

**NEW ITEMS IN ANNOTATED BIBLIOGRAPHY, VOLUME 4**  
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## Messages

Byrne, Peter. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment*. (6), 65-72.

In one study of 156 parents of first-admission patients, half reported making efforts to conceal the illness from others (Phelan *et al*, 1998).

People with mental illness are frequently portrayed as victims, pathetic characters, or “the deserving mad” (Byrne, 1997).

The rise of ‘politically correct’ language has been a key factor in the success of campaigns opposing discrimination based on gender, age, religion, color, size and physical disability (Thompson & Thompson, 1997).

Mental health professionals need to move beyond teaching psychoeducation in isolation (at the clinic) to full participation in planned programs of public education.

Dubin & Fink (in Fink & Tasman, 1992) describe how psychiatrists perpetuate many concepts underlying biased and stigmatizing attitudes, and suggest that the way in which psychiatry is structured maintains the status quo.

Acknowledging the existence of prejudice is an essential first step, and is no more ‘dangerous’ than enquiry into suicidal ideation.

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Deacon, Harriet. (2006). Towards a Sustainable Theory of Health-Related Stigma: Lessons from the HIV/AIDS Literature. *Journal of Community and Applied Social Psychology*. (16), 418-425.

HIV/AIDS provides a good case study for reviewing our theoretical understanding of health-related stigma because it provides evidence of the complex relationship between stigma and existing forms of prejudice and disadvantage, discrimination and the variety of different responses to stigma and discrimination by people living with HIV and AIDS.

This paper argues for research and interventions against health-related stigma to improve, we need to develop a more coherent, sustainable theory of stigma. In order to do this, we need a better understanding of stigma and its relation to discrimination and disadvantage.

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Link, B. and Phelan, J. (2001). Conceptualizing Stigma. *Annual Review of Sociology*. (27), 363-85.

Writing about disability, Fine & Asch (1988) identify five assumptions: (a) that disability is located solely in biology, (b) that the problems of the disabled are due to disability-produced impairment, (c) that the disabled person is a “victim,” (d) that disability is central to the disabled person’s self-concept, self-definition, social comparisons, and reference groups, and (e) that having a disability is synonymous with needing help and social support.

The vast majority of human differences are ignored and are therefore socially irrelevant.

The second component of stigma occurs when labeled differences are linked to stereotypes.

A third feature of the stigma process occurs when social labels connote a separation of “us” from “them” (Morone 1997, Devine *et al* 1999).

In the fourth component of stigma, the labeled person experiences status loss and discrimination.

Once in place, people's conceptions become a lay theory about what it means to have a mental illness (Angermeyer & Matshinger 1994, Furnham & Bower 1992).

Our conceptualization leads us to focus on two principles in considering how to really change stigma. The first is that any approach must be multifaceted and multilevel. It needs to be multifaceted to address the many mechanisms that can lead to disadvantaged outcomes, and it needs to be multilevel to address issues of both individual and structural discrimination.

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Steir, A. and Hinsahw, S. (2007). Explicit and implicit stigma against individuals with mental illness. *Australian Psychologist*. 42(2), 106-117.

Empirical findings and qualitative evidence indicate that stigma against mental illness remains rampant in many nations and cultures, constituting a significant barrier to successful treatment, reducing key life opportunities, and predicting poor outcomes over and above the effects of mental illness per se. In this article they define stigma on individuals with mental illness, and discuss underlying mechanisms. They focus in particular on assessment issues, highlighting the need for transcending explicit attitudinal measures of stigma, which are susceptible to social desirability concerns and are likely to underestimate true levels of stigma, to include unconscious/implicit indicators and direct behavioral appraisals. A primary goal is to facilitate means of accurately measuring stigma against mental illness as an important step toward reducing its pernicious effects.

It has been estimated that 1 in 5 persons will suffer from a mental illness each year, with approximately 6% showing forms that indicate high levels of severity (Kessler, Chiu, Demler, & Waters, 2005; World Health Organization, 2001a).

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Ross, Marvin (on behalf of the TAMI Steering Committee). (2004). Talking About Mental Illness: An evaluation of an Anti-stigma and Educational program in Hamilton, Ontario. *The Ministry of Health and Long-Term Care, Province of Ontario*.

A before-and-after evaluation of presentations on mental illness to secondary school students and to students in an adult education centre in Hamilton, Ontario suggests that although the participants had a generally positive attitude about mental illness and its causes to begin with, there was a further positive shift in those attitudes as a result of participating in the program. Participants became less stigmatizing and demonstrated an increased understanding about mental illness and those who suffer with it after receiving the program. This evaluation suggests that that program is achieving its goals and should be continued.

### **General Public**

Feldman, D. and Crandall, C. (2007). Dimensions of Mental Illness Stigma: What about mental illness causes social rejection? *Journal of Social and Clinical Psychology*. 26(2), 137-154.

This article address which characteristics across mental disorders lead to stigmatization and social rejection. Participants read case histories depicting individuals with 40 mental disorders, rated those individuals on 17 dimensions (e.g., dangerousness to others, treatability, social disruptiveness), and indicated how willing they were to reject these individuals on social distance scale. This yielded a ranking of mental disorders by degree of stigmatization; most importantly it reveals the structure of

mental illness stigmatization. Only three dimensions were essential in accounting for rejections: personal responsibility for the illness, dangerousness, and rarity of the illness. These dimensions provide an efficient and effective account of the causes of social rejection in mental illness.

### **Faith Based**

Stanford, M. (2007). Demon or disorder: A survey of attitudes toward mental illness in the Christian church. *Mental Health, Religion & Culture*. 10(5), 445-449.

This study assessed the attitudes and beliefs that mentally ill Christians encountered when they seek counsel from the church. Participants completed an anonymous online survey in relation to their interactions with the church. Analysis of the results found that while a majority of the mentally ill participants were accepted by the church, approximately 30% reported a negative interaction. Negative interactions included abandonment by the church, equating mental illness with the work of demons, and suggesting that the mental disorder was the result of personal sin. Analysis of the data by gender found that women were significantly more likely than men to have their mental illness dismissed by the church and/or be told not to take psychiatric medication. Given that a religious support system can play a vital role in recovery from serious mental disorders, these results suggest that continued education is needed to bring the Christian and mental health communities together.

### **Public Policy and Law**

Zechmesier, I., Kilian, R., McDaid, D., and the MHEEN group. (2008). Is it worth investing in mental health promotion and prevention of mental illness? A systemic review of the evidence from economic evaluations. *BMC Public Health*. 8(20).

This paper aims at identifying and assessing economic evaluations in both mental health promotion (MHP) and mental disorder prevention (MDP) to support evidence based prioritization of resource allocation. A systematic review of health and non health related bibliographic databases, complemented by a hand search of key journals and analysis of grey literature has been carried out. Study characteristics and results were qualitatively summarized. Economic evaluations of programs that address mental health outcome parameters directly, those that address relevant risk factors of mental illness, as well as suicide prevention interventions were included, while evaluations of drug therapies were excluded.

14 studies fulfilled the inclusion criteria. They varied in terms of topic addressed, intervention used and study quality. Robust evidence on cost-effectiveness is still limited to a very small number of interventions with restricted scope for generalisability and transferability. The most favorable results are related to early childhood development programs. Prioritization between MHP and MDP interventions requires more country and population-specific economic evaluations. There is also scope to retrospectively add economic analyses to existing effectiveness studies. The nature of promotion and prevention suggests that innovative approaches to economic evaluation that augment this with information on the challenges of implementation and uptake of interventions need further development.

### **Workplace**

HealthDay News. (2009) People With Schizophrenia Say Bias Is Part of Their Lives. *The Washington Post*. 21 January.

People living with schizophrenia often expect to be discriminated against, and are, in various aspects of their life, new research finds.

The study, which included 732 people with schizophrenia in the United States and 26 other countries found that 47 percent reported discrimination in making or keeping friends, 43 percent from family members, and 27 percent in intimate or sexual relationships. Also, 29 percent of the participants said they experienced discrimination while trying to find or keep a job.

The researchers also found that 64 percent of the participants didn't bother applying for work, training or education because they expected to fail or to face discrimination, and 55 percent anticipated discrimination when seeking a close relationship. However, more than a third of participants expected these types of discrimination did not actually experience it.

### **Lesbian, Gay, Bisexual, Transgender, or Questioning**

Ida, D.J. (2007). Cultural Competency and Recovery within Diverse Populations. *Psychiatric Rehabilitation Journal*. 31(1), 49-53.

Reports on youth suicide found that gay and lesbian youth are up to five times more likely to attempt suicide (Fleisher & Fillman, 1995, Hershberger, 1997).

### **Ethnic Groups**

Ida, D.J. (2007). Cultural Competency and Recovery within Diverse Populations. *Psychiatric Rehabilitation Journal*. 31(1), 49-53.

While African Americans and Latinos make up only 12% and 13% of the total adult population respectively, approximately 40% of all jail inmates were African American and another 15% were Latino (U.S. Bureau of Justice Statistics, 2002). Only 8.5% of Latinos/Hispanics meeting DSM-III-R criteria for a psychiatric disorder used mental health services (Vega, Kolody, Aguilar-Gaxiola & Catalano, 1999).