Reducing Stigma Related to Mental Disorders: Initiatives, Interventions, and Recommendations for Nursing

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Twenty percent of Americans suffer from mental disorders, but most do not receive treatment. Stigma is an important barrier to mental health treatment and recovery. This article aims to summarize current national initiatives to reduce stigma, clarify the current knowledge of stigma-reducing interventions, and provide recommendations to nurses on implementing and investigating stigma-reducing interventions.

ONE IN FIVE Americans suffers from a mental disorder; however, most do not receive effective treatment (Department of Health and Human Services, 1999). Underutilization of mental health services and early termination of mental health treatment are largely attributed to stigma (Corrigan, 2004a). Thus, individuals with mental disorders fear the consequences of stigma and are particularly concerned with how influential others may view them once they disclose their disorder (Corrigan, 2004a). Stigma is a "collection of negative attitudes, beliefs, thoughts, and behaviors that influence the individual, or the general public, to fear, reject, avoid, be prejudiced, and discriminate people" (Gary, 2005a, p. 980). Stigma is a serious problem and a barrier for achieving life goals in those with mental illness. Stigma impedes mental health treatment seeking, erodes self-esteem, and limits one's social network and employment opportunities (Corrigan, 2004a).

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0883-9417/1801-0005$34.00/0
doi: 10.1016/j.apnu.2008.02.010

National calls to reduce stigma toward mental disorders have been issued by both President George W. Bush, in his New Freedom Commission on Mental Health (2002), and the Surgeon General (Department of Health and Human Services, 1999). Despite these national initiatives, little progress has been made to establish effective stigma-reducing interventions. More evidence about the effectiveness of existing stigma interventions along with a better understanding of the nature, causes, and consequences of stigma are urgently needed. This article summarizes current national initiatives to reduce stigma, clarifies the current evidence on stigma-reducing interventions, and encourages nurses to take specific actions to reduce stigma toward mental disorders.

CURRENT NATIONAL INITIATIVES TO REDUCE STIGMA

Over the last 10 years, stigma toward mental disorders has been acknowledged as a barrier to mental health treatment and recovery. In 1999, the Surgeon General called for approaches to overcome stigma as a priority for the new millennium. In April 2002, President George W. Bush launched The New Freedom Commission on Mental Health. The President's New Freedom Commission on Mental Health (2007) strives to help individuals with mental disorders lead normal lives similar to individuals without mental disorders. Both the Surgeon General's Report on Mental Health and

The New Freedom Commission on Mental Health affirm that overcoming stigma is the key to improving access to mental health treatment and supporting recovery.

Currently, in the United States, many organizations have initiatives to reduce stigma toward mental disorders. In 2003, the U.S. Department of Health and Human Services Substance Abuse and Mental Health Service Administration (SAMHSA) published the first semiannual memorandum discussing purpose, current antistigma programs, and research efforts (U.S. Department of Health and Human Services: The Resource Center to Address Discrimination and Stigma With Mental Illness, 2003). Today, SAMHSA is a resource and liaison for individuals and groups interested in combating stigma. SAMHSA publishes a quarterly memorandum that reports advances in stigma research and highlights successful stigma-reduction programs. Approximately six times a year, SAMHSA hosts teleconference trainings to advance knowledge about stigma and stigma reduction and to foster partnerships between consumer groups, businesses, local government agencies, and other organizations interested in combating stigma. SAMHSA offers a free resource tool kit, Developing a Stigma Reduction Initiative (available at www.stopstigma.samhsa.gov), to raise awareness about mental health and assist organizations in fighting stigma.

The National Alliance on Mental Illness (NAMI, 2007), the nation's largest grassroots mental health organization, works to eliminate the stigma associated with mental disorders and improve the quality of life for those with mental disorders. In an effort to fight stigma, NAMI uses protest, personal contact, and community education. *StigmaBusters* is a protest approach used by NAMI to fight stigma. StigmaBusters approaches individuals in the media who inaccurately portray mental disorders and demands that they stop inaccurate portrayal. *In Our Own Voice*, a manualized contact and educational program, is designed to increase mental health knowledge and reduce stigma. In Our Own Voice consists of two consumers (people who have recovered from a mental disorder and have received In Our Own Voice training) sharing their experiences of living with and recovering from a mental disorder. In Our Own Voice has been presented to lay and professional audiences.

The Carter Center Mental Health Program offers a broad approach to combating stigma by supporting policy change (Palpant, Steimntiz, Bornemann, & Hawkins, 2006). Policy change is facilitated through the Mental Health Task Force, promotion of mental health, illness prevention, and support for mental illness recovery (Palpant et al., 2006). Projects and programs for decreasing stigma and promoting mental health issues at the Carter Center include symposiums on mental health policy, mental health forums, public outreach (Conversations at the Carter Center), and fellowships for mental health journalism (Palpant et al., 2006).

More recently, seven nonprofit organizations (representing health care professionals and individuals with mental disorders) have developed the coalition Depression is Real (2007) and plan to eliminate stigma toward mental disorders. In September 2006, the *Depression is Real Campaign* was launched with the mission of clarifying misconceptions about depression. The Depression is Real Campaign utilizes public service announcements (radio, television, and print) to educate the public about depression and offer hope to those with depression. The campaign web site (DepressionIsReal.org) provides information about depression screening, treatment, and signs and symptoms of depression. Information about depression throughout the life span, depression in minorities, mental health disparity, how to find social support, and how to locate mental health professionals is also available on the web site.

Global approaches to combat stigma toward mental disorders are beginning. In 1996, the World Psychiatric Association began an initiative — the *Open the Doors* program — to combat stigma associated with schizophrenia and increase mental health knowledge. Open the Doors is collaborative, multicentered, and involves family and patient organizations. Open the Doors encourages action to decrease prejudice and discrimination. Outreach is driven from the perspective of those experiencing stigma opposed to established mental health theory that may not have been tested in diverse cultures (Okasha, 2007). Open the Doors recognizes cultural, socioeconomic, and demographic differences. The program has been adapted for different countries and is available in nine different languages.

EVIDENCE ON INTERVENTIONS TO REDUCE STIGMA

To summarize the current evidence of stigma-reducing interventions, we conducted a literature

review focusing on the disciplines of nursing, psychology, and medicine (psychiatry). Although evidence from several randomized clinical trials would have provided the highest level of evidence upon which to base nursing practice and research (Melnyk & Fineout-Overholt, 2005; Oxford Centre for Evidence-Based Medicine, 2001), few randomized clinical trials related to stigma-reducing interventions have been conducted. Therefore, a narrative review approach was used because stigma is grossly understudied and is an evolving concept in nursing (Collins & Fauser, 2005).

CINAHL, MEDLINE, and PsycINFO databases were searched for the following terms: *stigma* and *intervention* (7 results), *mental illness* and *stigma* (25 results), *depression* and *stigma* (21 results), *schizophrenia* and *stigma* (41 results), and *bipolar disorder* and *stigma* (2 results). Search limitations were set for humans, English, and the publication period January 2002–December 2006. *Depression*, *schizophrenia*, and *bipolar disorder* were chosen as search terms because these disorders are often stigmatized (Crisp, Gelder, Goddard, & Meltzer, 2005; Mann & Himelein, 2004). Although some articles included *stigma* in the title, they failed to discuss stigma in the body of the article. Therefore, articles were further limited by the requirement that *stigma* must be stated in the title and the abstract at least once. Search limitations were set to maintain a focus on stigma toward mental disorders.

Because stigma research (particularly intervention research) is immature, it is important that promising studies with less evidence be considered in literature reviews (Collins & Fauser, 2005). A random sampling of publications was used to capture a variety of stigma research opposed to a limited view that was investigator biased (Fink, 2005).

Most of the articles yielded from the search were found in psychology, psychiatry, and nursing and discussed the consequences of stigma. Most of the research has been nonexperimental, correlational, and qualitative in design. Qualitative and nonexperimental research is valuable and contributes to the science by providing a greater understanding of the stigma and its associated variables. However, these methods of inquiry do not directly translate into effective stigma interventions. Few intervention studies have been conducted in the United States (particularly with adolescents and youth). Most of the studies have been conducted in the United Kingdom and Australia.

Nursing

Overall, the nursing literature provides (a) a description of those individuals who tend to stigmatize, (b) insight into the experience and management of stigma, and (c) information about stigmatized individuals' preference for stigma-reduction efforts and their preference for accessing mental health services. Only one intervention study in nursing (conducted in the United Kingdom), Essler, Arthur, and Stickley (2006), successfully reduced stigma among adolescents using a school-based intervention. This intervention consisted of a mental health workshop (with a contact approach component) and theatrical drama.

Few nurses are investigating stigma toward mental illness, and fewer are testing stigma interventions. Historically, nursing research related to stigma has been qualitative and nonexperimental. Nonexperimental and qualitative methods of inquiry are important and yield valuable information about the complex phenomenon of stigma; however, findings from these studies do not provide strong empirical evidence for stigma interventions. Levels of evidence associated with evidence-based practice guidelines designate qualitative and nonexperimental methods as weaker support for practice change than experimental studies (Melnyk & Fineout-Overholt, 2005; Oxford Centre for Evidence-Based Medicine, 2001). Nevertheless, qualitative research captures unique perspectives and information about phenomena that were previously unknown to nurses. Findings from qualitative and nonexperimental research can help nurses design interventions and provide a foundation for future intervention studies that use experimental design. For a description of nursing studies on stigma, see Table 1.

Psychology and Psychiatry

Research from the psychology and psychiatry disciplines has advanced the science of stigma interventions with use of preexperimental and experimental design. For example, Griffiths, Christensen, Jorm, Evans, and Groves (2004) reported on a randomized clinical trial study that successfully reduced stigma in Australian adults using an interactive web-based program.

Overall, the psychology and psychiatry literature (a) tests innovative approaches (e.g., web-based program, personal contact, video presentations) to

reduce stigma, (b) provides information (from pretest measures) about populations that are potentially most affected by various stigma interventions, (c) describes characteristics of individuals who stigmatize, and (d) describes how individuals stigmatize conditions and illnesses differently. For a description of stigma studies from psychology and psychiatry, see Table 1.

The best approach for reducing mental disorder stigma is unknown; however, some interventions, such as contact and education, repeatedly demonstrate effectiveness in various samples across disciplines (Rusch, Angermeyer, & Corrigan, 2005). Of a combined contact and education approach, contact appears to be the more influential component (Rusch et al., 2005). Contact is the personal interaction between at least two individuals, one with mental disorders and one without a disorder. This interaction violates the stereotype held by those without mental disorders. The goal of contact is attitude and behavior change toward individuals with mental disorders.

Recommendations for Nursing

Nurses should think "outside of the box" for ways to become involved in stigma reduction. Approaches for reducing stigma are not exclusively for nurse scientists and advanced practice nurses. Health care professionals and those interested in reducing stigma can also contribute. One example is active involvement in antistigma organizations and directing other colleagues and clients to these resources. Practicing nurses may protest by participating in letter-writing campaigns, watching for inaccurate representations of mental disorders, and advocating for fair representation and treatment of those with mental disorders. Nurses are in a unique position to make a positive impact on the public. Nurses already hold the trust of the public as nurses continue to top the list for the past 8 years as the most "ethical and honest" profession (Saad, 2006). Furthermore, nurses can use their position of trust to help the public recognize the role and opportunity for advocacy to end stigma (Happell, 2005).

Regardless of the level of practice or area of expertise, all nurses can affect change by sharing knowledge with the community in venues such as churches, schools, and workplaces. Those nurses living with mental disorders who feel comfortable with disclosure may simultaneously implement the contact and education approaches in various settings. Because the community has a high level of respect for nurses, it could be hypothesized that a contact and education intervention administered by a nurse (with a mental disorder) may magnify stigma reduction.

Nurses often facilitate communication between disciplines, clients, and health care providers. Nurses speak the language of different health care disciplines and bring a unique perspective to the table when collaborating with other members of the health care team. Nursing can emerge as a leader in the national stigma initiatives by facilitating dialogue between groups and disciplines for a unified effort in stigma reduction. A starting point is local entry into national organizations such as NAMI. Involvement in antistigma organizations is important, and nurses must use their skills in mass approaches for stigma reduction.

On an individual level, nurses can advocate for clients by policing the health care system for stigmatizing attitudes. This includes careful attention to use of language, discriminating behaviors, and advocating for clients who do not receive the full scope of treatment. Advanced practice nurses may lead stigma-reduction efforts by investigating stigma. Moreover, developing, evaluating, and implementing stigma-reducing interventions are urgently needed.

Recommendations for Future Research

Although the call by the U.S. Surgeon General and the New Freedom Commission on Mental Health to reduce stigma has spurred interest in stigma research and prompted new initiatives across the United States, stigma reduction is still in its infancy. Empirical studies that evaluate national stigma programs are nearly absent in the literature and interventions studies are few. Therefore, it is difficult to determine which stigma programs/interventions are effective and how these programs/interventions work to reduce stigma.

Programs/interventions (including those for stigma) should be based upon a theoretical framework, informed by pilot work, and targeted to the population of interest (Sidani & Bradden, 1998). When a theoretical framework, pilot work, and the population of interest are considered in the program/intervention design, researchers can evaluate program outcomes most completely; programs can be evaluated to (a) determine overall program performance, (b) determine if and how the theory

Table 1. Stigma Studies

Study	Design	Population	Objective	Variables	Results
Corrigan et al. (2005)*	Secondary data analysis; pre- and posttest design	Adolescents (N = 303)	To extend a validated adult model of mental illness stigma and alcohol abuse to adolescents.	Familiarity with mental illness, responsibility, pity, anger, dangerousness, fear, help, and avoidance.	Alcohol abuse was more harshly stigmatized, followed by mental illness. Subjects stigmatized mental disorders less when they believed that the disorder is caused by a brain tumor as opposed to the disorder being idiopathic in origin. Subjects who thought that individuals are responsible for their illness discriminated more. Familiar with mental-illness-reinforced stigma.
Edwards and Timmons (2005)†	Qualitative	Postpartum women (N = 6)	To explore postpartum women's experience, feelings, and emotions about stigma. To explore women's perceptions of themselves in the role of a mother.		Disclosure, access to services, feelings of being a bad mother, and label/diagnosis emerged as themes.
Essler, Arthur, and Stickley (2006)†	Pre- and posttest design without control group	Adolescents 13–14 years of age (N = 104)	Determine the effects of a school-based intervention (drama and games) on mental health knowledge and stigma.	Mental health knowledge and stigma.	Postintervention subjects had more knowledge and had lower levels of stigma.
Griffiths et al. (2004)*	Randomized control trial	Adults with positive depression screen (N = 525)	Determine the effects of web-based depression literacy and cognitive–behavioral intervention on stigma.	Demographics, clinical history, psychological distress, stigma, level of depressive symptoms, and mental health knowledge.	Both the web-based depression literacy and cognitive–behavioral intervention produced a small but significant reduction in stigmatizing attitudes.
Halter (2004a)†	Nonexperimental, correlational	Nursing students (N = 136)	Examine attitudes toward depression treatment and identify variables that influence treatment seeking.	Demographics and stigma.	Subjects were more likely to endorse care seeking for themselves if they thought that depression was out of their control. Older subjects, women, upper-class individuals, and Catholics were more likely to endorse treatment. A psychiatric–mental health nursing course reduced stigma and increased care-seeking intention.
Halter (2004b)†	Nonexperimental, correlational	Adults (N = 122)	Examine the influence of stigma on care seeking for depression.	Demographics, stigma, fear, and behavioral avoidance of people with mental illness.	Subjects were less angry and more likely to endorse care seeking if mental illness was thought to be out of one's control. Pity was associated with endorsement of care seeking. Gender mediated stigma and care seeking.

Penn, Chamberlin, and Mueser (2003)*	Pre- and posttest design with control group	Undergraduate college students (N = 163)	Determine if a media presentation about schizophrenia can reduce stigma.	Mood, stigma, behavioral intention to interact with a person who has schizophrenia, attitude, and personality.	Individuals exposed to the media presentation about schizophrenia attributed less blame to individuals for their illness and saw individuals as more likely to change. The intervention had no effect on attitude or intention to interact with individuals with schizophrenia.
Pinfold et al. (2003)*	Pre- and posttest design without control group. Qualitative component.	Secondary school students (N = 472)	Determine the effectiveness of a school-based mental health awareness workshop to increase mental health literacy and challenge negative stereotype.	Social distance, attitude, demographic data, personal experience with mental illness, and stigma.	Subjects had a more favorable attitude about individuals with mental illness postintervention and at 6 months follow-up. Female students and individuals who had contact with mental illness had more favorable attitudes. The qualitative analysis yielded descriptions of mental illness as derogatory.
Raingruber (2002) †	Phenomenology	Mental health clients, health care providers, police officers, teachers, counselors, and parents	Identify issues that influence the care of clients with mental illness.		Two themes emerged: (a) mental health system can reinforce stigma. (b) Interventions to reduce stigma and increase awareness are needed. Open communication, community awareness, education, prevention, community-centered or in-home services may minimize stigma and help increase access to care.
Schreiber and Hartrick (2002) †	Grounded Theory	Women treated for depression within the last 5 years (N = 43)	Examine how women experience and manage depression. Investigate women's explanatory models of depression.		The overarching theme was “Keeping It Together.” Core categories were “Taking Up the Biomedical Explanation Model (BEM) of Depression,” “Using BEM to Manage Stigma of Depression”, and “Inadvertent Consequences of Using the BEM.”

* Psychology and Psychiatry.
† Nursing.

accounts or does not account for the observed outcomes, and (c) determine what may have gone wrong and how to best refine and strengthen the program (Beadnell, 2007). The authors are unaware of any national stigma-reduction programs guided by a theoretical framework. Use of theory to develop stigma-reduction programs is critical for effective stigma reduction.

Stigma is driven by a social structure and psychological process (Hinshaw, 2005). Stigma can be seen in both microaggressive and macroaggressive forms (Deegan, 2007). Manifestations of stigma can be outward or discrete and may include negative, hostile, and derogatory language, as well as disrespect in personal relationships and behavior (Deegan, 2007; Gary, 2005a; Sue et al., 2007). Powerful members of society determine what conditions should be stigmatized, blame individuals with mental disorders for their condition, and disadvantage individuals with mental disorders by depriving them of opportunities and withholding resources (Hinshaw, 2005; Link & Phelan, 2001). The effects of disenfranchisement are magnified for ethnic minorities. Gary (2005b) suggests that health disparities that exist among ethnic minority populations may be explained by mental disorder stigma. Thus, reframing stigma as a social injustice and not solely as a health problem is a more persuasive approach for eliminating stigma and may ultimately help correct health disparities in ethnic minority populations (Corrigan, Watson, Byne, & Davis, 2005).

To facilitate mental health treatment, future nursing research should include developing and evaluating theory-based interventions to reduce stigma both on the micro and macro level. Implementation can occur by targeting groups that hold influence over people with mental disorders (e.g., teachers, policymakers, employers, landlords, health care providers, media) and tailoring interventions to these groups (Corrigan, 2004b). Testing the effectiveness of theory-based interventions for these targeted groups is helpful to program evaluation, replication, and dispersion of the intervention effect.

Media approaches, including print, presentation, and audio visual, should be evaluated for effectiveness in various populations. Perhaps research in this area can be based upon a Diffusion of Innovation (Rogers, 2003) or Theory of Planned Behavior (Ajzen, 1985, 1991) framework. Both theories have been used successfully in mass media campaigns for health behavior awareness and behavior change (Elwood & Ataabadi, 1997; Stead, Tagg, MacKintosh, & Eadie, 2005).

Diffusion of Innovation Theory explains how ideas are communicated throughout a social system and the degree in which new ideas are adopted. Individuals adopt new ideas at different rates. The spread of an idea is highly predicted by the perception of the idea's relative advantage, compatibility, complexity, trialability, and observability. Communication within a social system is also important. The stigma media message should contain clear ideas that are beneficial, relevant, and simple to understand and perform from the potential adopter's perspective to maximize adoption of an idea. Results of the intervention should also be visible. Early adopters (local leaders and individuals who are socially well connected) are most critical for spread (Rogers, 2003). Thus, interventions should be directed at early adopters first.

The Theory of Planned Behavior assumes that individuals have deliberate control over their behavior. The harder individuals try to perform a behavior, the more likely they are to succeed. Individuals are more likely to perform a behavior if they have a favorable attitude (perception of consequences of the behavior) and subjective norm (perception of other's approval) about the behavior and have a high degree of perceived control (perception of difficulty to perform the behavior). Media interventions that work on changing attitudes and subjective norms to be more favorable and to increase perception of control could be effective in reducing stigma.

A comprehensive approach to combat stigma that includes the environmental context is needed (Corrigan & Watson, 2007). Understanding how families manage and support other family members with mental disorders and how the public view these families are important to advancing the science (Corrigan, & Miller, 2004). Because little is known about these phenomena, qualitative inquiry is an appropriate starting point.

Exploration of stigma in understudied and high-risk groups (such as minorities and adolescents) is vital because these groups are less likely to receive appropriate care (Department of Health and Human Services, 1999). Stigma research in adolescents is scarce and accounts for less than 4% of stigma research (Link, Yang, Phelan, & Collins, 2004).

Furthermore, adolescents hold high levels of stigma toward mental disorders (Chandra & Minkovitz, 2006). Pinto-Foltz, Usui, and Logsdon (2007) found that the stigma scores of 14- to 15-year-old female adolescents were double that of female young adults. Reducing stigma during adolescence is important for early identification of illness, early treatment, and increasing adolescents' comfort in discussing mental disorders.

Because information about effective stigma-reducing interventions is limited and the contact approach provides the strongest support for changing attitudes, pilot testing established contact approach programs is a natural next step. Most often, established programs are easily extended into larger population subsets. Gaining knowledge about diverse groups and larger samples of the population can quickly advance the science. Piloting testing interventions with demonstrated success in international research is also an appropriate starting point.

Contact and educational interventions are showing promise across disciplines as effective ways to reduce stigma. Moreover, people who view mental disorders as biologically based, and not under one's own control, stigmatize less. More stigma intervention research is needed to close the knowledge gap and establish best practice. This article provides a summary of current stigma-reducing interventions, but is limited by the inability to provide clinical recommendations. Clinical recommendations cannot be made until more evidence is available and a rigorous appraisal of the evidence, such as a systematic review, is undertaken. At that time, best practice can be identified and implemented with confidence.

The time is ripe for nursing to take the lead on this public health concern affecting millions of people. Nurses at all levels can play an active role in reducing stigma. Advocating for change and fair treatment of people with mental disorders should be examined from a social justice framework and can be easily incorporated into daily practice. Nurse scientists and advanced practice nurses can design, evaluate, and implement theory-based stigma-reducing interventions to advance the science. Through continued effort and advances in research, the progress made in eliminating stigma will not only relieve the millions of people and families that suffer but also lead to healthier communities.

ACKNOWLEDGMENT

The authors would like to thank Karen M. Robinson, DNS, RN, BC, FAAN, for her review and comments on an earlier draft of this article.

REFERENCES

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhl, & J. Beckman (Eds.), *Action-control: From cognition to behavior* (pp. 11–39). Heidelberg, Germany: Springer.

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, *50*, 179–211.

Beadnell, B. (2007). Testing mediating mechanisms in theory-based interventions: Contributions to efficacy research. *Journal of Adolescent Health*, *41*, 317–318.

Chandra, A., & Minkovitz, C. S. (2006). Stigma starts early: Gender differences in teen willingness to use mental health services. *Journal of Adolescent Health*, *38*, 754.e1–754.e8.

Collins, J. A., & Fauser, B. C. (2005). Balancing the strengths of systematic and narrative reviews. *Human Reproductive Update*, *11*(2), 103–104.

Corrigan, P. (2004a). How stigma interferes with mental health care. *American Psychologist*, *59*(7), 614–625.

Corrigan, P. W. (2004b). Target-specific stigma change: A strategy for impacting mental illness stigma. *Psychiatric Rehabilitation Journal*, *28*(2), 113–121.

Corrigan, P. W., & Miller, F. E. (2004). Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health*, *13* (6), 537–548.

Corrigan, P. W., Watson, A. C., Byrne, P., & Davis, K. E. (2005). Mental illness stigma: Problem of public health or social injustice? *Social Work*, *50*(4), 363–368.

Corrigan, P. W., et al. (2005). How adolescents perceive the stigma of mental illness and alcohol abuse. *Psychiatric Services*, *56*(5), 544–550.

Corrigan, P. W., & Watson, A. C. (2007). The stigma of psychiatric disorders and the gender, ethnicity, and education of the perceiver. *Community Mental Health Journal*, *43*(5), 439–458.

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

Deegan P. E. (2007, Sept). Healing from self-stigma. ADS Teleconference Training. Retrieved September 26, 2007 from http://www.stopstigma.samhsa.gov/teleconference09262007.htm.

Depression is Real. (2007). Retrieved from Depressionisreal.org on April 15, 2007.

Edwards, E., & Timmons, S. (2005). A qualitative study of stigma among women suffering from postnatal illness. *Journal of Mental Health*, *14*, 471–481.

Elwood, W. N., & Ataabadi, A. N. (1997). Influence of interpersonal and mass-mediated interventions on injection drug and crack users: Diffusion of innovations and

HIV risk behaviors. *Substance Use & Misuse*, *32*(5), 635−651.

Essler, V., Arthur, A., & Stickley, T. (2006). Using a school-based intervention to challenge stigmatizing attitudes and promote mental health in teenagers. *Journal of Mental Health*, *15*(2), 243−250.

Fink, A. (2005). *Conducting research literature reviews: From Internet to paper*. Thousand Oaks, CA: Sage.

Gary, F. A. (2005a). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing*, *26*, 979−999.

Gary, F. A. (2005b). From the guest editor — Research on the stigma of mental illness among ethnic minority populations in the United States. *Issues in Mental Health Nursing*, *26*, 971−977.

Griffiths, K. M., Christensen, H., Jorm, A. F., Evans, K., & Groves, C. (2004). Effect of web-based depression literacy and cognitive–behavioural therapy interventions on stigmatising attitudes to depression. *British Journal of Psychiatry*, *185*, 342−349.

Halter, M. J. (2004a). Stigma and help seeking related to depression: A study of nursing students. *Journal of Psychosocial Nursing*, *42*(2), 42−51.

Halter, M. J. (2004b). The stigma of seeking care and depression. *Archives of Psychiatric Nursing*, *18*(5), 178−194.

Happell, B. (2005). Mental health nursing: Challenging stigma and discrimination towards people experiencing a mental illness. *International Journal of Mental Health Nursing*, *14*(1), 1.

Hinshaw, S. P. (2005). The stigmatization of mental illness in child and parents: Developmental issues, family concerns, and research needs. *Journal of Child Psychology and Psychiatry*, *46*(7), 714−734.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*, 363−385.

Link, B. G., Yang, L. H., Phelan, J. C., & Collins, P. Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin*, *30*, 511−541.

Mann, C. E., & Himelein, M. J. (2004). Factors associated with stigmatization with persons with mental illness. *Psychiatric Services*, *55*, 185−187.

Melnyk, B. M., & Fineout-Overholt, E. (2005). *Evidence-based practice in nursing and healthcare*. Lippincott, Williams, & Wilkins: Philadelphia, PA.

National Alliance on Mental Illness. (2007). Retrieved from http://www.nami.org on April 15, 2007.

Okasha A. (2007). Message from the WPA president: The WPA global program against stigma and discrimination because of schizophrenia an update. Retrieved from http://wpanet.org/generalinfo/letter1203.html.

Oxford Centre for Evidence-Based Medicine. (2001). Levels of evidence. Retrieved from www.cebm.net/index/aspx?o=1025.

Palpant, R. G., Steimnitz, R., Bornemann, T. H., & Hawkins, K. (2006). The Carter Center Mental Health Program: Addressing the public health crisis in the field of mental health through policy change and stigma reduction. *Preventing Chronic Disease: Public Health Research, Practice, and Policy*, *3*(2), 1−6.

Penn, D. L., Chamberlin, C., & Mueser, K. T. (2003). The effects of a documentary film about schizophrenia on psychiatric stigma. *Schizophrenia Bulletin*, *29*(2), 383−391.

Pinfold, V., et al. (2003). Reducing psychiatric stigma and discrimination: Evaluation of educational interventions in UK secondary schools. *British Journal of Psychiatry*, *182*, 342−346.

Pinto-Foltz, M. D., Usui, W., & Logsdon, M. C. (2007). *Psychometric evaluation of the stigma scale for receiving psychological help in female adolescents*. Submitted for publication.

President's New Freedom Commission on Mental Health. (2007). Retrieved from http://www.mentalhealthcommission.gov/ on April 15, 2007.

Raingruber, B. (2002). Client and provider perspectives regarding the stigma of nonstigmatizing interventions for depression. *Archives of Psychiatric Nursing*, *16*(5), 201−207.

Rogers, E. M. (2003). *Diffusions of innovations*. (5th ed.). New York: Free Press.

Rusch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry*, *20*, 529−539.

Saad L. (2006). Nurses top list of most honest and ethical professions. Gallup News Service. Retrieved from http://www.calnurses.org/media-center/in-the-news/2006/december/page.jsp?itemID=29117737.

Schreiber, R., & Hartrick, G. (2002). Keeping it together: How women use the Biomedical Explanatory Model to manage the stigma of depression [Electronic version]. *Issues in Mental Health Nursing*, *23*, 91−105.

Sidani, S., & Bradden, C. J. (1998). *Evaluating nursing interventions: A theory-driven approach*. Thousand Oaks, CA: Sage Publications.

Stead, M., Tagg, S., MacKintosh, A. M., & Eadie, D. (2005). Development and evaluation of a mass media Theory of Planned Behaviour intervention to reduce speeding. *Health Education Research*, *20*(1), 36−50.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007, May–Jun). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *1*, 271−286.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services: The Resource Center to Address Discrimination and Stigma With Mental Illness. (2003). Memorandum: Informational update addressing discrimination and stigma associated with mental illness. Retrieved from http://www.stopstigma.samhsa.gov/memoranda/indexspring2003.htm.