STIGMA ASSOCIATED WITH MENTAL HEALTH: A CONCEPT ANALYSIS

By

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Stigma Associated with Mental Health: A Concept Analysis

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Abstract

Timely access to mental health care is vital to people who are experiencing mental health concerns. However, mental health stigma often interferes with obtaining help. Therefore, an important step in improving access to mental health care is to better understand mental health stigma. Within the literature, there are gaps in knowledge, particularly pertaining to the complexities of mental health stigma. Moreover, the concept of stigma has evolved in the past 50 years, as have Canadian lifestyles. It is important to understand these evolutionary changes to address the issue of inadequate mental health care related to mental health stigma. Using Rodgers' Evolutionary Model (Rodgers & Knafl, 2000), a concept analysis was conducted to better understand mental health stigma. This analysis provides a better understanding of the concept and a foundation for further research needed in the areas of education, policy and clinical practice.

Table of Contents

Chapter 1: Introduction and Background

1.1 Introduction

It is estimated that at any given time, one in five Canadians are suffering with a mental health concern (Smetanin et al., 2011). For many people, receiving help can make a significant difference in their quality of life. Access to appropriate mental health care can reduce the burden felt by those affected with mental health concerns. However, many people are reluctant to seek help when experiencing concerns about their mental health. Often, this reluctance occurs because of past experiences of ridicule, discrimination, judgment, or self-doubt. In some cases, even the anticipation of these experiences, whether previously experienced or not, can result in a hesitance to seek help. Ridicule, discrimination, judgment, and self-doubt are products of the stigma that is associated with mental health concerns. Ultimately, the consequence of unaddressed mental health stigma is a lack of adequate and appropriate mental health care for many people. (Canadian Mental Health Association of Canada [CMHA] Ontario, 2015; Clement et al., 2015; Corrigan, Roe & Tsang, 2011; Knox et al., 2014; Mental Health Commission of Canada [MHCC], 2015a). Lack of adequate mental health care is a significant issue affecting all members of society, regardless of gender, age or socioeconomic status (CMHA, 2009; Meyer, Castro-Schilo & Aguilar-Gaxiola, 2014; Sripada et al., 2015).

For many people, the terms *mental health*, *mental disorder* or *mental illness* evoke certain thoughts and ideas. Often, these thoughts and ideas are negative and tend to be more pronounced than what might be associated with the term *physical illness*. The Canadian Medical Association (2008) estimates that only 50% of Canadians would discuss their mental health with others, compared to 70% with other conditions such as diabetes. Notably, three

times as many people in Canada are living with a mental health concern when compared to those living with type 2 diabetes (MHCC, 2015b).

Given the devastating effects of mental health stigma, it is imperative to develop a more comprehensive understanding of how best to address this gap in mental health care. To effectively manage this need, it is essential to first have a clear understanding of stigma as it relates to mental health. A clearly understood concept can provide a foundation and direction for practice, policy, education, and future research (Rodgers & Knafl, 2000; Tofthagen & Fagerstrom, 2010). A concept analysis of mental health stigma was conducted employing Rodgers' Evolutionary Model of concept analysis (Rodgers & Knafl, 2000). This analysis provided insight and understanding that can inform future activities geared towards reducing and, ultimately, decreasing the stigma associated with mental health.

1.2 Background

The World Health Organization (2014) defines mental health as a "state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community" (para. 2). Mental health is an integral part of overall health at work, school, and home. Inadequate care for mental health contributes directly to reduced quality of life, increased health care and workplace costs, and in some cases, death as a result of self-neglect or suicide (Booth, Francis, McIvor, Hinson & Barton, 2014; Canadian Association for Suicide Prevention, 2008; Dardas & Simmons, 2015; Dennehy, 2015; MHCC, 2016; Pan, Knapp, Yeh, Chen & McCrone, 2013; Statistics Canada, 2014). As such, mental health and the associated stigma warrant the same level of attention as other health issues. This includes activities and discussions related to policy, health care, education and the media. When mental health is

threatened, not only is the individual affected, but so too are family, friends, colleagues, and communities (Corrigan, Ker & Knudsen, 2005).

The number of people experiencing mental health concerns in Canada has increased over the past 20 years and is expected to continue growing (MHCC, 2009; Smetanin et al., 2011). This growth may be due, in part, to increased awareness and recognition of mental health issues. In addition to increased awareness, the demands of the contemporary Canadian lifestyle have changed dramatically (Haghighat, 2001; MHCC, 2015a; 2015b). Canadians now have access to more opportunities than ever before. While these opportunities enhance life in many ways, they are also more demanding of resources (e.g., time, money, skills). Steps must be taken to address not only the increased incidence of mental health concerns, but also to develop strategies better aligned with the contemporary Canadian lifestyle. This means using an approach that is reflective of the current reality of widespread technology use and a variety of social structures. By utilizing new knowledge and adapting the way in which we understand and communicate information about mental health, relevant and effective strategies can be developed.

Changes related to increasing knowledge and communication about mental health, are needed at all levels and must include a variety of stakeholders, such as individuals, groups, and government organizations. As stakeholders, the health care team can make significant contributions towards change efforts. The health care team, including nurses, regularly interact with a variety of people, many of whom are affected by mental health concerns. These interactions provide an ideal opportunity to address stigma and the gaps in mental health care. However, because stigma is often unrecognized or misunderstood, these opportunities may be missed.

In light of the number of people affected by mental health, one might expect to see a strong, cohesive, health care strategy similar to those in place for other health issues. For example, the Canadian Breast Cancer Foundation works with several corporate partners to conduct a highly visible awareness and fundraising campaign (Canadian Breast Cancer Foundation, 2016). Unfortunately, when addressing mental health, it is more common to see exclusionary practices, whether intentional or not. These exclusionary practices serve to bolster the separation and isolation associated with stigma in mental health. The practice of separating and isolating individuals or groups from oneself is referred to as *othering*. Othering, "magnifies and enforces" (Johnson et al., 2004, p. 254) differences rather than mitigating the issues associated with stigma (Thompson & Kumar, 2011).

When groups of people are divided, or othered, based on certain characteristics, the result is the creation of silos. Currently, silos exist that identify and differentiate between people experiencing mental health concerns and those who are not. Often, people tend to avoid association with the labels *mental disorder* or *mental illness* in an effort to protect themselves from ridicule, discrimination or judgment. In so doing, an *us* versus *them* mentality is perpetuated (Link & Phelan, 2001). The MHCC (2009) states: "At the core we are all the same. There is no us and them" (p. 7). If people continue to be subjected to ridicule, discrimination or judgment, the silos will remain, and stigma towards people affected by a mental health concern will continue.

Stigma is best described as endorsement of negative, often inaccurate, stereotypes and attitudes that lead to harmful, discriminatory and prejudicial behaviour (CMHA Ontario, 2015; Knox et al., 2014; MHCC, 2015c). These stereotypes, and attitudes stem from a variety of sources and are perpetuated in many overt and covert ways. Stigma is deeply rooted within

social constructs, meaning that each society determines those attributes that are socially acceptable or unacceptable. Members of a society who reflect or demonstrate socially unacceptable traits or attributes tend to be rejected from the society by members who wish to distance themselves from that which is socially unacceptable. Ultimately, this leads to the stigmatized group being subjected to limitations in social, financial, and health related areas of their lives (Dardas & Simmons, 2015; Hinshaw & Stier, 2008).

Stigma is often associated with conditions, disorders or behaviours perceived as socially unacceptable or within the control of an individual, such as HIV/AIDS, obesity, lung cancer, cirrhosis, type 2 diabetes or addiction. A belief of this nature further contributes to stigma as it assumes a conscious choice is being made by the individual. (Pinto-Foltz & Logsdon, 2008). Mental health concerns are often included in this category. Even *mental health*, which many consider to be a positive term or state of being, can have negative connotations associated with it. While stigma is not exclusive to mental health, stigma related to mental health is a significant contributor to the health and well-being of individuals with a mental health concern, particularly in the receipt of adequate health care.

Stigma and stigmatizing messages are present throughout the media, interpersonal relationships, work or school environments, as well as health care and service organizations. This, in combination with familial belief systems, personal values, and past experience can determine how friends, family, colleagues, and health care providers view each other and themselves in the context of their mental health. Further, the way in which government, workplaces, educational institutions or health care facilities develop and implement policies and procedures can also influence what types of messages are communicated when addressing mental health. Given the magnitude and dynamic nature of this issue, it is imperative that

stigma associated with mental health is clearly understood to fully address the gaps in mental health care.

In reviewing the literature pertaining to stigma and mental health, three concept analyses addressing stigma and mental health were identified. Each of these three articles focused on a particular population or type of stigma. Pinto-Foltz and Logsdon (2008) contend that stigma towards mental health concerns is not only poorly understood, but also frequently unrecognised, which has harmful consequences for all people suffering from a mental health concern. The aim of these analyses are to clarify the concept of stigma towards mental health concerns and promote dialogue in nursing by using stigma and postpartum depression as an exemplar. The authors highlight the complex nature of stigma, including the differences that may occur within varied contextual settings.

Omori, Mori, and White (2014) focus specifically on self-stigma (the internalization of negative attitudes and stereotypes held by the public) in individuals with schizophrenia. Self-stigma is presented as a distinct form of stigma, thus requiring a tailored approach. This analysis uses the unique features of schizophrenia as well as the relationship to other mental health issues to aid in the conceptualization of self-stigma.

Dardas and Simmons (2015) discuss the effects of stigma towards mental health disorders in Arabian families. They differentiate between self-stigma and social stigma (negative attitudes and stereotypes held by the public) while exploring the complex relationships between individuals, families, and the public. Further, the effect of culture, particularly when dissimilar to Western cultural norms, is considered.

Each of these concept analyses provide important information regarding mental health stigma within a specific context. However, little information exists in regards to understanding

mental health stigma as a concept more broadly. Moreover, mental health stigma within the context of today's culture is underexplored. The aim of this paper is to report on a concept analysis of the overall concept of mental health stigma within today's society.

Chapter 2: Methods

In this chapter, the methodology used to conduct this concept analysis is discussed. First, Rodgers' Evolutionary Model of concept analysis (Rodgers & Knafl, 2000) is described. Next, methods are detailed with a description of each phase, including the application of Rogers' Evolutionary Model to this concept analysis.

2.1 Rodgers' Evolutionary Model

Rodgers and Knafl (2000) suggest that the purpose of a concept analysis is "to define the concept of interest in terms of its critical attributes" in an effort to "reveal precisely what the concept *is*" (p. 77). Concepts are described as dynamic in nature and have a pragmatic role in developing an understanding that may contribute to clinical practice, policy development, and research. Rodgers introduced her Evolutionary Model of concept analysis in 1989 comprising a significant component of the text *Concept Development in Nursing: Foundations, Techniques, and Applications* (Rodgers & Knafl, 2000). This text, and Rodgers' model of concept analysis provide the foundation for this concept analysis.

"Clear concepts are necessary to characterize phenomena of interest, to describe situations appropriately, and to communicate effectively" (Rogers & Knafl, 2000, p. 80). A concept analysis can provide clarity where ambiguity exists regarding a particular phenomenon, such as mental health stigma. In reference to evolutionary analysis, Rodgers and Knafl note, "this position is compatible with the perspective generally accepted in nursing, which espouses a view of reality and human beings" and is "constantly changing" (p. 77). For this reason, Rodgers' evolutionary view of concept analysis is best suited to analyse the concept of stigma in mental health. Rodgers' model of concept analysis (Rodgers & Knafl, 2000), as an inductive process, is meant to "identify a consensus of a concept," give direction and provide a

"foundation for further research" (p. 97). Rodgers' Evolutionary Model of concept analysis (Rodgers & Knafl, 2000) includes seven phases. These phases are outlined in the following sections of this paper.

2.2 Methods

2.2.1 Phase 1: Identify the concept of interest.

Rodgers' method of concept analysis is described as being iterative in nature with associated activities to be carried out simultaneously. However, establishing the concept of interest is required prior to conducting the remaining phases. Words are often used to express a concept, but "a concept is not a word" rather, "the idea or characteristics associated with the word" (Rodgers & Knafl, 2000, p. 85).

Given the increasing rates of mental health concerns, the associated stigma and lack of receipt of appropriate care, the concept of interest chosen for this analysis is mental health stigma. Stigma has been clearly shown to interfere with mental health (Corrigan, Roe & Tsang, 2011; Dardas & Simmons, 2015; Link & Phelan, 2001; Pinto-Foltz & Logsdon, 2008). However, what is not fully understood, are the various ways in which stigma impacts mental health. Furthermore, it is not clear how best to approach stigma reduction. In choosing this concept, the goal is to increase the understanding of mental health stigma, facilitating a reduction in stigma and an improvement in access to mental health care.

2.2.2. Phase 2: Identify the setting and sample.

For this concept analysis, the *setting* refers to the time period, disciplines and type of literature examined. The *sample* includes literature both available and pertinent to the concept of interest. The recommended strategy for obtaining the sample is to use a database search,

employing relevant keywords. It is further suggested that at least 30 items should be reviewed for the sample to be valid (Rodgers & Knafl, 2000).

The setting chosen for this concept analysis included a broad time frame (1994-2016) to ensure the evolution of the concept was captured. This time frame aligned with the introduction of the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM IV) in 1994 that included the recognition of a greater number of disorders, as well as increased requirements for inclusion in the manual (American Psychiatric Association, 1994). For this analysis, it was determined that the focus of the literature review should be on current data (2011-2016), but not to exclude historical data. Therefore, a selection of relevant articles was chosen from the 1994 - 2010 time period. Peer-reviewed literature from the disciplines of health, psychology and sociology, as well a selection of grey literature, were reviewed.

Four electronic databases (CIHNAL, Medline, PsycINFO and Sociological Abstracts) were searched using the terms *stigma, concept and mental** (truncated to capture *mental illness, mental disorder, mental health* and other relevant terms). The terms *depression* and *anxiety* were searched specifically, as they appeared frequently in the literature. No limits were applied with regards to age or gender. Articles focused on intellectual developmental disorders or neurological disorders (e.g. Down syndrome, autism spectrum disorder, dementia) were excluded Articles from non-peer reviewed journals, dissertations, literature reviews and editorials were also excluded. The electronic database searches yielded 538 records. Once duplicate and irrelevant records were removed, 126 records remained. The remaining 126 abstracts were screened, after which, 51 full text articles were assessed for relevancy, based upon inclusion and exclusion criteria (see Table 1).

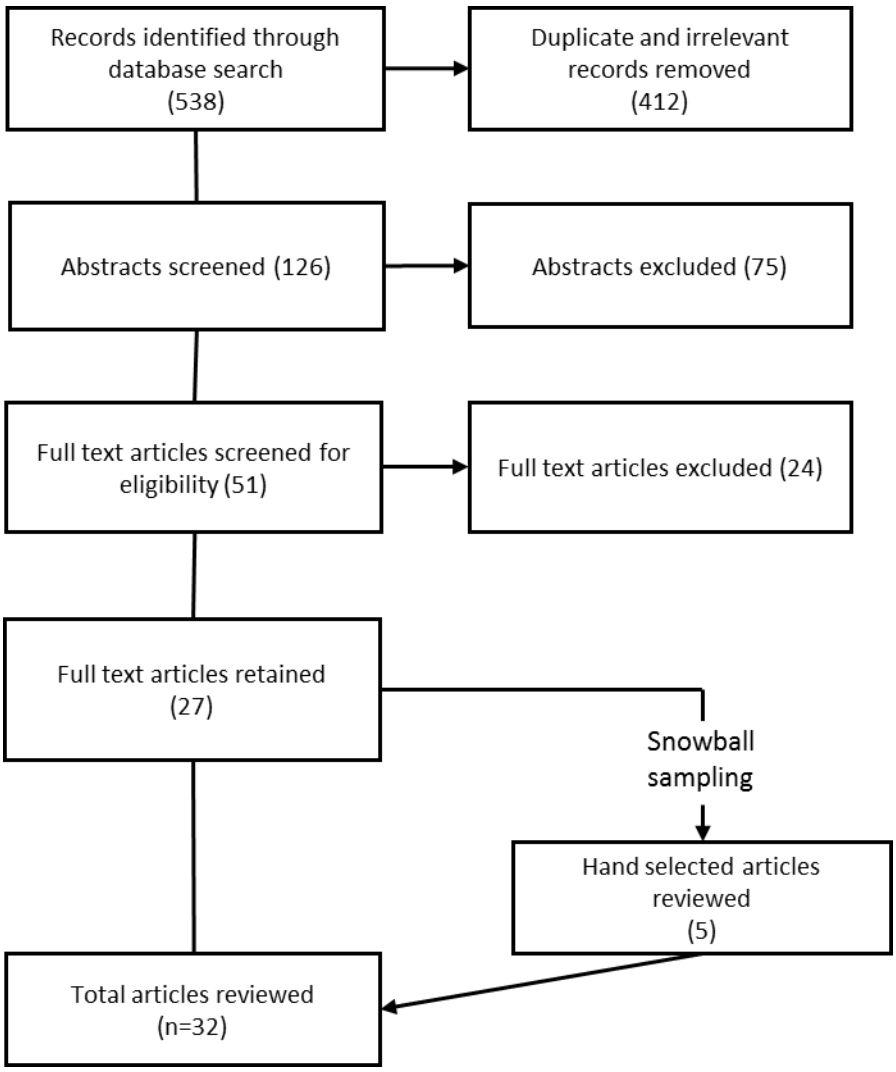
Table 1

Peer reviewed literature search inclusion and exclusion criteria

Criterion	Inclusion	Exclusion
Time period	2011-2016 1994-2010 (limited)	Prior to 1994
Language	English	Non-English
Origin of study	Canada, United States, Australia, United Kingdom, other international locations.	Developing countries
Type of mental health concern	All mental heath concerns, including serious mental illness, anxiety, depression	Intellectual developmental disorders, neurological disorders.
Type of article	Peer-reviewed literature Qualitative, quantitative, mixed methods, narrative, descriptive Stigma related to mental health Focus on mental health stigma as a concept	Non-peer reviewed literature Dissertations, literature reviews, editorials Stigma not related to mental health Focus not on mental health stigma as a concept Focus on disorder or condition, not stigma

Ultimately, 27 full text articles were retained for analysis. Of these remaining 27 articles, five additional articles were hand selected from reference lists, through snowball sampling, a type of purposive sampling, in which the initial sample was expanded to support the needs of the research design (Maruyama & Ryan, 2014). Additional articles were screened as per the procedures for the articles derived from database searches. All of these were retained for the concept analysis for a total of 32 peer-reviewed articles from nursing, psychology, sociology and medicine included in the sample (see Figure 1).

Figure 1. Literature review flowchart



Traditionally, peer-reviewed literature has been a primary source of data for research. Given that grey literature can be produced more quickly and can be more accessible than peer-reviewed literature (Primary Health Care Research & Information Service, 2016, University of Michigan Library, 2016), grey literature was also included as part of the data set. It provided insight not only into the type of information that can be accessed by policy and decision-makers, providers, and the public, but also how such information can be accessed. Several sources of grey literature were included in the sample as they "may be beneficial in bridging the gap between…providers and…recipients of care" (Rodgers & Knafl, 2000, p.87). Grey literature can

originate from many sources and it was beyond the scope of this paper to review all sources. The grey literature search strategy involved online searches of government agencies, health ministries and not-for-profit organizations. The inclusion criteria were similar to that of the peer-reviewed literature with the exception of the time frame of 2006-2016. This time frame was chosen to obtain the most current data. A time frame of 2011-2016 did not produce sufficient results, therefore it was necessary to expand the time frame to increase the amount of data available for analysis. The nature of obtaining grey literature via online sources did not allow for the same parameters as would be utilized for a traditional literature search. This was due, in part, to the inconsistent presentation of grey literature. The results of the grey literature search produced 12 items that were screened for relevancy based on criteria similar to that of the peer-reviewed literature (see Table 2). Of those items, seven were chosen for inclusion in the review. These sites were deemed reputable based on authorship (government organizations or highly recognized mental health organizations), references, and current sources.

2.2.3. Phase 3: Collect data to identify attributes.

"The attributes of the concept constitute a *real* definition, as opposed to a *nominal* or dictionary definition" (Rodgers & Knafl, 2000, p. 91). Attributes are those characteristics most often associated with a concept (Rodgers & Knafl, 2000). Attributes are often different from antecedents, consequences, surrogate terms and related concepts, but may also be similar.

Phases 3 and 4 (see below) were closely linked and represented the start of data collection. The process of identifying attributes began with reading each item to determine the "general tone of the work," (p. 93). For this concept analysis, identification of the attributes was initiated with a review of 32 peer-reviewed articles. A data extraction table (Appendix A) was used to compile and organize data. As each article was read, content helpful in identifying the

Table 2

Grey literature search inclusion and exclusion criteria

Criterion	Inclusion	Exclusion
Time period	2006-2016	Prior to 2006
Language	English	Non-English
Origin of document	Canada, United States, Australia, United Kingdom, other international locations.	Developing countries
Type of mental health concern	All mental heath concerns, including serious mental illness, anxiety, depression	Intellectual developmental disorders, neurological disorders.
Type of document	Government, not-for-profit, health ministry reports and websites News, magazines	Commercial, for-profit organizations Fictional media, television, movies
	Stigma related to mental health	Stigma not related to mental health
	Focus on mental health stigma as a concept	Focus not on mental health stigma as a concept Focus on disorder or condition, not stigma

attributes were noted. A similar process was repeated for grey literature (e.g. websites, reports), using a separate data extraction table (Appendix B).

2.2.4. Phase 4: Collect antecedents, consequences, surrogate terms and, related concepts.

Antecedents are those events or situations that must be present for the concept of interest to occur. Consequences are those events or situations that occurred as the result of the presence of the concept. Surrogate terms and related concepts are sometimes used interchangeably but are,

in fact, distinct. Surrogate terms are different words or phrases used to express the concept. Related concepts are similar to the concept of interest but do not share all the same attributes.

Antecedents, consequences, surrogate terms, and related concepts were identified concurrently with Phase 3. In Phase 4 of the concept analysis, articles deemed particularly useful or relevant were read a second time. This process was completed first for the peer-reviewed literature and then for the grey literature. In some cases, articles were read a third time to clarify or confirm results. Once saturation was reached, when no new data or themes were revealed, the focus of the process turned to data analysis.

2.2.5. Phase 5: Analyse the data.

In this concept analysis, the data were analysed at the completion of data collection. Rodgers (Rodgers & Knafl, 2000) cautioned that concurrent data collection and analysis can mistakenly lead to viewing the data as saturated, thus overlooking important data. A thematic analysis was used to analyse data according to the following categories: attributes, antecedents, consequences, surrogate terms, related concepts, and contextual information. Each category was examined to identify common themes.

2.2.6. Phase 6: Identify the exemplar.

According to Rodgers (Rodgers & Knafl, 2000), the purpose of an exemplar is to, "provide a practical demonstration of the concept in a relevant context," (p. 96). She stresses that an exemplar should be identified, and not created, as it is intended to provide contextual, *real life* understanding. The exemplar is not intended to be a model case, nor is it intended to act as a final statement regarding the concept. Further, care must be taken to avoid bias and remain neutral by not selecting an exemplar representative of personal interests.

An exemplar was compiled based on data obtained through the literature search, as well as the author's observation of mental health stigma in a variety of health care settings. The exemplar provided a means to further illustrate and clarify the concept of stigma associated with mental health as it occurred in real life settings. Identifying details of the exemplar have been changed and attention to bias was considered.

2.2.7. Phase 7: Identify implications for practice and future research for concept development.

Concept analysis is considered by Rodgers & Knafl (2000) to be the basis for further inquiry rather than the end of the process. Increased awareness and knowledge of mental health stigma were two key areas identified along with implications for practice. Future research strategies included advancing and integrating knowledge into the areas of clinical applications, policy development, and education. Ultimately, by identifying implications for practice and areas of future research, the goal was to close gap in knowledge related to mental health stigma with the potential to improve access to mental health care.

Chapter 3: Results

In this chapter, the results of the concept analysis will be presented. Definitions from reference works and the literature will be outlined. The evolution of the concept will be explored, and the attributes of the concept (antecedents, consequences, surrogate terms and related concepts) described. Finally, an exemplar, demonstrating the concept within a relevant context, will be provided.

3.1 Definitions.

Merriam Webster ("Stigma", n. d.) provides the following simple definition of *stigma*: "a set of negative and often unfair beliefs that a society or group of people have about something." Merriam Webster ("Stigma", n.d.) also discuss historic, medical and religious definitions such as: "a scar left by a hot iron (brand), a mark of shame or discredit, an identifying mark or characteristic (a specific diagnostic sign of a disease) or bodily marks or pains resembling the wounds of the crucified Jesus and sometimes accompanying religious ecstasy (stigmata)." Roget's Thesaurus ("Stigma", 2013) lists the following synonyms for stigma: shame, scar, stain, blame, blemish, disgrace and dishonor. Antonyms for stigma included: approval, esteem, honor, respect, credit and pride.

From a sociological perspective, Goffman (1963) defines stigma as "an attribute that is deeply discrediting" that causes a person to move "from a whole and usual person to a tainted, discounted one" that is "incongruous with our stereotype of what a given type of individual should be" (p. 2). Link & Phelan (2001) state stigma existed "when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold," (p. 367).

Corrigan and associates (2011), provide a definition of stigma from a psychological perspective. They make the distinction between three types of stigma:

> Public stigma is the harmful effect that occurs when the general population endorses prejudice and subsequently discriminates against people with mental illness. Self-stigma occurs when people internalize the stigma and beat themselves up with [*sic*]. Structural stigmas are the social forces that emerge after many years of public stigma (p. xiii).

Academic definitions of stigma have long included a distinction between more than one type of stigma (Goffman, 1963). As the concept evolved, a further distinction was made between mental health stigma and other forms of stigma. In more recent literature (Corrigan, Roe & Tsang, 2011; Richman & Lattanner, 2014), definitions change to move beyond social/public stigma and self-stigma to include structural stigma as a related, but distinct form of stigma. As society changes and knowledge increases, it has become necessary to continuously update definitions to remain relevant.

Social stigma, sometimes referred to as public stigma or enacted stigma, is "the negative attitudes held by members of the public about people with devalued characteristics" (Corrigan & Rao, 2012, p. 464). Associative, or courtesy stigma, is a form of social stigma that occurs when a group or individual experience stigma as a result of their connection with a stigmatized group or individual. This includes family members, friends or professionals who live or work with people experiencing a mental health concern (Dardas & Simmons, 2015; Pinto-Foltz & Logsdon, 2008).

Self-stigma, "occurs when people internalize these public attitudes and suffer numerous negative consequences as a result" (Corrigan & Rao, 2012, p. 464). In some cases, there is an awareness of the symptoms of self-stigma, but not a realization that it is distinct from social stigma. Self–stigma is considered to be especially harmful when neither realized nor

acknowledged. Self-stigma is also referred to as internalized, felt, or perceived stigma (Corrigan et al., 2005; Corrigan et al., 2011; Herek, 2007; Herek, Gillis, & Cogan, 2009; Rüsch, Angermeyer & Corrigan, 2005). Individuals who experience self-stigma as a result of social stigma may avoid situations where they might be faced with further exposure to stigma (Goffman, 1963; Pinto-Foltz & Logsdon, 2008).

Finally, structural stigma is referred to as the laws, policies or regulations created by social institutions that restrict or inhibit the rights and opportunities of stigmatized groups or individuals. Groups and individuals in positions of authority often make decisions about mental health care based on years of exposure to social stigma. These decisions are also reflective of historical, political or economic factors. Many decisions about laws, policies and regulations that govern social institutions are based on what was accepted in the past, what was popular or what was profitable. (Corrigan, Markowitz & Watson, 2004; Corrigan et al., 2011; MHCC, 2013a; Richman & Lattanner, 2014).

Definitions are a useful component to aid in understanding a concept. It is important to also be aware of surrogate terms and related concepts. Previously, the terms prejudice, discrimination, stereotyping, and shame were used as surrogate terms for stigma. To some degree these terms are still used as surrogate terms, but are actually constructs of stigma rather than surrogate terms. As the concept evolves, it is more accurate to refer to these terms as related concepts as they do not share the same attributes as stigma (Corrigan, 2000; Corrigan et al., 2011; Pinto-Foltz & Logsdon, 2008; Stigma, n.d.).

3.2 Evolution of Stigma

In discussing the origin of the concept of stigma, many, if not most, researchers (Corrigan, 2000; Livingston & Boyd, 2010; Phelan & Link, 1998; Pinto-Foltz & Logsdon, 2008)

refer to Goffman's (1963) seminal work: *Stigma: Notes on the Management of Spoiled Identity*. Goffman was the first to popularize the term stigma and identified Ancient Greece as the birthplace of the term. Stigma was used to refer to "bodily signs designed to expose something unusual and bad about the moral status of the signifier" (p. 1). Bodily signs might have included burning or cutting and were performed on slaves or those individuals deemed as traitors and criminals. Goffman also identified three types of stigma (physical deformities, blemishes, and tribal stigma). More recent versions of the concept differ from the original Greek concept in that rather than placing a physical mark on the signifier, the mark tends to take the form of language, actions, or inaction. Use of derogatory terms to refer to another person's actions or thoughts perpetuates mental health stigma. Other terms, not intended to be derogatory, but rather descriptive or factual, can take on negative connotations (Corrigan et al., 2011). For example, the term schizophrenia is more likely to have stigma associated with it than with other terms related to health, such as diabetes. Overall, schizophrenia and BPD tend to be more stigmatized than other mental health conditions such as depression or anxiety (Bonnington & Rose, 2014; Omori et al., 2014; Rose et al., 2011). Members of a stigmatized group might be excluded from opportunities or be subjected to treatment that would not be experienced by people who are not part of a stigmatized group. A less obvious contributor to mental health stigma is inaction, which occurs at individual or organizational levels (Corrigan et al., 2011). Not recognizing or acknowledging stigmatizing attitudes and behaviours, lack of funding for services or research, and antiquated policies reinforces mental health stigma by suggesting acceptance and approval of current practices (Corrigan et al., 2011).

Over the past 50 years, interest in understanding mental health stigma has gained momentum. Following Goffman's work in 1963, the study of stigma continued with the work of

Link (1987), Phelan and Link (1998) and Corrigan (2000), from the disciplines of sociology and psychology respectively. More recently, researchers from other disciplines, such as nursing, have studied stigma (Dardas & Simmons, 2015; Dyrbye et al., 2015; Knox et al., 2014; MacLean et al., 2015; Omori, Mori & White 2014; Pinto-Foltz & Logsdon, 2008).

Technology has changed significantly since Goffman, and others, began studying stigma. Canadian internet use has risen from 61% to 83% between 2005 and 2012 (Statistics Canada, 2010, 2013). This increase is reflective of a change in the way in which people communicate and obtain information using computers, tablets and smartphones. Given that interpersonal relationships are necessary for stigma to occur (Link & Phelan, 2006; Major & O'Brien 2005; Pinto-Foltz & Logsdon, 2008; Rusch et al., 2005) and that communication is part of these relationships, the use of these forms of media (e.g., texting, social networking) is relevant to understanding mental health stigma.

3.3 Attributes

Attributes are the characteristics mostly frequently associated with a concept. The attributes of mental health stigma, as described elsewhere in this text in (3.1 Definitions), are stereotyping, prejudice and discrimination. Other attributes of mental health stigma include discrediting, and treating differently, people with mental health concerns (othering). As suggested by Dardas & Simmons (2015), some of the attributes of self-stigma are distinct from social stigma, such as an "unpleasant personal experience due to internalizing the society's stereotypes" (p. 673). Like all aspects of mental health stigma, it is important to recognize the shared and distinct attributes of social, self and structural stigma.

Antecedents. In the most basic sense, for mental health stigma of all types to exist, a mental health concern needs to be present and societal norms in place. In an attempt to

understand or qualify a mental health concern, labels or a diagnosis are often applied. Some labels and diagnoses are associated with particular behaviours or qualities that are perceived as inferior to the norm, personally dangerous, a threat to social fabric, or unpredictable in nature (Coker, 2005; Pinto-Foltz & Logsdon, 2008). A power imbalance, with a sense of superiority and inferiority, can also exist and is closely linked to the concept of *othering*. Without separation and isolation of specific groups, stigma in all forms could not exist (Johnson et al., 2004; Link & Phelan, 2001; Omori et al., 2014; Thompson & Kumar, 2011).

The antecedents for self and structural stigma are similar to those for social stigma, but in addition to shared qualities, antecedents for self and structural stigma have unique characteristics. In the case of self-stigma, societal stereotypes are believed, accepted and applied to self. Often, for people experiencing self-stigma, there is also a sense of personal responsibility for the stigmatizing actions from others (Corrigan et al., 2011; Omori et al., 2014). For structural stigma to occur, there must first be a longstanding history of exposure to and belief in social stigma by people in a position of power. Further, a power imbalance among members of society or between society and people in positions of authority usually exists. (Corrigan et al., 2004).

Some researchers suggest that interpersonal relationships between people with mental health concerns and others were a necessary antecedent to social stigma (Link & Phelan, 2006; Major & O'Brien 2005; Pinto-Foltz & Logsdon, 2008; Rusch et al., 2005) while others found that social and self-stigma may actually be reduced through interpersonal relationships (Sandelowski & Barroso 2003). Therefore, interpersonal relationships can contribute to or reduce mental health stigma. Relationships ranged in intensity from weak to strong and include acquaintances, coworkers, friends and family. Many of these relationships develop in person, but

can also occur without face-to-face meetings, such as in online chatrooms, texting and other forms of social media.

Consequences. The consequences of mental health stigma are varied in nature and intensity and are felt not only by the individual, but also by families, friends and communities (Corrigan et al., 2011; Dardas & Simmons, 2015; Omori et al., 2014; Pinto-Foltz & Logsdon, 2008). Fear of rejection or discrimination contribute to impaired interpersonal relationships through the avoidance of situations where stigma is anticipated. This avoidance manifests as social distance or isolation and affects personal and work relationships as well as interactions within public or community settings (Corrigan et al., 2011; Sandelowski & Barroso 2003). Restricted social activities, increased absenteeism from employment, and avoidance of activities such as grocery shopping or obtaining health care services exacerbates mental health issues. Ultimately, if left unaddressed, the result, or consequence, of stigma is poor quality of life, and in some cases, death as the result of self-neglect or suicide (Corrigan et al., 2011; Dardas & Simmons, 2015; Omori et al., 2014; Phelan et al., 2008; Pinto-Foltz & Logsdon, 2008).

Contextual information. Investigation of contextual information is vital to the process of evolutionary concept analysis. Over time, needs and goals change requiring re-evaluation and refining of concepts (Rodgers & Knafl, 2000). Mental health stigma and our understanding of the same has changed over time (Corrigan et al., 2011; Dardas & Simmons, 2015; Goffman, 1963; Theriot, 2013). When the evolution of the concept is examined, it is possible to identify some of the key contextual influences, such as diagnosis, gender, age, culture, occupation, and changes in technology.

Particular mental health diagnoses are associated with distinct qualities of how stigma is experienced. People diagnosed with schizophrenia tend to experience some of the most intense

stigma as a result of others' perceptions of violent behavior (Omori et al., 2014; Rose et al., 2011). Bipolar disorder is also considered one of the most stigmatized diagnoses because symptoms such as impulsivity or mood swings result in frustration or fear in others (Bonnington & Rose, 2014). For women experiencing post-partum depression, a social phenomenon referred to as "mother-blaming" exists whereby the mother is blamed for "undesirable choices" outside of her control (Pinto-Foltz & Logsdon, 2008, p. 29). Not only is social stigma perpetuated, but self-stigma is reinforced. While many similarities exist in relation to the stigma associated with mental health concerns, there are also unique qualities related to the stigma associated with specific diagnoses.

Differences in how mental health stigma presents in regards to gender are also evident. This is experienced not only by people with mental health concerns, but also by those displaying or endorsing stigmatizing attitudes and behaviours. Societal norms and expectations frequently play a role in determining how gender impacts mental health stigma. Often, men are expected to demonstrate "agency" (Moss-Racusin & Miller, 2016, p. 321) and not show weakness when experiencing mental health concerns. Conversely, in similar situations, women are expected to instead demonstrate "communality" or "niceness" (Moss-Racusin & Miller, 2016, p. 321). These expectations, particularly for men, contribute to poor mental health care by perpetuating mental health stigma (Moss-Racusin & Miller, 2016). While there is a consensus among researchers that gender does have an influence on mental health and mental health stigma, a strong consensus about the manner in which gender affects mental health and mental health stigma is lacking. At present, gender, in relation to mental health stigma, is acknowledged, but not well understood (Chandra & Minkovitz, 2006; MacLean et al., 2013; Moss-Racusin & Miller, 2016; Stickney, Yanosky, Black & Stickney, 2012).

Generational or age differences related to mental health stigma are also noted. Younger adults tend to have higher levels of self-stigma when compared to older adults (Werner, Stein-Shvachman, & Heinik, 2009), while older adults are less likely to seek out mental health care and are more likely to endorse social stigma. Some of these differences are attributed to changes and differences in societal norms and beliefs between different age groups (Werner et al., 2009). Individual experiences, as well as generational experiences can impact these changes. Someone of the Baby-boomer generation will have had an upbringing and experiences that are different from that of a person from the Millennial generation. Furthermore, as people age and mature, values and belief systems can change.

Cultural practices can vary in relation to social structures and beliefs (Dardas & Simmons, 2015; Park et al., 2015). A person living in Canada, with mental health concerns, whose cultural beliefs are not the same as those perceived to be the norm in western culture may experience stigma two-fold. Not only might they experience mental health stigma, but also stigma related to their cultural beliefs. Dardas and Simmons (2015) explain that for Arabs who follow the teachings of Islam, seeking treatment for mental health concerns is difficult. Islamic teachings suggest followers must seek help for illness. However, because of mental health stigma, many Arab people avoid seeking treatment, thereby defying their religious and familial beliefs. For those who do seek care, it is often through religious healers rather than a health care professional. While this may address important spiritual concerns, it may not address their mental health concerns. Park et al., (2015) describe how in Asian cultures, particularly with older adults, mental health concerns are perceived as a weakness and are a personal or family concern. Further, there is a belief that a family should be the primary source of help where mental health

concerns exist. These beliefs add to the existing challenges faced for those in need of mental health care.

People working in certain occupations, such as firefighters, military, and police have had unique experiences with mental health stigma based on the requirements and expectations of their jobs. Many of these occupations have an element of danger associated with them and there is a greater potential for physical injury or increased mental health concerns. Despite these increased risks, those employed in these professions are more likely to be concerned about perceived weakness than those employed in other professions, particularly from their family, friends and colleagues. There are expectations to be stoic; seeking help is perceived as being weak (Crawford et al., 2015; Elnitsky et al., 2013; Royal Canadian Mounted Police, 2014; Stickney et al., 2012; Treatment Solutions, 2012).

Finally, technology has become ever present in daily life in the form of internet, smartphones, tablets and online communication. In the literature, much focus has been paid to the importance of examining traditional media (e.g., television, newspapers, movies) where representations of mental health are often biased, negative or inaccurate, and have the potential to perpetuate stereotypes and reinforce stigmatizing beliefs and attitudes (Caputo & Rouner, 2011; Clement et al., 2013; Theriot, 2013; Townsend, Gearing, & Polyanskaya, 2012). Some evidence exists to suggest that media can have a positive influence in reducing stigma, but this is limited (Clement et al., 2013; Theriot, 2013). Examples of strategies to address mental health stigma using newer forms of communication, such as social media and texting, are found in the grey literature. For example, in Canada, Bell Media uses a variety of platforms to raise awareness of mental health stigma, such as *Let's Talk* and *Clara's Big Ride* in 2014 (Bell Media, 2016). In the United Kingdom, and globally, Kate Middleton and other members of the royal

family (the younger generation) have publically supported measures for increasing awareness of mental health and reducing mental health stigma. Videos and websites related to their projects appear on social media and, online entertainment and news sites (Daily Mail Online, 2016; Perry, 2016, March). On the other hand, the role of anonymity and personal accountability, related to stigmatizing behaviours and social media are not discussed.

Context, in regards to mental health stigma, is generally focussed on the stigmatized person. Little is written about the role of context, mental health stigma and those who display stigmatizing attitudes and behaviours (stigmatizer). Stickney et al., (2012) suggest that the ethnicity of the stigmatizer may play a role in the degree of stigma directed towards people with mental health concerns. The results of their research indicated that, "Asian American and African American respondents will be less stigmatizing of mentally-ill individuals versus Caucasian respondents" (p.251). Older populations are also more inclined to endorse stereotypes related to mental health, thus perpetuating mental health stigma (Werner et al.,2009).

3.4 Exemplar

The exemplar presented here is a composite representation of data obtained from the literature and the author's professional experience. This strategy deviates from Rodgers' (Rodgers & Knafl, 2000) description of the process for identifying an actual exemplar, and was chosen to avoid confidentiality issues.

Christina, a 32-year old administrative assistant, has missed a number of days of work and has now exhausted her sick time and vacation days. She has also been late on several occasions and some work assignments were not completed on time. Christina's supervisor wanted to be understanding, but also needed a reliable employee. Although Christina was doing her best she knew she was not fulfilling her job responsibilities. Often, she was exhausted and

struggled to get out of bed some days. She frequently felt ill, with chronic headaches occurring almost every day.

Christina was having difficulty outside of work as well. She was a month behind on her rent, had received collection notices for unpaid bills, and struggled to pay for food, and gas for her car. Her friends and family invited her to social events, but she was often too tired to attend or experienced intense anxiety about the event. As a result, she often canceled plans at the last minute, which was frustrating for Christina and her friends and family. Christina was becoming increasingly isolated and withdrawn. While her friends rarely commented, Christina noticed that she received fewer invitations to social events. She thought her friends were angry with her because she declined or canceled invitations. Christina preferred to avoid family gatherings as she feared being asked questions about her work or other aspects of her life. On one occasion, her mother told her that she was *thoughtless* and *irresponsible* for cancelling plans at the last minute. Her mother could not understand why, when she was so smart and capable, she was having financial difficulties. Her mother then told her she needed to *grow up* and *start making something of herself*. Sometimes, Christina overheard her family referring to other people as *crazy* or *not all there* when people made choices or demonstrated behaviours deemed to be outside of the family norm.

Christina had hidden the severity of her depression and anxiety from her family, friends, coworkers and employer. She felt ashamed and embarrassed that she could not accomplish what everyone *knew she could* and felt that she was letting her family, friends, and coworkers down.

As a young adult, Christina had been hired as an assistant at a small office. She preferred the smaller office environment as she felt less anxious with fewer people around her. Initially, she was thriving at her new job. She was well liked by her coworkers and received praise from

her supervisor. However, after a year of employment, Christina's grandfather died and her anxiety and depression returned. This was when her difficulties at work began. Feelings of worthlessness returned and she contemplated suicide. Many people in Christina's life were feeling frustrated. Some were concerned about Christina's health, but did not know what to do or felt uncomfortable discussing mental health. Most were not aware of what was happening to Christina because she went to great effort to conceal her struggles.

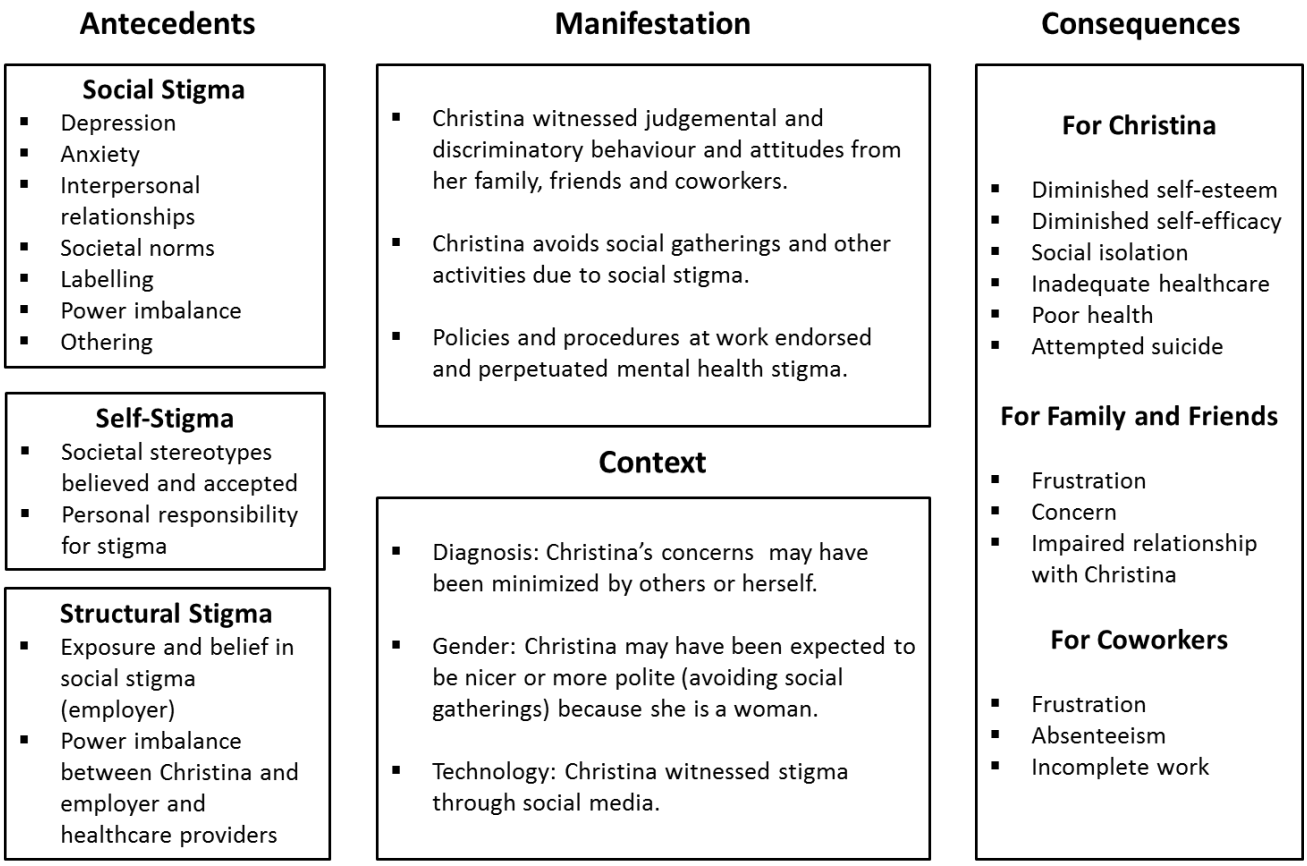
Christina knew that she needed some help but did not want to go to the doctor because she was worried she would be reprimanded for not being compliant with care. She did not take her medication consistently, as the side effects were intolerable. She had stopped attending therapy when she could not get time off work. Finally, she stopped treatment all together, because she could no longer afford to pay for it. She did have health insurance through work, but did not want to make a claim. The manager responsible for health insurance claims was also responsible for payroll, vacation and sick time requests. In the past, Christina had heard the manger criticizing employees for taking *mental health* days because *they weren't really sick, just lazy*. The manager also instituted a policy where a note from a doctor was required if an employee was absent for more than two days. If Christina claimed her health expenses, she was worried she would be perceived as weak or incompetent. She was also worried that other staff members would find out about her treatment or the reason for her absences and treat her differently. She had seen comments and jokes that her coworkers had posted online that were critical or judgemental of individuals with a mental health concern or about mental health issues in general. Words like *crazy* or *psycho* were used freely and negatively. Because of her fears and worries, Christina continued to avoid treatment in an effort to protect herself from judgement, ridicule and devaluation.

Christina's thoughts and experiences are indicative of three types of stigma: social; self; and structural stigma. Social stigma occurred when friends, family, colleagues or health care providers endorsed and perpetuated prejudicial and discriminatory stereotypes. This led to feelings of inferiority, low self-esteem and devaluation, which caused Christina to avoid situations where she anticipated stigmatizing attitudes and behaviours. This avoidance, compounded with her belief in the stigmatising messages she was receiving about herself, were described as self-stigma. Unfortunately, this type of stigma also increased her isolation as she avoided participating in situations where she would be subjected to the same. Structural stigma was evident in the personnel policies implemented at her place of employment. The person who was responsible for all personnel matters, clearly displayed stigmatizing attitudes and behaviours consistent with social stigma. There was no other option but to interact with this person for matters of sick leave and health insurance. This, combined with perpetuating stereotypes about mental health (e.g., lazy, not real) and implementing a policy requiring a doctor's note for absences, contributed further to Christina's avoidance of care for her mental health.

Throughout the course of her struggle with anxiety and depression, Christina experienced a substantial amount of stigma related to her mental health. The consequences of mental health stigma were far-reaching and impactful. Social stigma was apparent in her interactions with her family and friends. At work, structural stigma occurred in a way that prevented Christina from seeking help. As a result of her belief in the stigmatizing messages she was receiving from a variety of sources, Christina also felt self-stigmatized. This exemplar illustrates the multi-faceted nature of mental health stigma (see Figure 2).

The results of this concept analysis demonstrate the complexity of mental health stigma. While dictionary definitions exist, they provide only a simple description of the word *stigma*.

Figure 2: Exemplar for mental health stigma



Scholarly definitions from the peer-reviewed literature contain a more dynamic explanation of mental health stigma as a concept, including a distinction between types of stigma. However, as Rodgers (Rodgers & Knafl, 2000) note, a definition is not sufficient to fully understand a concept. The evolution of the concept, ranging from Goffman's (1963) work through to advances in technology and newer methods of communication, are outlined. Finally, an exemplar is presented to provide a practical example of how the concept might appear in a real life setting. These results are the basis for the final phase of the concept analysis (Phase 7), which is to identify implications and future research for concept development.

Chapter 4: Discussion

A concept analysis was undertaken to better understand the concept of mental health stigma. The results of this concept analysis demonstrate the dynamic and complex nature of mental health stigma. Existing definitions provide relatively simplistic descriptions of what stigma is, but do not explain the unique qualities, or attributes of stigma, particularly as they relate to mental health. Three types of stigma: social stigma; self-stigma; and structural stigma, are impacted by each other as well as by contextual variances (e.g., diagnosis, gender, age, culture, occupation, technology). The nature and context of stigma are not independent of each other, but rather are interdependent, with one influencing another. These complex and interrelated components of mental health stigma highlight the need to better understand the intricacies of this concept. Mental health stigma is pervasive in our society and varies by context. Context contributes significantly to the dynamic nature of mental health stigma and plays an important role in understanding the concept. Several contextual factors have been identified, with some of the key findings of this concept analysis being the need to recognize differences in the way that mental health stigma manifests in relation to a specific condition or diagnosis, gender, culture and technology.

Much of the current, peer-reviewed literature focusses on mental health stigma related to serious mental illnesses (SMIs), such as schizophrenia, but not other mental health concerns, such as anxiety. Many people with mental health concerns, whether classified as a SMI or not, are at risk of experiencing the negative effects of mental health stigma. Minimizing a particular concern or condition can contribute to poor mental health by leading an individual to avoid seeking care as they feel their concern is not valid, and does not warrant help. Some diagnoses are subject to increased levels of mental health stigma (e.g., bipolar disorder vs. anxiety) or to different types of mental health stigma (e.g., social stigma vs. self-stigma) (Bonnington & Rose,

2014; Omori et al., 2014; Rose et al., 2011). Building on what is currently known about how stigma presents, dependant on diagnosis, or lack of diagnosis, is important in developing tailored strategies to reduce mental health stigma that recognize, rather than minimize, particular diagnoses.

Men and women both can experience mental health stigma, but it may present differently because of various social expectations. There is also inconsistent information regarding the part that gender, or gender specific roles play for those displaying stigmatizing behaviours. To better address mental health stigma within the context of gender, more research is needed to identify the nuances of this contextual factor as it relates to mental health stigma.

Canada is a multicultural country, with citizens of many diverse backgrounds. Like other health concerns, it is important to recognize and acknowledge how culture impacts mental health and mental health care, including mental health stigma. One must seek to better understand and consider practices and beliefs that may necessitate alternative ways in which mental health stigma is addressed. As Park and associates (2015) note, in some cultures, mental health issues are viewed as being very personal, as a sign of weakness, and should be managed within the family. This can pose a challenge and create conflict for those in need of mental health services. The best approach, in regards to reducing mental health stigma, will vary from person to person, family to family, and within cultural groups. Interventions and strategies must be culturally appropriate and relevant to be effective (Dardas & Simmons, 2015; Park et al., 2015).

The advent of technology, such as social media, texting and the internet have forever changed the way we communicate. The volume of information available, and the way in which we share it, has changed significantly over the past 25-30 years and has had a direct impact on mental health stigma. There is now access to a nearly unlimited selection of topics, and

unrestricted channels for interacting with each other. Many people now seek health information, particularly mental health, online (Townsend, Gearing, & Polyanskaya, 2012). There is an aspect of convenience and anonymity associated with the internet and some people may be more comfortable participating in online chat rooms or discussion groups than they are speaking directly with their friends and family. Unfortunately, the convenience and anonymity provided by new communication technology can also have negative effects, such as cyber-bullying, which can contribute to mental health stigma (Caputo & Rouner, 2011; Clement et al., 2013; Theriot, 2013; Townsend, Gearing, & Polyanskaya, 2012). There is some research regarding the benefits of technology as it relates to mental health stigma, but research is limited (Clement et al., 2013; Theriot, 2013). Further research related to how new communication technology impacts mental health and how it might enhance efforts to reduce mental health stigma is warranted.

Finally, the role of the stigmatizer, especially in light of contextual factors, has not been fully addressed in the literature. Most studies concerning stigma are specific to the person who is experiencing stigma, as opposed to the stigmatizer. It is vital to understand the motivation behind stigmatizing attitudes and behaviours to disrupt the cycle of mental health stigma. This analysis provides an opportunity to consider and discuss how contextual variables might impact how, and why, stigmatizing attitudes and behaviours are endorsed and perpetuated, as well as what might assist in reducing stigma.

Mental health stigma is a complex and dynamic phenomenon. Although much information on mental health stigma is available, gaps in articulation and understanding of the concept are evident. Most authors agree that more investigation is needed to better understand not only the relationship between the types of stigma, but also the contextual variances (Conner

et al., 2010; Dardas & Simmons, 2015; Moss-Racusin & Miller, 2016; Omori et al., 2014; Park et al., 2015; Pinto-Foltz & Logsdon, 2008; Werner et al., 2009).

4.1 Implications for further development of the concept

Based on this analysis, several areas for further research and development of mental health stigma are identified. These include more focus on mental health concerns other than SMIs, contextual variances, and the role of the stigmatizer. By focusing on, and addressing these gaps in knowledge, it will be possible to advance the concept of mental health stigma. Further research and development in theses areas will facilitate the creation of new strategies to reduce mental health stigma. Furthermore, policies, clinical practice, and curricula will need to be revaluated and updated.

Health care providers have an opportunity to recognize mental health stigma in various practice settings. Stigmatizing attitudes and behaviours can be observed within ourselves. Self-reflection among health care providers should be promoted. Stigma may also be recognized in others, including our colleagues, managers, clients or patients and their family and friends. Stigma may result in a variety of ways such as the care provided or not provided and conversations with others. Once stigma is recognized, the next step is to move towards further understanding the nature of mental health stigma to increase awareness, reduce mental health stigma, and improve access to care. Tailoring of care must acknowledge the unique individual or family context (Dardas & Simmons, 2015). Incorporating mental health information into workplace learning similar to other topics (e.g., safety, orientation to specific equipment) is another way to address mental health stigma among health care providers. In fact, education on mental health stigma for all health care providers should be a regular component of continuing education activities.

Integrating mental health stigma into post-secondary curriculum for health care providers can aid in increasing knowledge and reducing stigma, thereby leading to improvements in access to care (Rutter, Taylor & Branford, 2013). By integrating mental health stigma into educational programs, health care providers have the opportunity to increase their knowledge and develop skills from the start, at the beginning of their careers. Moreover, by including mental health stigma as part of the regular curriculum, mental health and mental health stigma become a normalized part of overall health, further reducing stigma and improving mental health care (Rutter et al., 2013). Limited research focused on curriculum planning or evaluating outcomes related to mental health stigma and post-secondary education exists. There is room for growth in this important area that could potentially have a positive impact on mental health care.

Health care organizations as a whole, including decision-makers, have a responsibility to recognize and address mental health stigma when planning and creating policies that impact patient and client care. Organizational policies and structural stigma impact not only clients and patients, but staff (e.g., health benefits and policies). Health care organizations have a dual responsibility as providers of care to the community as well as employers, to ensure that mental health is acknowledged and addressed in a manner that is reflective of all health priorities. Government agencies and other organizations have a similar responsibility to recognize and address mental health stigma in the policies, procedures, and regulations they create. This is true whether the policies are directed towards funding of mental health services or directed towards access, planning and implementation of health care services, housing and employment for those with mental health concerns (Corrigan et al., 2004). Research in the area of policy development should begin by determining what best practices are. By understanding best practices, appropriate and effective policies can be developed to address mental health and stigma.

4.2 Strengths and limitations of the concept analysis

A key strength of this paper is the use of Rodgers' Evolutionary Model to explore and clarify the concept of mental health stigma in a broader context. In using this framework, it was possible to approach the concept in a way that accounts for a variety of changing contextual factors. By identifying these contextual factors, discussions can occur that will consider not only how different types of mental health stigma manifest, but what role context plays. Further, this framework emphasizes the need to continuously revaluate the concept as it evolves.

The complex and multifaceted nature of mental health stigma presented some challenges in the process of gathering and analysing data. While many areas of the concept were clarified, such as types of stigma, attributes and contextual variances, and gaps in knowledge identified, not all areas were fully explored. These deficits may have attributed to the literature search and chosen terms, or the nature of a developing concept and its relatively early understanding of some of the contextual factors, such as technology.

Another limitation of this concept analysis is the lack of a more systematic approach to the grey literature search. It was important to include grey literature in this analysis as a means to provide data about the type of information that may be accessed by those who have limited access to other forms of data such as the peer-reviewed literature. However, because grey literature is produced and presented differently from peer-reviewed literature, a systematic approach can be more challenging. Furthermore, due to the breadth of grey literature available, a concept analysis on mental health stigma specifically focussed on the grey literature could be undertaken. It was not within the scope of this paper to complete an in-depth analysis of the grey literature.

Ultimately, the purpose of a concept analysis is to identify areas for development and inquiry rather than provide a final statement on the topic of interest. While this objective was achieved, it also revealed additional areas for exploration. Having multiple areas of focus requires shifting attention between each area and can make generalizing results difficult. In the future, it may be helpful to continue to analyse mental health stigma by either focusing on one type of stigma (social, self, structural) or a single context (technology, gender, age, occupation).

Chapter 5: Conclusion

This concept analysis explored the nature and nuances of the relationship between stigma and mental health to gain a better understanding of the concept thereby potentially facilitating the improvement of access to mental health care and quality of life. Using Rodgers' Evolutionary Method as a guide, a literature review was completed using peer-reviewed and grey literature. Various definitions and attributes were identified and described and an exemplar case was presented. Implications for practice and further advancement of the concept were outlined.

This concept analysis is unique in that it highlights the pervasive nature of mental health stigma while exploring the impact of contextual factors. The complex nature of mental health and mental health stigma make it essential to expand the focus of strategies geared towards reducing stigma in an effort to reflect the diverse nature of this issue. Given the significant consequences of mental health stigma, timely action is required. Current, available literature demonstrates a growing interest in better understanding of the changing landscape of mental health stigma. However, much of this information is slow to become available and is not easily accessed by all stakeholders affected by mental health concerns.

This analysis has the potential to improve access to mental health care by highlighting the need to increase awareness of mental health stigma. By developing new and innovative strategies focused on mental health stigma, based on the information gathered through this concept analysis, improvement in access to mental health care can be realized. Setting priorities to address inadequate mental health services will result in more effective allocation of funding and other resources. Policy change at all levels can also assist in more effective ways of managing mental health stigma and providing more appropriate mental health care for all citizens.

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Appendix A

Peer Reviewed Literature Data Extraction Table

Author	Context	Purpose	Findings
1. Bonnington, O. & Rose, D. (2014)	• Qualitative study explores stigma among people with bipolar (BD) or borderline personality disorder (BPD)	• Explore stigma and BD and BPD, as focus is often on schizophrenia and depression • Explain stigma in light of structural antecedents	• People with BD and BPD experienced stigma and discrimination in social contexts. • BD most often with employment. BPD most often with health care • Oppression, marginalization and violence experienced by both groups.

Author	Context	Purpose	Findings
2. Coker, E. M. (2005)	• Qualitative/ quantitative study explores psychiatric stigma in Egypt	• Elicit responses and viewpoints about stigma and social distance from a lay perspective	• Mental health stigma varies with cultural meanings • Illness is a reflection of society, not the individual, resulting in less social isolation. If family unable to resolve illness social isolation can occur. • Social distance linked with societal role, not bizarre behavior or a mental illness label
3. Corrigan, P. (2004)	• Stigma and mental health care • Public and self-stigma	• Describe how stigma interferes with mental health care	• People experiencing stigma avoid/do not fully participate in care • Social disapproval, decreased self-esteem with labeling

Author	Context	Purpose	Findings
4. Corrigan, P. W., Kerr, A. & Knudsen, L. (2005)	• Mental illness and stigma and diminished QOL • Public and self-stigma	• Evidence review of mental illness and the impact stigma as well as strategies to reduce the negative impact of stigma	• Life opportunities hampered by public and personal stigma • Cognitive, motivational, structural models explain mental health stigma
5. Corrigan, P.W., Markowitz, F.E & Watson, A.C. (2004)	• Structural stigma discrimination and mental health	• Explore the relationship between structural stigma and mental health	• Structural stigma is intentional or unintentional • Structurally focused strategies challenge individually focused strategies
6. Corrigan, P. W. & Rao, D. (2012)	• Self-stigma in mental illness	• Examine advantages and disadvantages of disclosure	• People internalize stigma when exposed to social stigma, but not all • Participating in a group to identify/challenge self-stigma may be beneficial

Author	Context	Purpose	Findings
7. Dardas, L. A. & Simmons, L.A. (2015)	• Concept analysis of mental health stigma in Arab families	• Clarify the concept of mental illness stigma as it applies to Arab families.	• Culture belief and practices influence mental illness and stigma in a variety of ways
8. Dyrbye, L. N. et al. (2015)	• Stigma, personal experiences and help-seeking behaviors of medical students with burnout	• Evaluate help-seeking behaviors of medical students with burnout and compare their stigma perceptions with the general population	• Few students with burnout seek help. Stigma, negative experiences and learning culture may contribute to inaction may contribute to this inaction
9. Hasson-Ohayon, I. et al. (2012)	• Shame and guilt related to self-stigma and mental illness	• Examined the relationship of shame and guilt to mental illness and self-stigma	• Shame but not guilt affects the relationship between insight and self-stigma.

Author	Context	Purpose	Findings
10. Hinshaw, S. P. & Stier, A. (2008)	• Stigma and mental illness	• Multi-disciplinary review of mental illness and stigma. Define and explore different perspectives, including historical	• Stigma results in devaluation, harm to person and family • Several factors influence (self-stigma, severity, society) • Study of same important and lacking
11. Johnson, J. L., et al. (2004)	• Othering in health care	• Explore interactions between health care providers and South Asian immigrant women • Describe othering and their effects of same	• Three forms of othering noted: essentializing, culturalist and racializing explanations • Coping strategies and managing othering experiences described

Author	Context	Purpose	Findings
12.Knifton, L. (2012)	• Mental illness stigma in ethnic minority communities • Community based participatory research.	• Examine beliefs, stigma and effectiveness of campaigns to address mental health with multi-cultural communities	• Mental illness prevalence is higher in communities experiencing multiple prejudices and disadvantages
13. Knox, et al. (2014)	• Mental health stigma in Australian pharmacies	• Explored experiences of mental health stigma of pharmacy consumers and caregivers	• Stigma impedes ability to engage with community pharmacies • Good relationships can reduce stigma
14. Link B. G. & Phelan J. (2001)	• Mental health stigma	• To conceptualise mental health stigma	• Revisited stigma concept after Goffman. • New definition of mental health stigma developed • Emphasized social context/influences and identified new areas of study

Author	Context	Purpose	Findings
15. Link B. G. & Phelan, J. (2014)	• Focus on stigmatizer	• Examine how the goals of stigmatizer are hidden in the coping efforts of people with mental illnesses.	• "Stigma power" is the actions of the stigmatizers leading to further stigmatization
16. Link, B. G., Wells. J., Phelan, J. C., & Yang, L. (2015)	• "Symbolic Interaction Stigma" • Reactions of others related to mental health stigma	• Examine the differences between self and public stigma and how the reactions of other impact care.	• Awareness of symbolic interaction and differences between self and public stigma useful in anti-stigma programs
17. MacLean, A., Hunt, K., & Sweeting, H. (2013)	• Mental health, children and adolescents and gender differences in understanding and help-seeking	• Explore understanding of symptoms of mental health problems and beliefs about help seeking.	• Many delay/avoid disclosing problems. • Gender/age differences noted • Health promotion should begin early in school

Author	Context	Purpose	Findings
18. Omori, Y., Mori, C & White, A. H. (2014)	• Concept analysis of self-stigma in schizophrenia	• Clarify and define stigma in schizophrenia	• Mental illnesses may have different stereotypes • Lack of awareness is common in schizophrenia but not focused in self-stigma studies
19. Pinto-Foltz M. D. & Logsdon, M.C. (2008)	• Concept analysis of stigma and post-partum depression	• Clarify modern use of stigma and mental illness, within postpartum depression • Promote further dialogue about stigma in nursing	• Basis for more research • Nurses can protest inaccurate information to reduce incidence in public and media
20. Pattyn, E., Verhaeghe, M., Sercu, C. & Backe, P. (2013)	• Medicalizing versus psychologizing mental illness • General population study	• Explore how medicalizing versus psychologizing mental illness impacts stigma and help seeking	• Medicalizing mental illness involves biopsychosocial attributes • The “disease view” facilitates medical treatment, but labelling seems to add to stigma

Author	Context	Purpose	Findings
21. Pattyn, E., Verhaeghe, M., Sercu, C. & Backe, P. (2014)	• Public stigma, self-stigma and help seeking	• Examine the impact of public and self-stigma on help-seeking	• Self-stigma resulted in less importance re: care provided by professional • Public stigma resulted in less importance re: informal help seeking
22. Pedersen, E. R. & Paves, A.P. (2014)	• Public stigma, personal stigma, help seeking and young adults	• Expand on previous research and examine the discrepancies between perceived public stigma and personal stigma	• Young adults would not view someone differently (mental health treatment) • Women more likely to think others would view/treat them negatively (depression)
23. Perlick, D. A. et al. (2011)	• Self stigma in family members of people with mental illness	• Report preliminary findings from a family intervention to reduce self-stigma in family members	• Peer-led group may be more effective than clinician led in reducing family self-stigma for low-moderate anxiety

Author	Context	Purpose	Findings
24. Pescolido, B. A. & Martin, J. K. (2015)	• Stigma in general	• Conceptualize stigma through development of the transdisciplinary "stigma complex" framework	• Transdisciplinary practice enhances study but creates a "haze" of concept. • Research needed to understand stigma within various disciplines
25. Phelan, J. C., Lucas, J, W., Ridgeway, C.L. & Taylor, C. L. (2014)	• Stigma and status related to population health	• Consider novel conceptualizations of stigma to understand the relationship between stigma, status and public health	• Stigma is inter/intrapersonal, and a macro-level process • Impact on health should be given the same attention other status based factors
26. Rusch, N., Angermeyer, M. C., and Corrigan, P. W. (2005)	• Reducing mental illness stigma • Individuals and self-stigma	• Clarify the concept of mental illness stigma and discuss consequences	• Self-stigma and fear of stigma are barriers to health services. • Stigma reduction strategies: protest, education and contact with persons with mental illness

Author	Context	Purpose	Findings
27. Rusch, N., Evans-Lacko, S. & Thornicroft, G. (2012)	• Mental illness and public views of disclosure	• Explore public views and attitudes towards people with mental illness and reactions to one's own potential mental illness	• Use of the term "mental illness" may indicate higher mental health literacy • A broader concept of mental illness could increase negative attitudes but increase disclosure at work • Public views are context-dependent and should be taken into account in anti-stigma campaigns.
28. Rutter, P., Taylor, D., & Branford, D. (2013)	• Mental health curricula at schools of pharmacy in the UK	• Assess mental health education in the undergraduate pharmacy curricula in the UK to determine graduate preparation related to mental health.	• Some aspects of mental health were taught, but social aspects were overlooked • Undergraduate education prepared students in some areas but not all (i.e. social)

Author	Context	Purpose	Findings
29. Sadler, M. S., Meagor, E. L. & Kaye, K. E. (2012)	• Public stigma towards mental illness	• To examine how emotion affects public stigma towards mental illness	• Emotions share similar motivators as behaviour (avoid or approach) • Anti-stigma campaigns should emphasize ability and/or social connection
30. Verhaeghe, M., Bracke, P. & Christiasens, W. (2010)	• Stigma and client satisfaction of mental health services.	• Explore the relationship between stigma and client satisfaction of clients using mental health services • Focused on attitudes, emotions, and reactions	• Importance of studying multiple dimensions of stigma related to mental health along with multiple outcomes.
31. Vogel D. et al. (2011)	• Self-Stigma, masculine norms and help-seeking attitudes • Majority and non-majority populations	• Examined relationships between conformity, masculine norms and attitudes toward counseling	• Self-stigma linked to unfavorable attitudes towards help seeking • Focus on research and clinical practice specific to conformity and masculine norms

Author	Context	Purpose	Findings
32. Yearwood, E. L. & DeLeon Siantz, M. L. (2010)	• Global issues in mental health across the life span	• Describes and explores global issues in mental health across the life span	• Move away from pathologic view and involve government and organizations • Nurses have an opportunity to significantly affect care and treatment globally

Appendix B

Grey Literature Data Extraction Table

Source	Context	Purpose	Findings
1. Bell Media (2016)	• Canadian telecommunication company's anti-stigma campaign website	• Describe anti-stigma initiatives, provide information and news about mental health, as well as links to help resources.	• Well publicized anti-stigma initiative, uses celebrity spokespeople. • Uses texting as a medium to communicate about mental health and raise funds for anti-stigma initiatives. • Easily accessible to general public, clear, concise information. • References well known advocacy and research organizations (i.e. CMHA, MHCC)
2. Canadian Mental Health Association Ontario (2015)	• National, voluntary, mental health advocacy/education organization formed in 1918 • Document on website	• Describe stigma and discrimination	• Describes stigma and discrimination and influences on mental health. • Provides strategies for counteracting same.

Source	Context	Purpose	Findings
3. Government of British Columba (2010)	• Online version of a provincial government plan intended to address mental health and substance abuse.	• Three overarching goals provided: improve mental health and well-being of the population, improve quality and accessibility of services and reduce the economic costs.	• Detailed document outlining a ten-year plan to address mental health and substance abuse. • Refers to the Mental Health Commission of Canada's national anti-stigma initiative as part of an action plan. • One goal of the action plan is to have more people living with mental illness report more inclusiveness (through less stigma) by 2015.
4. Government of Ontario (2011)	• Online version of a provincial government plan intended to address mental health and substance abuse	• Four overarching goals: improve mental health and well-being, create healthy communities, identify mental health and addictions problems early and provide person-directed health and human services	• Detailed document outlining a plan to address mental health and substance abuse. • Multiple areas addressing specific goals. • One goal to "create healthy, resilient, inclusive communities" through reduced public stigma

Source	Context	Purpose	Findings
5. Mental Health Commission of Canada [MHCC] (2013)	• The MHCC is funded by Health Canada • Has a 10-year mandate (2007-2017). • Reduce stigma, advance knowledge exchange and help people who are homeless living with mental health problems.	• Final report on structural stigma related to mental illness	• Describes structural stigma characteristics. • Provides strategies for addressing same (e.g. education, research) including plan of action.
6. Mental Health Commission of Canada (2015c)	• See above	• Document on website outlining mental health stigma	• Describes stigma, activities to reduce stigma and relevant learnings
7. Royal Canadian Mounted Police (2014)	• The Royal Canadian Mounted Police (RCMP) is the Canadian national police service	• Webpage outlining RCMP mental health strategy (2014-2019) for employees	• Describes mental health stigma and how it affects members of the RCMP and civilian employees. • Outlines mental health stigma within the RCMP • Outlines goals and 5 key strategy areas, including strategies to reduce mental health stigma