coles & Coleman, 2010).

Effective treatments for anxiety disorders include CBT and medication (Keeton, Kolos & Walkup, 2009; Szkodny et al., 2013). SSRIs and SNRIs are generally the first line of medication treatment for anxiety disorders (Myette, 2008). Masi et al. (2013) note response rates to SSRIs as high as 60%. Benzodiazepines, a class of psychoactive drugs, used to be the first line of medication for anxiety disorders (Power et al., 1990). A major issue with benzodiazepines are diminished efficacy, dependency and withdrawal symptoms (Power et al., 1990). Side effects include drowsiness, dizziness, lack of coordination, decreased alertness and concentration (Power et al., 1990).

CBT has been widely studied in depression and anxiety disorders and it is highly regarded as effective (Szkodny et al., 2013). Specifically, CBT is effective as it is able to target the symptoms of anxiety. These include identifying triggers of early anxiety, challenging and disrupting the factors associated with worry, testing validity of erroneous beliefs, developing more adaptive ways of responding to worry and desensitization techniques (Szkodny et al., 2013).
Keeton et al. (2009) have noted that a combination of both therapies offered additional benefits when compared to each treatment separately. This data was supported by Power, Simpson, Swanson and Wallace (1990), who sampled 101 patients with GAD and found that a combination of CBT and SSRIs had the greatest improvement in severity of symptoms over a 10 week period. Other types of treatment can include applied relaxation, biofeedback (training patients to control physiological processes) and self-help interventions (Cuijpers et al., 2014; Matcham et al., 2014). These treatment options are less available and less widely studied.

GAD is still the least successfully treated anxiety disorder with only 50% no longer meeting clinical significance at 6 and 12 month follow-up (Szkodny et al., 2013). Moreover, metacognitive therapy is also commonly used to treat anxiety disorders and sometimes depression (Cuijpers et al., 2014; Szkodny et al., 2013). By understanding a patient’s beliefs about how their mind works and their thoughts, the purpose is to show how these beliefs lead to unhelpful reactions and responses that unintentionally prolong or worsen symptoms (Szkodny et al., 2013). Finding successful alternative coping mechanisms to respond to thoughts can alleviate or reduce symptoms.

Metacognition is an effective tool for anxiety disorders as it addresses both Type 1 and Type 2 worry (Szkodny et al., 2013). Type 1 worry relates to feared future events such as relationships, work and finances, these types of worry are common (Szkodny et al., 2013). Type 2 worry or meta-worry is “worry about worry” (Szkodny et al., 2013). Type 2 worry can be both positive and negative. Negative beliefs include worrying about uncontrollable factors such as plane crashes (Szkodny et al., 2013). Positive beliefs are imagined fears that do not occur and therefore cannot be realized as untrue such as ‘worrying keeps me safe and prepares me for worst
case scenarios,’ (Szkodny et al., 2013). Metacognitive therapy and acceptance-based behaviour therapy emphasize the function of worry as an avoidant strategy of internal experiences (Cuijpers et al., 2014).

Other psychotherapies and techniques that have had some success for patients with anxiety include: psychodynamic therapy, non-directive supportive therapy, spiritual therapy and self-management (Cuijpers et al., 2014; Myette, 2008). A self-management approach is sometimes utilized before seeking traditional care. The aims of self-management are activities that help create order, discipline and most importantly control (Crowe et al., 2011). The support of family and friends is often considered the first line of defence (Blumner & Marcus, 2009). Access to community resources, written or web-based, is also involved (Myette, 2008). Women are more likely to try lifestyle changes such as physical activity, diet and confiding in friends (Hogg, 2011). Men, on the other hand, tend to use less positive attempts at recovery including alcohol and sex (Hogg, 2011). Self-management can also include a combination of therapy, group psycho-education, family interventions and medication management (Crowe et al., 2012). Self-management is a positive treatment option as it can specifically address some of the potential discrimination and stigma (Myette, 2008).

In general, effective treatments are often impeded by a person’s own stigmatizing attitude that leads to reduced help-seeking behaviour and increased social distance (Cook et al., 2010). Lewis (2000) found that only one third of individuals were “very” or “somewhat” satisfied with the treatment of their mood disorder. Stigma has been identified as a primary cause for the under-diagnoses and under-treatment of mood disorders (Rüsch et al., 2008).
2.2.1 Stigma of Mental Illness:

There are numerous preconceived notions about the nature of mental illness. Media outlets can perpetuate stereotypes by focusing news coverage on negative situations (Corrigan, Markowitz, & Watson, 2004). In the 90’s, up to 86% of news coverage regarding mental ill people focused on violence. This has decreased by one third, but there is still a focus on negative attributes such as unpredictability or medical treatments (Corrigan et al., 2004). Notably absent are stories highlighting positive experiences such as overcoming a mental illness (Corrigan et al., 2004). One plausible reason is that people with mental illnesses could be viewed as responsible for causing their illness (Rüsch et al., 2005).

Stereotypes and stigmatization are learned in diverse ways. Cognitively constructed stereotypes which are learned through interaction on a regular basis with people belonging to a specific group (Corrigan, 1998). The second way, is through socially given stereotypes, these usually represent cultural lore and are handed down by older members of society (Corrigan, 1998). Stigma can be perceived as a form of deviance that deems an individual illegitimate for societal participation (Brohan, Slade, Clement & Thornicroft, 2010). This could be due to the perception that they lack skills and ability, or they are dangerous and unpredictable (Brohan, et al., 2010). As many as 35% of people would not rent a room to someone with depression (Angermeyer & Matschinger, 2004).

A study by Wang and Lai (2008) reported that 45% of participants felt that those with depression were unpredictable and that 20% felt they were dangerous. Once someone is no longer seen as capable of engaging in normal social behaviour, they become ignored or excluded by a group or society (Brohan, et al., 2010). The major issue with this learned stigmatization is
that it is often very difficult to change. It is not based on previous experiences so it is much more difficult to affect even with contradictory evidence (Corrigan, 1998). The closure and deinstitutionalization of many mental health care facilities could also be increasing certain stereotypes (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999). Backlash from communities in response to attempted residences for people with mental illnesses can increase stigma and negativity (Link et al., 1999).

Corrigan, Edwards, Green, Diwan and Penn (2001) studied the paths between prejudicial attitudes and behavioural discrimination, namely social distance. Their findings suggest that social distance is influenced by a belief that those with mental illnesses need to be cared for by a paternalistic health care system or that people with mental illnesses are innocent and childlike (Corrigan et al., 2001). Ethnicity and familiarity with people who had mental illnesses further influenced prejudices (Corrigan et al., 2001). The results by Norman, Sorrentino, Windell and Manchanda (2008) provide confounding evidence that personal beliefs and attitudes about stigmatized groups do not relate strongly to behavioural discrimination.

2.2.2 Leprosy

Mental illness is not the only aspect of society that is affected by stigma. Other areas include people associated with HIV/AIDS and leprosy. An issue that affects the stigma of leprosy is the medical system in India. There are three major systems of medicine in India: Ayurveda, Siddha, and Unani. These types of medicines are homeopathic and use botanicals as the primary form of therapy. The preference of this traditional type of medicine as well as the stigma of using government-run clinics, does not necessarily translate into increased utilization
(Jacob & Franco-Paredes, 2008). In one community, only 30% of individuals claimed to have a strong and positive knowledge of leprosy (Jacob & Franco-Paredes, 2008).

Since 1997, the National Leprosy Elimination Program (NLEP) has made modifications to their leprosy elimination campaigns by using statewide case detections, house searches in specific areas and strong awareness programs through mass media, school education, and community outreach to inform the public (Jacob & Franco-Paredes, 2008). By 2005, the nation’s prevalence was less than one case per 10,000, compared to 1981, two years before the NLEP campaign began, the prevalence was over 50 cases per 10,000 (Jacob & Franco-Paredes, 2008).

One major issue preventing the dissemination of stigma around leprosy is the current cultural belief system in many third world countries. In Nepal for example, those with leprosy are called “khori” which loosely translates to “curse,” (Cross, 2006). The inference here being that the person is a curse, they have been singled out by supernatural forces and therefore the stigma is justified (Cross, 2006). Religious dogma held fast to the belief that acquiring the disease was a punishment for sins (Nevon, 1998).

In Thailand, some researchers note that leprosy sufferers throughout the years have not been secluded and that the majority did not face any social issues (Nevon, 1998). Others note that there was still a reluctance to marry or employ those with leprosy and banishment and stoning were common (Nevon, 1998). Further exploration finds that beggars with leprosy led to many negative misconceptions about the disease (Nevon, 1998).
2.2.3 HIV/AIDS

There are over one million people in the US infected with HIV (Florom-Smith & De Santis, 2012). Of that, nearly 50% are gay men (Florom-Smith & De Santis, 2012). While African Americans make up about 12% of the population, they almost half (46%) of the population living with HIV (Florom-Smith & De Santis, 2012). One potential reason is that in Black and Hispanic culture, gay men are highly stigmatized and consequently may not seek help or participate in interventions within the gay community (Florom-Smith & De Santis, 2012).

Women also experience a high degree of stigma when it comes to HIV. Due to social and gender disparities, women may not feel comfortable asking their partner to use a condom or enquire about their partner’s sexual past. It’s easy to see that both genders are highly stigmatized when it comes to HIV infection.

In the US, rates of depression among those living with HIV/AIDS are nearly twice as high compared to the general population (Li, Lee, Thammawijaya, Jiraphongsa & Rotheram-Borus, 2009). Negative health effects have been linked to lower quality of life, poorer clinical outcomes and most disturbingly, faster disease progression (Palmer et al., 2011). People living with HIV/AIDS report feelings of loneliness, stress, devaluation and perceived social inequality (Li et al., 2009). Antiretroviral therapy (ART) is a constant reminder of the virus and people have reported feelings of contamination and being unclean (Palmer et al., 2011).

An attempt to address stigma toward HIV positive gay and bisexual men produced a significant shift in reduced stigma related behaviours and attitudes (Adam et al., 2011). A website called hivstigma.com was created where bloggers moderated discussions to stimulate community building in local communities of gay and bisexual men (Adam et al., 2011). The
program showed that those that visited the site were significantly more aware of stigma and its relation to HIV transmission (Adam et al., 2011). In a study in Thailand, it was noted that emotional social support was a protective factor against HIV/AIDS related stigma (Li et al., 2009).

2.3.1 Self-Stigma

While society and the negative viewpoint it can have may be affecting, a greater issue is self-stigma. By viewing the concerns of society as legitimate, people are more likely to internalize these feelings and less likely to fight this type of stigma (Rüsch, Todd, Bodenhausen, Olschewski, & Corrigan, 2010). This can lead to shame, lowered self-esteem, empowerment and self-efficacy (Rüsch et al., 2010). It can also prevent treatment seeking and result in avoidant coping (Kanter et al., 2008). Self-stigma and depression work in a vicious cycle wherein a person becomes depressed, experiences stigma, internalizes negative attitudes, and becomes further depressed (Kanter et al., 2008).

Rüsch et al. (2010) set out to study shame-related reactions as a predictor to perceived legitimacy of discrimination. Those that have shame related association to mental illness have a higher vulnerability to accepting stigma as fair; therefore, decreasing their chances of resisting or fighting stigma (Rüsch et al., 2010). This is supported by Quinn and Chaudoir (2009) who examined the anticipated stigma of people with concealable identities. Even if their illness was concealed, concerns about not knowing what would happen if they revealed their identity negatively affected behaviour (Quinn and Chaudoir, 2009). Even if they did not have any direct experience with stigma, knowing their identity could be exposed and was devalued reveals the insidious and undermining effects of stigma.
If people avoid talking to others about their depression social isolation can increase (Kanter et al., 2008). Another concern is going off medication without a doctor’s approval, the very thing that could be most effective in alleviating the condition (Kanter et al., 2008). Kanter et al. (2008) found that those who had psychotherapy had less of an association with stigmatization; however, this was not the case with people taking anti-depressant medication (Kanter et al., 2008). Another possible issue with medication adherence is psychomotor activation/retardation, a potentially noticeable trait, thus making people more self-conscious and less likely to stay on medication (Pyne et al., 2004).

Barney et al. (2010) set out to develop and validate a self-stigma measurement for depressed individuals (Barney et al., 2010). The Self Stigma of Depression Scale (SSDS) used subscales focusing on shame, self-blame, social inadequacy and help-seeking inhibition (Barney et al., 2010). Their findings suggest that the degree that a person believes their condition is controllable greatly influences their response to stigma (Barney et al., 2010). People who had more depressive symptoms or lower self-esteem reported more self-stigma (Barney et al., 2010).

Pyne et al. (2004) support these results with their finding that the only significant predictor of perceived stigma was based on how severe their current depression was. The more severe the depression, the more likely cognitive distortions accentuated all-or-nothing thinking leading to more perceived stigma (Pyne et al., 2004). This is further supported by Rüsch et al. (2006) that depression and perceived discrimination greatly affected a person’s vulnerability toward lower self-esteem (Rüsch et al., 2006). Their results suggest that low perceived legitimacy of discrimination could help protect a person’s self-esteem.
Furthermore, by analyzing how both the general population, and psychiatric inpatients, perceive stigma Graf et al. (2004) examined the consequences of those beliefs on the quality of life of those affected. 1737 people from the general population, and 280 psychiatric inpatients were interviewed (Graf et al., 2004). There was significantly less education and less partnerships for patients (Graf et al., 2004). Both groups believed that former inpatients were exposed to discrimination and devaluation and that most people are rejecting to those who are/were formerly hospitalized with a mental illness (Graf et al., 2004). The fear of being labelled mentally ill, and its consequences, may hamper individuals from seeking support for their issues (Graf et al., 2004). Surprisingly, people with affective disorders; in particular depression, estimated their quality of life as significantly lower than people diagnosed with schizophrenia (Graf et al., 2004).

Moreover, studies have shown that racial minorities are less likely to seek out mental health specialists (Menke & Flynn, 2009). Menke and Flynn (2009) reported that African Americans had more depressive symptoms overall, when compared with Caucasians. Griffiths et al. (2006) studied Japanese and Australian sample populations, Japanese people were more likely to believe people with mental illness could ‘snap out of it,’ were weak or didn’t actually suffer from an illness. The work completed by Hsu et al. (2008), further support this data by noting that mental symptoms, in particular psychotic symptoms, were more stigmatized by Chinese Americans. African Americans felt more shame and were less likely to follow through with mental health visits when compared to Caucasians (Menke & Flynn, 2009). One possible explanation is that seeking treatment for mental illnesses may be considered a sign of weakness in certain ethnic communities.
The paradox of self-stigma and mental illness is characterized by some people developing low self-esteem while others react with empowerment and anger (Rüsch, Lieb, Bohus, & Corrigan, 2006). It has been hypothesized that two variables influence a personal response to public stigma: group identification and perceived legitimacy of the discrimination. In group identification, a person believes that the concerns of the public are legitimate and the result is lower self-esteem (Rüsch et al., 2006). If alternatively, they regard this discrimination as unfair and have a strong sense of group identification than the likely outcome is empowerment and anger (Rüsch et al., 2006).

Studies have shown that the three most typical coping strategies among people with mental illness are secrecy, education, and avoidance/withdrawal; these have been shown to be ineffective for the long-term wellbeing (Verhaeghe, Bracke, & Bruynooghe, 2008). Social withdrawal and perception of devaluation/discrimination have been shown to be strongly predicted with negative self-esteem by Link, Struening, Neese-Todd, Asmussen & Phelan (2001). A study by Verhaeghe et al. (2008) found that stigmatization is negatively associated with self-esteem where as a peer support system was positively linked (Verhaeghe et al., 2008). Peer groups help to gain insight, support and problem solve more effective ways of confronting stigma (Verhaeghe et al., 2008).

2.3.2 Family Stigma

Courtesy or associative stigma is experienced by family members through the association with a stigmatized individual (Wong et al., 2009). As many as 70% of caregivers believe that the devaluation of patients also extends to their families (Wong et al., 2009). It is further supported by the work of Perlick et al. (2007) that up to 40% of caregivers of people with mental illnesses
also report feelings of depression. There is also increasing evidence that those with daily contact with a sibling, spouse or family member with mental illness experience more shame and are somehow more responsible (Corrigan, Watson & Miller, 2006). Only 20% would discuss a close relative’s depression with colleagues, neighbors or acquaintances (Angermeyer & Matschinger, 2004).

It is important that family members seek help and support regarding stigma, especially if caring for young people. Mental health disorders accounted for 45% of total morbidity for young people and were the most prevalent disability (Dalky, 2012). For those that avoid seeking help, this can cause maladaptive coping and longer treatment initiation (Wong et al., 2009). Those who blame their relatives for the onset of their illness are more likely to react angrily and become more socially avoidant (Corrigan et al., 2006). Furthermore, blame and stigma can also develop for caring and housing potentially dangerous or violent relatives (Dalky, 2012).

In a sample of 156 parents, and spouses, at least half reported some degree of concealment regarding their family member’s hospitalization (Phelan, Bromet, & Link, 1998). What was surprising was the expectation that social avoidance of others was minimal (Phelan, Bromet, & Link, 1998). This is especially true for woman in Arab cultures where families worry that mentally ill daughters, wives and sisters could disgrace the family name (Dalky, 2012). Perlick et al. (2009) reported that the stigma faced by caregivers negatively affected their own mental health and therefore effective coping techniques. Blame can also be attributed to parents through parental incompetence or the inability for parents to teach proper developmental skills (Corrigan et al., 2006).
What does affect family stigma is the degree of the illness’s characteristics as well as the social characteristics of the family (Phelan, Bromet, & Link, 1998). This data is supported by Corrigan et al. (2006) who stated that their sample produced stigma scores that were higher for those with family members with schizophrenia than depression. Pryor, Reeder and Monroe (2012) studied courtesy stigma of those with abominations of the body and tribal stigma. They found that when the relationship between the stigmatized person and the companion was considered meaningful was stigma related attitudes devalued (Pryor et al., 2012).

While caring for someone with a mental illness can cause much stress, there are also positive aspects. Learned life lessons and love were considered positive aspects of caring for relatives (Dalky, 2012). Positive coping skills were also seen as more effective. Acceptance, meditation, spiritual guidance and most importantly emotional and social support were the most effective coping mechanisms (Dalky, 2012). Concealment and remaining silent were also coping mechanisms utilized though less efficiently (Dalky, 2012).

2.3.3 Workplace Stigma

Currently, very few studies focus on mental illness related workplace discrimination. Employment can be a positive step towards recovery, it provides daily routine, financial security, improves social skills, broadens social supports, enriches quality of life and most importantly improves self-esteem and self-image (Batastini, Bolanos & Morgan, 2014; Stuart, 2006). For those with mental illness, securing employment and maintaining employment are not always easy. Workplace stigma is still far too commonplace. There are factors beyond stigma that can also contribute to difficulty securing employment, such as underdeveloped social skills,
impairment related to symptomology, lower education and diminished cognitive capacity (Batastini et al., 2014).

For those attempting to gain employment, issues such as unfavourable labor market dynamics, low productivity, lack of appropriate vocation, failure of protective legislation and ineffective work incentive programs are current barriers towards obtaining employment (Tsang et al., 2007). These issues are on top of the stigma due to a lack of employment and the stigma of their mental illness (Stuart, 2006).

Employers may be wary of hiring those with mental illnesses as due to excessive absenteeism or cognitive disturbances that impede work performance (Tsang et al., 2007). Concerns regarding hiring those with mental illnesses include dangerousness, reduced productivity, risk of relapse, presence of strange behaviours and disorganized thought which could interfere with ability to follow instructions and complete tasks (Tsang et al., 2007). Glozier (1998) found that when comparing current employment, number of jobs, hours worked and employment rates, those with diabetes were comparable to those with depression. This did not deter personnel officers from believing that someone with diabetes would perform just as well as someone without diabetes 97.5% of the time compared to those with depression expecting to perform worse or much worse by 66% (Glozier, 1998).

A study by Tsang et al. (2007) noted that helping individuals with mental illness present themselves as skilled, motivated and qualified was a positive first step. Furthermore, educating employers, namely addressing worries regarding job performance and incorporating a strategic disclosure technique could be beneficial avenues to addressing employment discrimination (Tsang et al., 2007).
Negative effects of workplace discrimination are critical to examine as they can lead to lower job satisfaction, increased feelings of tension/stress and lower levels of job commitment (Stromwall et al., 2011). Up to 36% of individuals with psychiatric illness reported some type of discrimination within the last five years (Batistini et al., 2014). As many as 42% of people would refuse to recommend someone from a job if they suffered from depression (Angermeyer & Matschinger, 2004). Employment rates also vary wildly depending on the diagnostic group, for major depression the range is between 40-60%, anxiety disorders are 20-35% and lastly for the most severe and persistent psychiatric disabilities such as schizophrenia the rates can be as low as 10-20% (Stuart, 2006).

Corrigan and Rüsch (2012) studied how stigma influenced employment past and present for those with mental illness. Their results suggest that those that have been employed, combined with the stereotype that those with mental illnesses are dangerous, lead to greater social avoidance (Corrigan & Rüsch, 2012). Those that had worked recently had stronger correlations with self-esteem and self-degradation, which results in the “why try” effect (Corrigan & Rüsch, 2012). Those that internalized stigma believed they were not worthy or capable of working, which prevented them from trying to pursue meaningful employment (Corrigan & Rüsch, 2012). This is supported by Glozier (1998) who noted that subjects with depressive symptoms rated themselves as worse on a self-role functioning assessment than did patients with a history of diabetes.

Even those in the mental health profession, despite their involvement with anti-stigma campaigns, still hold stigmatizing attitudes (Stromwall et al., 2011). The World Psychiatric Association (WPA) and WHO, declared stigma related to mental illness to be the most
significant challenge facing the field of mental health (Stuart, 2006). Joyce, McMillan and Hazelton (2009) interviewed nurses with a psychiatric diagnosis and identified four subthemes regarding stigma in the workplace: declaring mental illness, collegial support, managerial support, and enhancing support.

Employees with mental health issues fear stigma and discrimination by coworkers if their illness becomes known (Stuart, 2006). Concerns for nurses were the implication that they would make unsound decisions, could not be depended upon and be discredited (Joyce et al., 2009). This is backed up by Stromwall et al. (2011) and their study regarding mental health employee’s perceptions, employees perceived significantly more discrimination than clinicians. This was especially high in female, or Caucasian employees, however male clinicians felt more stigmatization compared to employees without a similar job title (Stromwall et al., 2011).

Length of time working with colleagues and knowing colleagues could be trusted to be supportive, made disclosure more likely; but many still withheld their illness to represent themselves as ‘normal’ (Joyce et al., 2009). It seems that disclosure can become an issue if those in the mental health field fear the transition to patient. This in turn could affect the employee’s ability to provide safe and competent practices.

2.4 Coping with Stigma

Coping with stigma can be a complicated and tricky process. Alonso et al. (2009) noted that decreased quality of life, work/role limitation and more social limitation was associated with perceived stigma. The perceived opinions of society constitute an additional burden for recovery
Finding positive adaptive strategies is paramount to successfully respond to stressful and stigmatizing situations.

Many suggestions have been made towards coping with stigma. The main components typically involve a combination of empowerment, life satisfaction, re-establishment of identity, tenacity and hope (Tsang et al., 2007). Ilic et al. (2012) noted that strategies such as humour, positive in-group stereotyping and community involvement were associated with higher self-esteem. People that view themselves and their group in a positive regard experience improved mental health (Ilic et al., 2012). The same is true for those that attribute positive characteristics to group members. This is supported by Rüscher et al. (2009) that those that view their group in high regard may be more resilient to stigma.

Coping techniques that were less affective were attempts to over-compensate, disprove stereotypes, selective disclosure and secrecy (Ilic et al., 2012). Rüscher et al. (2012) also confirmed these findings noting that secrecy and hopelessness were strongly associated with low group value, leading to lower self-esteem. It’s understandable that those that hold their group in low value would have little desire to be associated with that group. Information seeking, selective withdrawal, comparisons of past and present social positions and normalization of illness through a medical framework were unrelated to self-esteem either positive or negatively (Ilic et al., 2012).

Strategies within society have also been used to fight stigma, namely, protesting, education and contact (Rüscher, Angermeyer & Corrigan, 2005). Protest interventions have had some success with changed public statements (Rüscher et al., 2005). Quinn et al (2013) provide
contradictory evidence that the effectiveness of protesting can lead to negative reactions and have little effect on the public’s attitudes.

Education through books videos and programmes have been used to diminish stigma, but consistently provide contradictory evidence (Rüscher et al., 2005). Large scale anti-stigma campaigns may not be effective enough as subpopulations hold a variety of different stigmatizing attitudes (Want & Lai, 2008). Programs that carefully target key groups and use social models of mental health have been effective (Quinn et al., 2013).

Members of a majority group that have encountered those with a mental illness are less likely to have stigmatizing attitudes, possibly diminishing the perception of “otherness” (Corrigan & Watson, 2012; Rüscher et al., 2005). However, Wang and Lai (2008) reported that attitudes towards depression in regards to unpredictability and danger were not affected by depression literacy and personal contact. Corrigan et al (2005) noted adolescents had the opposite effect, they were more discriminating and stigmatizing towards those with mental illnesses if they had direct contact. Perry, Pescosolido, Martín, McLeod and Jensen (2007) reported that people viewed children and adolescents with depression as more dangerous compared to adults, but were also paradoxically more concerned for their well-being.

Equating mental illness as a medical or brain disorder has some supporting evidence, namely that people are less likely to endorse avoidance and blame (Corrigan & Watson, 2012). Policy makers, clinicians and advocates have also utilized this approach in an attempt to increase low service use, adherence rates and stigma (Pescosolido et al., 2010). One issue with this approach is that it can also exacerbate viewing mental illness as a disorder that one cannot recover from (Corrigan & Watson, 2012).
It can also increase benevolence stigma, namely the belief that they are childlike, require a parental figure, have no control over their behaviours and are therefore unpredictable/violent (Corrigan & Watson, 2012). The work by Yap, MacKinnon, Reavley and Jorm (2014) supports the theory that those with depression and schizophrenia are considered more dangerous and unpredictable compared to anxiety disorders and Post Traumatic Stress Disorder (PTSD). One explanation is that anxiety disorders are characterized with behavioural withdrawal and therefore associated with less harm to others. Hsu et al. (2008) also back up the belief that considering depression a ‘physical illness’ did not diminish stigma. Pescosolido et al. (2010) note that while endorsement of treatment of doctors and psychiatrists increased 10% between 1996 and 2006, social distance and perceived danger did not decrease significantly. Moreover, in Germany between 1990 and 2001, there was a slight increase in pity and aggression; however, fear remain unchanged (Angermeyer & Matschinger, 2004).

Psychosocial explanations focus on trauma and environmental stressors as causal factors such as poverty, childhood abuse and stress (Corrigan & Watson, 2012). This reframes mental illness as an understandable and relatable reaction to life events (Corrigan & Watson, 2012). Angermeyer and Matschinger (2003) conducted a study in Germany, they reported that two thirds of those surveyed endorsed life events as the cause of depression. This also strengthens the argument that those with mental illnesses can recover and in doing so, reduce blame reactions from the public (Corrigan & Watson, 2012). Angermeyer and Matschinger (2003) mentioned that while the natural course of mental illness was viewed pessimistically, prognosis and treatment was met with optimism. Focusing on abilities, competencies and community integration would further reduce stigma (Pescosolido et al., 2010).
A multidimensional approach to anti-stigma campaigns will likely be most effective. Campaigns should address biological and psychosocial factors, effectiveness of treatments and the ability to overcome mental illness. Providing accurate information about the low incidence of violence is also an effective approach to stigma reduction (Corrigan & Watson, 2012).

2.5 Qualitative Method

Scientific research relies on two important principles: qualitative and quantitative methodology (Stake, 2010). Quantitative methods rely heavily on measurements, linear attributes and statistical analysis (Stake, 2010). Qualitative methods rely on human perception and understanding such as personal experience (Stake, 2010). It is a method of analysis used for written, verbal and visual content (Elo & Kyngäs, 2007). The most important distinction between qualitative and quantitative methods is the difference between aiming for an explanation versus understanding (Elo & Kyngäs, 2007; Stake, 2010). For the researcher, the difference is a personal versus an impersonal role (Stake, 2010). Qualitative method focuses strongly on the ‘why’ and ‘how’ of decision making (Elo & Kyngäs, 2007; Stake, 2010).

The researcher is considered an instrument, often intentionally playing a subjective role, using his or her firsthand experiences to make interpretations (Stake, 2010). The researcher can make methodological choices based on personal preferences; however, data collection is gathered objectively (Stake, 2010). The approach to all qualitative data requires the researcher to go through seven steps: formulating a research question to be answered, selecting a sample to be analyzed, applying categories to define the data, outlining the coding process, implementing the coding process, determining trustworthiness and analysis of the results of the coding process (Hsieh & Shannon, 2005).
Observation, interviewing, and examination of artifacts, are the most common methods used in qualitative research (Stake, 2010). Content analysis is a useful research method used in journalism, sociology, psychology, even business and communications (Elo & Kyngäs, 2007). It is a systematic and objective method to describe and quantify data, taking broad descriptions and classifying the data into content related categories (Elo & Kyngäs, 2007). Several types of qualitative analysis include grounded theory, phenomenology, ethnography and historical research (Hsieh & Shannon, 2005). The main uses interviews, focus groups and observations (Hsieh & Shannon, 2005).

Content analysis can be described as a subjective interpretation regarding the content of data, namely text, through systematic classification of identifying themes through coding (Hsieh & Shannon, 2005). This type of analytic approach can range from intuitive, interpretive analyses to a strict systematic textual analysis (Hsieh & Shannon, 2005). In the case of inductive content analysis, written material is read through and headings are written down that describe all aspects of the content (Elo & Kyngäs, 2007). Categories are freely generated at this stage. By avoiding preconceived categories this helps to avoid preconceived notions and allows the categories to flow from the data (Hsieh & Shannon, 2005). Grouping reduces the number of categories and begins to describe the data, increasing understanding and generating knowledge (Elo & Kyngäs, 2007; Stake, 2010). Subcategories with similar events are grouped together.

One of the aims of qualitative research is to understand one thing well (Stake, 2010). Credibility through peer debriefing, persistent observation, triangulation and member checks is important to establish (Hsieh & Shannon, 2005). Qualitative data is less linear than quantitative data. Qualitative data is less formulaic and standardized, it is much more flexible, there is not
one right way (Elo & Kyngäs, 2007). This can be considered one of the challenges to qualitative analysis.

Qualitative analysis has a broader, less rigid methodology. The understanding developed from this method, while different from quantitative, is just as important. Qualitative method’s biggest strength is giving researcher’s insight into understanding human behaviour and the reasons that regulate that behaviour.
Chapter 3
Research Question

3.1 Hypothesis

In this thesis, the thoughts, feelings, opinions, and experiences of people that were diagnosed with either depression or bipolar disorder were analysed. The purpose was to characterize the extent of stigmatization that they have experienced, in their personal lives, as well as experiences with their families, friends and coworkers and the ways in which they cope. Determining factors that were related to the stigma of mental illness was a secondary objective.

The Inventory of Stigmatizing Experiences (ISE) Questionnaire, a 36 item questionnaire, which has already been quantified and published, was utilized. The inventory was composed of two scales, one measuring stigma in life domains and the other assessing psychosocial impact. This left 18 open ended questions to be analyzed using a qualitative approach. A research question was generated by looking for trends and creating themes with the data. We hypothesize that people with mental illnesses, who have experienced stigma, will develop a variety of different coping mechanisms.

By focusing on a qualitative approach, the objective is to generate data regarding how the stigma of mental illness affects individuals with bipolar disorder and depression. This data will be utilized to understand stigma from a patient perspective. Implications for these results include but are not limited to, furthering stigma campaigns, psychoeducation and designing programs aimed at empowering those with mental illness by illustrating that the stigma of mental illness, while a barrier, can be overcome.
Chapter 4

Methods

4.1 Pilot Study

In the pilot study, which represents the first stage, relevant concepts and paradigms were pulled from theoretical, empirical, and qualitative literature. Viewing material that gave first-hand accounts of the experience of living with a mental illness was of utmost importance. These sources of data were invaluable in creating the ISE.

Mental health experts from Kingston, Ontario, Canada, reviewed the preliminary content of the instrument, as well its format and flow (Stewart, Milev & Koller, 2005). Pre-testing was conducted using a small number of eligible respondents. After each phase, items were refined and further re-tested (Stewart, Milev & Koller, 2005).

People with schizophrenia, as well as their family members, were used to evaluate face and content validity. They completed the study questionnaire and then provided feedback and comments regarding reliability, clarity, ease of use and comprehensiveness.

Participants were recruited from the community through hospital-based outpatient programs, community clinics and mental health advocacy groups (Stewart, Milev & Koller, 2005). Long-stay patients were not recruited as the 13 that were interviewed were unable to provide consent or were deemed too disabled to participate (Stewart, Milev & Koller, 2005). Of those interviewed, many were unable to provide examples of stigma and further recruitment was restricted to those that were using outpatient care within the community.
In the first field test, 30 surveys were completed. Upon reviewing the open-ended comments from the surveys, it became evident that an impact scale was required. Once the inventory was revised, an additional 58 surveys were completed (Stewart, Milev & Koller, 2005).

4.2 Questionnaire

First the ISE was created and refined. Afterward, the scales were used to start characterizing the extent of stigmatizing experiences that people with depression and bipolar disorder encountered. The study was approved by the Queen’s University Health Sciences and Affiliated Teaching Hospital Research and Ethics Board (Lazowski, Koller, Stuart & Milev, 2011).

Recruitment came from patients attending the Mood Disorders Research and Treatment Service in Kingston, Ontario, Canada, either through intake services or inpatient and outpatient mood disorders units (Lazowski, Koller, Stuart & Milev, 2011). Patients were recruited between August 2003 and September 2007 in three separate study waves depending on availability of research funding and support (Lazowski, Koller, Stuart & Milev, 2011).

All participants were registered patients and had received a clinical diagnosis of a mood disorder, either depression or bipolar disorder (Lazowski, Koller, Stuart & Milev, 2011). All individuals gave written informed consent; however, all questionnaires were kept anonymous. No restrictions were placed on age, gender, or ethnicity.

During data collection periods, all individuals attending the clinic were invited to participate. Staff did not formally keep track of participation; however, they reported that
virtually everyone who was asked did agree to participate (Lazowski, Koller, Stuart & Milev, 2011). Therefore, response rates are estimated at 80%, but are likely closer to 90%.

A total of 214 out of 450 participants were recruited (Lazowski, Koller, Stuart & Milev, 2011). While 58 participants had originally completed the pilot study, only 48 participants were used, as participants with missing data were omitted; 166 patients were recruited in the second and third waves (Lazowski, Koller, Stuart & Milev, 2011). As the study focused on depression and bipolar disorder, two participants were left out from the data as they indicated that they had been diagnosed with schizophrenia; therefore, a total of 212 participants were used in this study.

The ISE questionnaire, which was created in the pilot study above, was used to evaluate a patient’s experiences with stigma. Stigma was defined as “negative feelings people have towards people with a mental illness,” (Lazowski, Koller, Stuart & Milev, 2011). The questionnaire consisted of two different types of scales, the SES which measured frequency and prevalence and the SIS which measured the intensity of psychosocial impact (Lazowski, Koller, Stuart & Milev, 2011).

Reliability was previously tested in a heterogeneous sample of psychiatric outpatients. Reliability coefficients were high for both the SES 0.91, and for the SIS 0.83 (Lazowski, Koller, Stuart & Milev, 2011). Of the fifteen questions in the SES, thirteen were answered “yes,” “unsure,” or “no.” The two remaining questions used a Likert Scale consisting of “never,” “rarely,” “sometimes,” “often,” and “always.” The SIS consisted of seven questions (Lazowski, Koller, Stuart & Milev, 2011). Four questions rate the degree to which stigma had negatively affected an individual’s self-esteem, quality of life, social contact and family relationships. The three remaining questions focused on the family of the participant’s and their quality of life,
social contact, and other family relationships. All questions used a scale with 0 being the lowest score and 10 being the highest score (Lazowski, Koller, Stuart & Milev, 2011).

The questionnaire was originally a self-administered survey that people could take home and fill out in the privacy of their own homes in a comfortable setting; however, most questionnaires were administered over the phone or at the clinic in a semi-structured interview with a trained member of the research team (Lazowski, Koller, Stuart & Milev, 2011).

4.3 Qualitative Analysis

Questionnaires were transcribed in their entirety into a computer software program by summer students of Providence Care Health Services. Each question response was deconstructed sentence by sentence to identify categories and key themes. Categories were then compared across questions to create concepts. As the data was coded, further themes emerged. Frequency counts were made based on the major themes. Approximately thirty themes were created; these themes were later narrowed down to a final total of eighteen, as themes were merged together and smaller themes became sub-themes. Five questions had sub-themes and a total of seventeen sub-themes were created.

Interrater reliability was tested by another Queen’s university neuroscience student who went through and coded themes separately. A consensus was reached on which codes should be used and all codes for the answers were entered into a computer software program with the second coder on hand to ensure data was entered correctly and errors kept to a minimum.

The qualitative analysis had a total of sixteen questions emerge with responses suitable for coding. Examples of questions used in qualitative analysis are as follows: “Have you ever
been teased, bullied or harassed because you have a mental illness?” As the data was coded, it became clear that certain questions did not have enough relevance. In particular, questions 28, 29, 30, 31, 32 and 36, did not generate enough variability in the themes and response rates were well below compared to previous questions. The following is an example of a question omitted: “Have your experiences with stigma motivated you to participate in programs to educate the public about mental illness?” Only 38 out of a possible 212 people responded “yes.” Out of a total of sixteen possible questions for qualitative analysis, those six were omitted from further analysis due to a lack of response rate and low variability.

Once all data was entered, totals for each theme were generated by question and tallied. It is important to note that some of the respondents mentioned more than one experience or example, so responses fit into more than one theme; therefore, response totals did not add up to the total number of people, but rather how many different situations were discussed. The most common responses were further analyzed by question, gender, age, diagnosis, education, and age of first hospitalization, to look for commonalities or differences in the data set. These responses were broken down into groups of two or three to allow for a T-test or ANOVA to look for significant differences between groups.
Chapter 5

Results

5.1 By Question

Data was inputted into excel by a secondary source which was then transferred to SPSS where totals were then calculated. Analysis began by question, starting with the first open ended question, with question 16, “have you ever been teased, bullied, or harassed because you have a mental illness?” Of the 76 people who responded “yes” 100% felt that they had received some type of stigmatizing experience associated with teasing, bullying, or harassment. In regards to unfair treatment 75% discussed stigmatizing situations. Moreover, 29% of people had been teased, bullied, or harassed by a family member. While 17% people felt their significant other had behaved that way towards them. Co-worker harassment, teasing, or bullying, was felt by 30% of individuals; 13% people also felt similar experiences had happened in a social setting. A surprising 8% people chose to talk about positive experiences related to teasing, bullying, or harassment.
Figure 1. Question 16 response rate for experiences with teasing, bullying, and harassment.

Question 17 was, “have you felt that you have been treated unfairly or that your rights have been denied because you have a mental illness?” Of the 102 people who answered “yes,” 47% people discussed a specific stigmatizing experience related to unfair treatment or having their rights denied; a further 42% people felt that a co-worker or boss had been unfair. There were also issues for 21% people during treatment; of those individuals, 18% reported unfair treatment or their rights being denied by a staff member.

Question 18 was, “could you give us an example of a stigmatizing experience you have had in the last year?” Of the 133 respondents able to recall a stigmatizing experience, 68% discussed a specific situation relating to the stigmatizing experience theme. The most common
stigmatizing experiences were by family members with 25% people and in the workplace with 29%. A surprising result was that 38% described a positive experience.

Question 19 delved deeper into question 18 by asking, “was this the worst experience of stigma you have ever had?” Of the 133 respondents to question 18, 60% felt that the stigmatizing experience they discussed had been the worst, with the highest reported incidents occurring at work with 17% of people. Family and social settings received 14% each. Another 11% discussed a situation occurring during treatment with 10% of those people discussing an issue with a staff member.

Question 21 was, “have your experiences with stigma affected your recovery?” A total of 104 people, representing nearly half of all participants, responded “yes” and 71% of people discussed a particular stigmatizing experience. One person responded, “Stigma effects self-image, self-esteem, and confidence which in turn disrupts the process of recovery.” 16% went on to discuss the need for censoring their illness from others in order to protect themselves and not receive any more unwanted stigma. Of particular note is that 16% of people also had issues with co-workers regarding their recovery.

Question 22 was, “have your experiences with stigma caused you to think less about yourself or your abilities?” Over half or 132 people, responded “yes” to question 22. Of that, there were 72% who discussed personal issues regarding stigma. Of those individuals, the subtheme “emotional issues” was expressed by 38%, “insecurity” by 33% and 70% responded regarding a particular stigmatizing experience.
Figure 2. Question 22 response rate for experiences with stigma.

Question 22: Have experiences with stigma caused you to think less about yourself or your abilities?

- Emotional Issues: n=38
- Insecurity: n=33
- Stigmatizing Experience: n=70

Question 23 was, “have your experiences with stigma affected your ability to make or keep friends?” There were 101 people who responded “yes”; of that number, 87% of people discussed issues in social settings. There were also 35% of people who discussed a specific stigmatizing experience relating to friendship. Moreover, 24% discussed the theme of censoring themselves when it came to making and keeping friends.

Question 24 was, “have your experiences with stigma affected your ability to interact with your family?” 105 people responded “yes” of those people, 89% went on to discuss a specific situation where stigma had occurred within a family setting. One woman commented, “Sometimes my family is the worst source of stigma they expect me to be the “best” Mom etc. without realizing my limitations.” As well, 26% discussed a specific situation regarding a
stigmatizing experience. The concept of censorship was also discussed with 14% of individuals. It is encouraging that 13% were able to relate a positive experience with family members.

Question 25 was, “have your experiences with stigma affected your satisfaction with quality of life?” Over half, 126 people responded that stigma had affected their quality of life. 39% of people discussed a particular situation that had been a stigmatizing experience. Social settings were of particular note to 19%. As well, the trend of censoring their illness was reported by 18% of individuals.

Question 26 was, “do you think your family has been stigmatized because of your mental illness?” With one of the lowest totals, only 40 people, 19% responded “yes”, with 16% discussing a situation that was difficult for themselves or their family. Of those people that reported yes, 7% responded that they were unsure to what extent the stigma had affected their family members.

Question 27 was, “what do you do to cope with stigma?” 114 respondents, 54%, discussed positive coping mechanisms in regards to coping with stigma. Acceptance was the most discussed positive coping with 39% of people.

One person commented: Live my own life. Make my own decisions. Maintain my independence. Be as positive as I can be when I talk to people. Get help when and if I need it. Work to be as well as I can be – this is all anyone can really ask of you.

A further 26% discussed the positive coping mechanism of education to help others understand their mental illness. Meanwhile, 33% felt that some type of censorship was needed to cope with
stigma. There were 32% of individuals that used a negative coping mechanisms to deal with their stigma. The most popular negative coping mechanism was isolation, with 19%.

Question 35 was, “what do you think causes stigma?” 72% of people suggested that ignorance was the most likely cause for stigma, with fear receiving 22% of mentions from people. The media was also another potential cause of stigma with 14% of responses; 13% also suggested that stereotyping could also be a cause of stigma.

**Figure 3.** Question 35 response rates for possible causes of stigma.

The following questions were omitted from further investigation: question 28, “Do you try to conceal your mental illness from others?” received the highest response rate with 161 people however there were very few written responses. For question 29, “Do you try to avoid situations that may be stigmatizing to you?” also had a high response rate with 134 people responding “yes.” Very few written responses were recorded. Question 30, “Have you ever tried
to reduce stigma by educating your friends or family about your mental illness?” received a high
response rate with 142 “yes” responses. This question offered very little discussion within
responses. Question 31, “Have your experiences with stigma motivated you to speak out about
the rights of the mentally ill?” received a total of 78 “yes” responses. Lastly, question 32, “Have
your experiences with stigma motivated you to participate in programs to educate the public
about mental illness?” received the fewest amount of responses, with only 38 people indicating
“yes.”

5.2 Gender

Once all themes had been totaled by question, the data was reconfigured to look at the
most popular themes by gender. A total of 80 males and 131 females participated in the study;
one person chose to omit their gender, for a total of 211 participants.

Starting with question 16, women and men reported an almost identical amount of
incidents regarding their experience with teasing, bullying and harassment. 28% of women and
29% of men reported a similar type of incident. One female commented, “My husband has
belittled me, judged me and is even trying to get 100% custody of kids solely because of my
hospitalization.” Under the theme “stigmatizing experiences,” 22% of women and 24% of men
discussed a situation.

When asked in question 18 for an example of a stigmatizing experience that had occurred
in the past year, women were twice as likely to discuss an experience. 52% of women and 28%
of men discussed a stigmatizing situation. A non-parametric T-test indicated a statistically
significant difference (p = .001) between females and males using the theme ‘stigmatizing
experiences.’ When it came to discussing a positive experience, men reported a slightly higher
incidence of positive encounters with 31% of men, and only 19% of women respectively. A non-parametric T-test indicated a statistically significant difference (p = .044) between males and females using the theme ‘positive experiences.’

When asked if the stigmatizing experience they discussed in the last year was the worst they had experienced, women were almost twice as likely to agree with 18% discussing a stigmatizing experience and only 10% of men. What was interesting to note is that both men and women reported nearly the same amount of incidents taking place at work with 13% of men and 9% of women. One man commented, “I’m not able to freely talk to friends and people about how I feel – I don’t talk about employment. I say I’m a stay at home dad.”

Women were more likely to respond whether stigma had affected their recovery with 39% and 28% of men, discussing an incident. When asked if situations involving stigma had caused them to think less about themselves, women responded more often with 49%, compared to only 36% of men. Regarding the “personal issues” theme, 43% of women and only 29% of men discussed a situation. A non-parametric T-test indicated a statistically significant difference (p = .042). Women were also more likely to report issues with making/keeping friends and with family issues with over half of women, with 51% and 33% of men. A non-parametric T-test indicated a statistically significant difference (p = .008) between males and females using the theme ‘family issues.’
Figure 4. How stigma has impacted recovery by gender.

When asked if their experiences with stigma had affected their quality of life, the data was more varied. The theme “personal issues,” had an equal amount of discussion with 14% of men and 15% of woman. Interestingly enough, women were twice as likely to censor themselves with 14% when compared to men with only 6%.

Finally, when asked what they thought caused stigma, a near equal number of men and women thought that stigma was caused by ignorance. 76% of women and 74% discussed the theme of ignorance as a possible cause. Overall, women tended to report negative experiences more often than men.
5.3 Age

Regarding the age of respondents, the questionnaire asked, “what year were you born?” Due to the questionnaire being administered within a two year time frame, a person’s age at the time they filled out the questionnaire could not be determined. Therefore, two categories were created, those born before 1960 and those born after 1961. A total of 113 people were born before 1960 and 97 people were born after 1961, two people chose to omit their date of birth.

For those born before 1960 and after 1961, they both had similar experiences when it came to bullying, teasing or harassment. 25% of those born before 1960 and 31% born after 1961 discussed a situation concerning the theme unfair treatment. A similar incidence of stigmatizing experiences occurred for those born before 1960 with 22% and those born after 1961 with 24%, respectively.

In regards to whether their rights had been denied, there wasn’t a significant variance between groups. A total of 22% of people born before 1960 and 24% of people born after 1961, reported unfair treatment or stigmatizing experiences. The theme work-related issues received a similar response with 20% of people born before 1960 experiencing any sort of workplace discomfort and only 22% born after 1961.

A similar degree of people born before 1960 and after 1961, had a stigmatizing experience occur in the past year. 41% born before 1960 and 43% born after 1961 discussed a stigmatizing experience. A significant difference was not found regarding the theme positive experiences with only 22% born before 1960 and 25% born after 1961, respectively.
When asked if the stigma they experience in the last year was their worst experience, the unfair treatment theme had only 2 people born before 1960 and only 7 born after 1961 respond “yes.” This was the lowest response rate reported. A further 12% born before 1960 and 17% born after 1961 reported a stigmatizing experience. In regards to work related stigma, over twice as many people born after 1961 reported a work related incident with 15% and 6% born before 1960 discussing a similar incident. A non-parametric T-test indicated this data neared statistical significance (p = .058).

Furthermore, when asked whether stigma had affected their recovery, those born before 1960 reported near identical numbers as those born after 1961, 35% and 34% respectively. Of particular note, those born after 1961 reported a higher incidence of difficulty making and keeping friends. 48% born after 1961 discussed the theme “social issues” and 34% of those born before 1960 discussed a similar incident.

A similar amount of people noted that stigma had affected their satisfaction or quality of life, with 42% born before 1960 and 23% born after 1961, reporting a stigmatizing experience. In regards to the “personal issues” theme, 17% of people born before 1960 and 12% of people born after 1961 discussed a specific situation. Those born before 1960 and after 1961, censored themselves equally with 10% and 12% respectively.

One respondent replied: I don’t share my mental illness with people right away, when I feel more comfortable with someone I will tell them and hope that even if they previously had stigma towards mental illness, maybe I will help to change their views.
Figure 5. How stigma has affected quality of life by age.

When asked if experiences with stigma had affected their ability to make or keep friends, a non-parametric T-test indicated the data approached statistical significance ($p = .052$). The question whether their family members had been stigmatized due to their mental illness, more than twice as many born after 1961 discussed a stigmatizing experience. Those born after 1961 discussed an issue a family member had 21% of the time compared to only 12% of those born before 1960.

Finally, when asked what they thought caused stigma, a similar proportion of people both agreed that ignorance was the main cause. Those born before 1960 discussed the theme ignorance with 74% and those born after 1961 discussed it 78%. Over all, the proportions of people born before 1960 and after 1961 had quite a lot of similarities and not very many
noticeable differences. No statistical significance was met but a couple on instances neared significance.

5.4 Diagnosis

For diagnosis, categories were broken down into those who had depression or bipolar disorder. A total of 105 people reported that they had been diagnosed with depression and 85 people reported that they were diagnosed with bipolar disorder. There were 22 people who either did not put down one of these two disorders or who chose to omit their mood disorder altogether. There was very little variability within the data presented and only 6 questions had any variability more than 5% difference between the groups.

When asked if they had ever experienced any teasing, bullying or harassment, 30% of people with depression and 28% of people with bipolar disorder noted some type of unfair treatment. The same goes for stigmatizing experiences, with 21% of people with bipolar disorder and 27% people with depression discussing an incident.

Furthermore, when asked to discuss a stigmatizing situation that occurred wherein their rights were denied, 21% of people with bipolar disorder and 27% with depression reported a stigmatizing experience. When discussing positive experiences, very little difference was detected between groups with 26% bipolar and 24% depressed individuals reporting an incident. One person responded, “The friends that I have now make me feel like I’m worth something – encourage me. They know I have depression. Help me – and do everything they can.

When asked to discuss a stigmatizing incident that pertained to the last year, 50% of those suffering from depression and 40% of those with bipolar disorder discussed a stigmatizing
experience. When asked if this was the worst stigma they had ever faced, the results were very low with only 6% of depressed individuals and only 4% of those with bipolar disorder reporting an experience. What is interesting to note, is that while half of depressed individuals discussed a negative situation, there were also 20% with depression and 29% with bipolar disorder, that were able to recall a positive situation.

**Figure 6.** Stigma experiences by diagnosis.

Moreover, when asked whether stigma had caused them to think less about themselves, there was a high response rate with very little variability between the depression and bipolar groups. Those with bipolar disorder reported stigmatizing experiences 49% of the time, and those with depression had a slightly lower response rate with 44% of individuals.
When the topic of making or keeping friends was broached, 47% of people with bipolar disorder and 41% people with depression discussed issues within a social setting. Whereas 48% of individuals with bipolar disorder and 43% with depression discussed family issues.

Someone responded: When I was first diagnosed and during the first few years of having the illness part of my family would not talk to me or take my call, either because they found me too difficult, they were in denial, or it was because of stigma.

In contrast, when asked whether stigma had affected their life satisfaction, more bipolar individuals (28%) than depressed individuals (20%) discussed a situation relating to a stigmatizing experience. There were also more people with bipolar disorder 19%, compared to only 13% of those with depression that discussed the theme “personal issues.” What was very interesting to note, was that only 4% of individuals with bipolar disorder discussed censorship of their illness compared to 18% of depressed individuals, over four times as many respondents! A non-parametric T-test indicated a statistically significant difference (p = .002) between these two groups under the theme ‘censorship.’

Bipolar individuals felt that their family had been stigmatized more, 21% of the time when compared with depressed individuals. Only 14% of those with depression discussed a stigmatizing incident that had occurred to a family member. One person responded, “My mother in law did not want her daughter to marry me because of her prejudice against people with bipolar.”

There were more individuals with bipolar disorder, 61%, that chose to use positive coping mechanisms when compared with depressed individuals with 51%. Finally, when asked
what they thought caused stigma, slightly more bipolar individuals discussed ignorance with 81% compared with depressed individuals at 76%.

In general, the data between bipolar and depressed individuals had very low variability, with most data only different by 5-10%. It appears that there may be quite a few similarities between the experiences and difficulties faced by those individuals with depression and bipolar disorder.

5.5 Age of First Symptoms

All individuals with a mental illness experience the symptoms of their disorder before they are diagnosed. With that said, by looking at the age when a person first noticed the symptoms of their disorder, there may be similarities and differences in the data. Of the 212 participants, 94 first noticed symptoms before the age of 20 and 93 noticed their symptoms after age 21, there were also 25 individuals who chose to omit the age of their first symptoms or could not recall their age when symptoms first occurred.

When asked if they had ever experienced teasing, bullying or harassment due to a mental illness, a similar amount of people between groups reported some degree of unfair treatment. 28% of those with symptoms before age 20 and 31% of people with symptoms after age 21 felt that they had received unfair treatment of some kind.

Furthermore, when asked if they had been treated unfairly or felt their rights were denied, for those who presented symptoms before age 20, this occurred less often with 20% of respondents, compared to 26% of individuals that presented symptoms after age 21. This trend is also similar for the work-related issues theme. There were 17% of people who experienced their
symptoms before the age of 20 and 23% of people who noticed their symptoms after age 21 that reported some degree of work place issues. One respondent commented, “On the job – in general if it becomes known about your diagnosis – act as though they may catch it – those that react the most strong you find that they have suffered or know someone who has.”

When asked if they had experienced stigma in the last year, those that had experienced symptoms before age 20, had slightly more stigmatizing experiences with 46%, when compared to those who experienced their symptoms after age 21 with 40% of individuals. The same is true for positive experiences, with 27% of those who experienced their symptoms before age 20 and 23% who experienced symptoms after age 21 expressing similar events. When asked if this was the worst stigma ever faced, twice as many people who experienced stigma after age 21, 8% discussed a stigmatizing event compared to only 3% who experienced their symptoms after age 20. An identical amount of people, 16% in each group, discussed a stigmatizing experience.

When asked if their experiences with stigma had caused them to think less about themselves or their abilities, those who experienced symptoms after age 21 with 49% discussing a stigmatizing experience, while only 38% of those who experienced their symptoms before age 20 discussing a similar event. In regards to the personal issues theme, they were almost identical with 36% people who experienced their symptoms before age 20 and 38% people who experienced their symptoms after age 21 discussing similar events.
Moreover, when it came to social issues there was very little variability in the data with 43% people who experienced symptoms before age 20 and only 45% people who experienced symptoms after age 21. The same can also be said for family issues with only 46% of those who experienced symptoms before age 20 and 42% of those that had experienced symptoms after age 21. There was some variability when it came to whether their families had been stigmatized, with those who experienced symptoms after age 21 discussing a stigmatizing experience 19%, compared to those who experienced their symptoms before age 20, with 12% discussing a similar experience.

Lastly, slightly more people who experienced their symptoms before age 20, discussed using positive coping mechanisms with 59% and 53% of those who experienced their symptoms after age 21 discussing a comparable situation. One response regarding positive coping
mechanisms “Remind myself of the correct accurate information about myself and my mental illness. Remind myself that many people are misinformed.” Overall, the variability between those who experienced their symptoms before age 20 or after age 21 was not very high. In fact, there was only one instance where the data varied more than 10%. No statistically significant data was found using non-parametric T-tests.

5.6 Education

Education is an important part of life as it is a direct indicator of the type of job and social status one can expect. This was the only category that had three variables, those who had attended or completed high school, attended or completed a college degree and those that had gone to university or post graduate studies. A total of 65 people had gone to high school, 82 people had some college background and 63 people had either some university or higher education and 2 people chose to omit their educational background.

Regarding question 16, “have you ever been teased bullied or harassed because of your mental illness,” there was some variability within the data. Those that had attended either college or university had similar results, 31% and 35% respectively. Those that had some high school education discussed unfair treatment nearly half that with 17%. One way ANOVAs were completed to test for significance between the three groups. Question 16 using the theme ‘stigmatizing experiences,’ question 19 using the theme ‘work related issues,’ and question 24 using the theme ‘family issues.’ The data was not significance for all three ANOVAs however it approached significance on question 24 between the groups university and high school (p = .052).
Furthermore, a more variable pattern was detected when asked if their rights had been denied due to their mood disorder. Those with a college education reported the lowest score with only 16% discussing a stigmatizing experience. Those with high school education reported a similar experience 25% of the time. Finally, those with university education experienced the most with 30%. What is interesting to note, is that when discussing a work related incident, the data was very similar with 19% of those with high school education, 21% of those in college and 22% of those in university discussing similar events.

As well, when it came to whether their experience with stigma had affected their recovery, there was a little bit of variability within the data. Those with some university education discussing the most stigmatizing experiences with 38%, those with some college education with 35% and finally those with some high school reported the lowest scores with 29% of individuals.

When asked if their experiences with stigma caused them to think less about themselves, those with some university education reported the highest incidence of stigmatizing experiences with 51%, those with some high school reported the second highest scores with 45% and finally those in college experienced the least with 38%. The scores regarding personal issues were very similar with 40% for those with some university, 39% for those with some high school and finally 34% for those with some college.
In direct contrast, when asked if stigma had affected their overall quality of life, there was a low number of respondents and very little variability in the data. Those in college reported the most stigmatizing experiences with 24%, those in university reporting 22% and finally those with some high school with 20%. One response, “You begin to believe that you are always going to be different and not worthy of anything that gives you love.” What was interesting to note is that there was exactly 2% difference between each variable. When looking at the theme of “censorship,” those with some college discussed it the least with only 9%, those with some university 11% and finally those with some high school discussing censorship the most with 14%.

In addition, when asked whether their experiences with stigma affected their ability to make or keep friends, those with some university education reported the highest incidence of
social issues. With 51% of those with some university, followed by 42% with some high school and finally with the lowest totals 34% of those with some college education reporting issues within social settings.

**Figure 9.** Social issues by education.

With Question 24 was, “have your experiences with stigma affected your ability to interact with your family?” followed a nearly identical pattern, with those in university reporting the highest scores. Those with some university reported 54% of the time, 46% of those with some high school and finally those with college reported the least with 34% of people. Conversely, when discussing whether they thought their family had been stigmatized due to their mental illness, those with some university discussed the theme of “stigmatizing experiences” the most with 22%, followed closely by those with some high school education with 19%. Interestingly enough, those with some college discussed their stigmatizing experiences nearly half as often at only 10% when compared with the other two variables.
In addition, when asked what they did to cope with stigma, those with a university degree had the highest proponent of positive coping mechanisms with 60%. Those with some college education discussed a positive coping mechanism 52% of the time and finally those with some high school education discussed positive coping mechanisms the least with 49%.

Finally, when asked what they thought caused stigma, those with some university discussed the theme of “ignorance” most often with a whopping 81% of individuals. Those with college and high school followed with 73% and 72% respectively.

One respondent commented: Ignorance, intolerance, lack of education, fear, misinformation, I think that education is the key – especially education kids because they learn quickly and if they are taught to be accepting at a young age they will be accepting throughout their lives. I think it is really important that the myths of mental illness being a weakness or a flaw should be dispelled.

Overall, the data regarding education was the most variable in the set. It was also interesting to note that those with some university education had some of the highest response rates to any given question. Those with some college and high school had the most similar data by comparison.
Chapter 6

Discussion

6.1 Findings

The general findings of this study were overall low response rates and minor variability between groups. When asked to elaborate on their experiences, responses were minimal which amounted to low response rates on open ended questions, usually between 10-30%. Glozier (1998) also noted that response rates within his data sample were low, hovering slightly above 40%. A plausible explanation could be medication side effects such as drowsiness, could inhibit their ability to think clearly and recall past experiences. The stress of discussing emotionally affecting past experiences could have resulted in a fervent desire to avoid answering such questions.

The questions that consistently had the highest response rates were questions 18, 27 and 35. Question 18 asked for an example of stigma that had occurred in the last year, with most response rates averaging around 40%. Those with depression had one of the highest response rates at 50%. Men were the least likely to recall stigmatizing experiences in the past year with 28%. This data indicates that the stigma of mental illness is still prevalent.

In addition, when asked in question 27, “What do you do to cope with stigma?” the response rate hovered around 55%, with most describing a positive coping technique. This indicates that while stigma is a barrier to overcome, those that are faced with stigma are trying persevere. Those that reported the highest incidence of positive coping techniques had been...
diagnosed with bipolar disorder (61%). Positive coping mechanisms can help with issues such as self-esteem, medical adherence and improved chances of recovery.

As well, question 35, “What do you think causes stigma?” had the highest response rate, averaging over 70%. This indicates that those experiencing the stigma of mental illness have strong opinions as to the cause, namely ignorance. This data could be useful to anti-stigma campaigns by reminding the population that people with mental illnesses are everywhere and exists within many families.

Crisp, Gelder, Rix, Meltzer and Rowlands (2000) indicated that stigmatizing attitudes are less common among younger individuals, therefore targeting anti-stigma campaigns in schools could result in a positive effect. Crisp et al. (2000) also note that mental illness is becoming more common with over half of 1700 respondents knowing someone. Further informing the public using a patient’s perspective, regarding the experiences of being stigmatized, could be a useful tool. Those with bipolar disorder and university education were tied for the highest response rates (81%). There was also a tie for the lowest response rates, those with some high school education and those that experienced their first symptoms before age 20 (72%).

While these instances had the highest proportion of responses, much of the data had low response rates and low variability. This will be discussed in further detail in upcoming sections. Over all, while there was a lower response rate than expected, much of the data was generally consistent.
6.2 Similarities

Starting with question 16, when asked if they were ever teased, bullied or harassed, the data was very consistent all responses were between 25-30%. There was one exception with education. Those with some high school education reported “unfair treatment,” only 17%. This is supported by data by Dinos, Stevens, Serfaty, Welch and King (2004) who observed that 63% of their respondents discussed being personally harassed either verbally, physically or through malicious actions.

Similarly, question 17, when asked if they had ever been treated unfairly or had their rights denied, there was a low amount of respondents and the data was relatively consistent. The data regarding the theme “stigmatizing experiences” between 20%-25% with the only exception being those with some university education reporting 30%. It is possible that people with higher education are not expected to be affected by mental illness and are therefore more stigmatized. When looking at the data further under the theme “work-related issues,” the data was again very consistent and all data was around 20%.

Moreover, with question 19, when asked if the stigma they faced in the last year was the worst they had experienced, this had the lowest reported scores and very constant results not a single instance reaching over 8%. The data also had some of the lowest variability with all data ranging within 6%. The low response rate for this question could suggest that while stigma is still present in society, there is slowly more tolerance towards mental illnesses. This data could also indicate that people who have been stigmatized in the past are more cautious about disclosing.
In the same way, for question 25, when asked if stigma had affected their life satisfaction or quality of life, all the data ranged between 20-28%. When further explored, using the “personal issues” theme, the data again remained steady around 15%. In conjunction with the high response rate of positive coping mechanisms, this data could suggest that those with mental illnesses are finding more ways to overcome their mental illness in a positive way, which would affect their quality of life less. The work completed by Dinos et al. (2000) further supports this suggestion, they documented that 84% of respondents could discuss the positive aspects of their mental illness using positive coping mechanisms.

A plausible reason why the data generally resulted in low response rates, could be that these questions are regarding very sensitive topics. It can be very difficult for some individuals to relive painful memories and therefore decide not to answer. It is also not realistic to assume that a large percent of the sample would be subject to discrimination. Over all, most of the data was dependable, consistent and steady.

6.3 Differences

There were some instances where there was some variability in the data. For example, question 18, when asked if they were ever teased, harassed or bullied, there was some variability between genders. When discussing positive experiences that came from their mental illness, males reported 31% and females reported 19%. Males may choose to focus on the positive aspects of their mental illness as a coping mechanism. Males may also not feel comfortable admitting to their struggles as it could be considered a sign of weakness.

Similarly, when asked in question 21 if their experiences with stigma had affected their recovery, the same trend was found. Females were more affected by their experiences with
stigma with 39% reporting a stigmatizing experience. Males on the other hand, only reported 28% of the time, further indicating that males may be avoidant, less affected or focus more on their recovery. When discussing positive coping mechanisms in question 27, males reported similarly with 56% compared with 52% of females.

In contrast, with question 22, when asked whether stigma had caused them to think less about themselves or their abilities. Women felt more affected by stigma with 49% discussing a stigmatizing experience, whereas men discussed a similar experience 36% of the time. Side effects such as weight gain, tremors and other issues associated with medication be an issue.

When looking at the age when the symptoms of their mental illness were first experienced those that experienced their symptoms after age 21, reported stigmatizing experiences 48% compared to those that experienced their symptoms before age 20 with 38%. In addition, for education, those that were in college discussed a stigmatizing experience the least with 38%, those with some high school at 45% and finally those with some university education 51% of the time. This is the opposite result found by Cook and Wang (2010) who reported that those at higher educational levels were less likely to report stigmatizing attitudes.

One of the most surprising results of the data was with question 23, where participants were asked if experiences with stigma affected their ability to make or keep friends. When looking at age, those born before 1960 discussed the social issues only 34% when compared to 48% with those born after 1961. A possible explanation could be that those that are older have had their friends for a longer, allowing for stronger emotional. Another possible explanation is that those people who were born before 1960 may be more selective about which friends they choose to disclose their mental illness to.
Additionally question 23 also provided some interesting results regarding education. Those with the highest educational success, namely those with some university or graduate school education, discussed social themes the most (51%) and those with college reported the least (34%). This data seems contradictory as those with higher education would be expected to be the most tolerant and have the most open-minded viewpoints. A possible explanation is that college is generally a more stable experience where you spend your days with the same people and therefore can foster stronger relationships, where as university classes can have hundreds of students and therefore the experience can be more isolating. It may also be expected that those with higher education should be less likely to experience mental illnesses and therefore are more stigmatized.

Finally, the biggest difference in data was in question 24, whether stigma had affected a person’s ability to interact with their family. Men reported on the family issues theme less (33%) than women (51%). This data indicated that men may be less likely to disclose their mental illness to their families. Women are generally considered to discuss their feelings more often therefore increasing the odds of experiencing stigma from family members. This is supported by the work of Jenkins and Carpenter-Song (2009) who noted that women were twice as likely to discuss feelings of stigma by family members compared to men.

6.4 Significance

Data with two variables were compared using non-parametric T-tests to search for statistically significant differences between groups. Significance was met on four separate occasions when comparing males and females. Question 18, under the theme stigmatizing
experiences (p = .001) and the theme positive experiences (p = .044). Question 22, the theme personal issues met significance (p = .042) and question 24 under family issues (p = .008). The only other category that reached significance was diagnosis. Question 25 and the theme censorship was statistically significant (p = .002). This data is confounded by the work of Dinos et al. (2000) who noted that a significant number of people within their study had little to no difficulty disclosing their mental illness to others. These statistically significant sets of data do not really have any commonalities or similarities so it’s interesting to note which were significant.

6.5 Limitations

While this was a worthwhile study there were some limitations. The overall response rate on open ended questions was low, with only three questions reaching and exceeding more than a 50% response rate. One question did not even reach a response rate of 10%. As mentioned previously this could be due to the emotionally charged nature of some questions, medication side effects, the difficulty of reliving past trauma or a lack of negative experiences.

Another limitation was the low variability between groups, nearly all data had less than a 10% difference between groups. There was only one instance in the entire data set that broached a 20% difference in the data. This could be partly due to poor response rates, lack of experiences or patients not feeling comfortable discussing their experiences.

There were also some minor issues with data entry. There were instances where the data was illegible, entered incorrectly or into the wrong column. With generally such low response
rates, the few instances where this occurred could have impacted the data making variability higher or more varied.

6.6 Purpose

The purpose of this data was to understand stigma from the patient’s perspective. The understanding and experience of what it felt like to be a victim of stigma, what areas of their lives were most affected by stigma, and what possible ways this knowledge could assist the literature and anti-stigma campaigns. By using the data, namely question 35, we can see that most people felt that ignorance was a large factor as to why people. This data could be useful to further future anti-stigma campaigns wherein campaigns could focus on informing the public what it feels like to live with a mental illness. As previously stated, mental illness affects both genders, all ages and education levels. By creating campaigns that demonstrate mood disorders are common and affect many different types of people, this could help further reduce stigma.

This study also shows that the opinions of those with mood disorders are important. Future studies should focus their attention on adding the opinions of those with different mood disorders and mental illnesses including but not limited to: schizophrenia and anxiety disorders. Future studies can also compare and contrast the themes and experiences with those presented here. Semi structured interviews should also be strongly considered as this provides an opportunity for those with mental illnesses to express themselves in a safe environment.

To summarize, this data while somewhat low on variability and response rates, provided some important considerations. Namely, that men in general seem to focus more on recovery and positivity than women. Those with higher education may be more stigmatized than those with lesser education. Positive coping mechanisms are a common way to reduce stigma and that
focusing on recovery is paramount to success. The suspected cause of stigma is mainly ignorance. This data could be used for further informing the public through anti-stigma campaigns and to further the data and research available on the stigma of mental illnesses.
Chapter 7

Conclusion

The purpose of this study was to understand the impact that stigma had on those with mood disorders. The current data regarding a patient’s experiences with stigma is limited and is mainly focused on quantitative data. The data and insight gained through this study will further research and add to the mounting evidence that the stigma of mental illness is still prevalent in society and a barrier to overcome. Peer support groups and positive coping mechanisms provide beneficial support in the fight against stigma. The public needs to be informed and less ignorant on the subject matter if we are to expect popular opinion to change. The common theme of ignorance throughout the data suggests that the public is likely unaware that mental illnesses are something that people can overcome and that mental illness is not something to be ashamed of.

As much of the current data surrounding stigma and mental illnesses focuses on quantitative data, the qualitative data in this study helps provide new insights and compliments the current literature. This study was intended to give the perspective of the patient suffering with depression or bipolar disorder. This study aimed to present some important findings regarding the feelings and thoughts of those faced with stigma. It has shown that while they not only have to deal with debilitating aspects of their illness, the side effects of their medications, they can be battling their own sense of self-worth on top of the isolation and ignorance of a society that does not understand.

While this may be just the start of understanding mental illnesses from a patient’s perspective, it is nonetheless a worthwhile and crucial step forward in the fight against stigma. Stigma is still a barrier that needs to be overcome in order to make those suffering feel
comfortable seeking help and stay on a positive road to recovery. By helping to lower the stigma associated with mental illness, we could expect more adherence to treatment and higher remission rates. This paper is one positive step forward on the path towards equality for those with depression and bipolar disorder.
References


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Heather Stuart, https://quest-guccis.com

Information about you

First, we would like to know a bit about you and your contact with mental health treatment services. Please mark the correct box.

1. Gender  □ Male  □ Female

2. What year were you born?

3. What is your highest level of education?
   1. □ Public school or less (up to grade 8)
   2. □ Some high school
   3. □ Completed high school (grade 12 or 13)
   4. □ Some college or technical training
   5. □ Completed college or technical training
   6. □ Some university
   7. □ Completed university
   8. □ Graduate or professional degree

4. Are you currently living alone or with someone else?
   □ Alone
   □ Spouse/partner
   □ Parents
   □ Other relative(s)
   □ Other unrelated person(s)
   □ Other
   □ Specify

5. What is your current marital status?
   □ Never married
   □ Separated
   □ Widowed
   □ Divorced
   □ Common/law
   □ Married
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5. Are you employed?
   - Not employed
     - Unable to work because of mental health problems
     - Unable to work because of other health problems
     - Homemaker
     - Retired
     - Student
     - Volunteer
   - Supported employment
   - Part-time competitive work
   - Full-time competitive work

Information about your mental health problems.
This section asks about your mental health problems and the kinds of services you may have used.

7. What is your current diagnosis (check more than one if applicable)?
   - None
   - Schizophrenia
   - Manic Depression/Bipolar Disorder
   - Depression
   - Anxiety Disorder
   - Misuse of alcohol or street drugs
   - Other: __________

8. Compared to one year ago, would you say your mental illness is...
   - Better
   - About the same
   - Worse

9. How old were you when you first noticed you had symptoms?
Experiences with the Stigma of Mental Illness


10. How old were you when you first received treatment?

11. Would you say that you have come to accept your diagnosis?
   - No
   - Yes, if yes, how old were you when accepted your diagnosis?

12. Have you ever been hospitalized for a mental illness or suicide attempt?
   - Yes
   - No

   12a) Have you ever been hospitalized in:
       - A provincial psychiatric hospital
       - A general hospital psychiatric unit
       - A medical/surgical unit in a general hospital

   12b) Were you ever committed under Provincial mental health legislation (the Mental Health Act)?
       - Yes
       - No
       - Uncertain

   12c) Have you been hospitalized in the last year because of a mental health problem?
       - Yes, as a voluntary patient
       - Yes, as a committed patient
       - No

   12d) Have you ever been hospitalized on a forensic unit?
       - Yes
       - No
       - Uncertain
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13. In the last year have you attended an outpatient or community mental health program?
   - [ ] No
   - [ ] Yes. About how often do you attend?
     - [ ] Weekly or more often
     - [ ] 2 or 3 times a month
     - [ ] Once a month
     - [ ] Once every 2 or 3 months
     - [ ] Once every 6 months
     - [ ] Once or twice a year

Experiences with Stigma.

The next section asks about your experiences with stigma. By stigma we mean negative feelings people have toward people with a mental illness.

Do you have any questions about what we mean by stigma?

The next questions will ask about your own personal experiences with stigma.

14. Do you think that people will think less of you if they know you have a mental illness?
   - [ ] Never
   - [ ] Rarely
   - [ ] Sometimes
   - [ ] Often
   - [ ] Always
Experiences with the Stigma of Mental Illness

15. Do you think that the average person is afraid of someone with a serious mental illness?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Always

16. Have you ever been teased, bullied, or harassed because you have a mental illness?
   - No
   - Unsure
   - Yes

Please explain.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

17. Have you felt that you have been treated unfairly or that your rights have been denied because you have a mental illness?
   - No
   - Unsure
   - Yes

Please explain.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Experiences with the Stigma of Mental Illness

18. Could you give us an example of a stigmatizing experience you have had in the last year?

19. Was this the worst experience of stigma you have ever had?
   - Yes
   - No. If not, what was the worst stigmatizing experience you have ever had?

20. When did this happen? __________

21. Have your experiences with stigma affected your recovery?
   - No
   - Not sure
   - Yes. If yes, could you give us an example?


22. **Have your experiences with stigma caused you to think less about yourself or your abilities?**
   - No
   - Unsure
   - Yes

   If yes, could you give us an example of how you have been affected?

23. **Have your experiences with stigma affected your ability to make or keep friends?**
   - No
   - Unsure
   - Yes

   Could you explain?

24. **Have your experiences with stigma affected your ability to interact with your family?**
   - No
   - Unsure
   - Yes

   Could you explain?
Experiences with the Stigma of Mental Illness


25. Have your experiences with stigma affected your satisfaction with or quality of life?
   □ No
   □ Unsure
   □ Yes

   Could you explain?
   ______________________________________________________
   ______________________________________________________

26. Do you think your family been stigmatized because of your mental illness?
   □ N/A - No family contact
   □ No
   □ Unsure
   □ Yes

   If yes, could you give us an example of how your family has been affected?
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

27. What do you do to cope with stigma?
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
Experiences with the Stigma of Mental Illness


28. Do you try to conceal your mental illness from others?
   - No
   - Unsure
   - Yes

   Could you explain?

29. Do you try to avoid situations that may be stigmatizing to you?
   - No
   - Unsure
   - Yes

   Could you explain?
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30. Have you ever tried to reduce stigma by educating your friends or family about your mental illness?
   - No
   - Unsure
   - Yes

   Could you explain?

31. Have your experiences with stigma motivated you to speak out about the rights of the mentally ill?
   - No
   - Unsure
   - Yes

   Could you explain?
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32. Have your experiences with stigma motivated you to participate in programs to educate the public about mental illness.
   - No
   - Unsure
   - Yes

   Could you explain?

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

33. On a ten-point scale where 0 is the lowest possible amount, and 10 is the highest possible amount, how much has stigma affected you personally? Please circle the number that best quantifies this impact in the following areas.

   Quality of Life:
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   Social Contacts:
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   Family Relations:
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   Self Esteem:
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
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34. On a ten-point scale where 0 is the lowest possible amount, and 10 is the highest possible amount, how much has stigma affected your family as a whole? Please circle the number that best quantifies this impact in the following areas.

Quality of Life:

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Social Contacts:

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Family Relations:

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35. What do you think causes stigma?
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36. What should we do to fight stigma?


Thank you for taking your time to talk with us. Is there anything else you would like us to know about your experiences with stigma that we have not yet asked?

Additional Comments:


