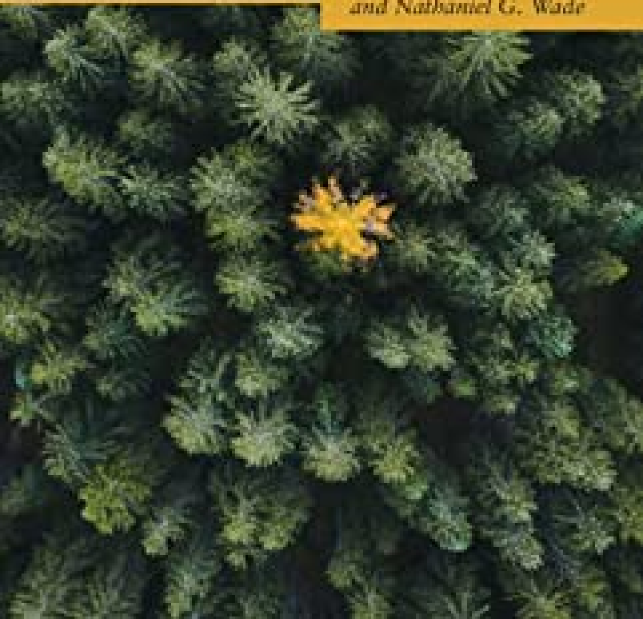
THE CAMBRIDGE HANDBOOK OF

STIGMA AND MENTAL HEALTH

Edited by David L. Vogel and Nathaniel G. Wade



The Cambridge Handbook of Stigma and Mental Health

The persistence of stigma of mental illness and seeking therapy perpetuates suffering and keeps people from getting the help they need and deserve. This volume, analyzing the most up-to-date research ways to intervene, is designed to give those who are working to overcome stigma a strong, research-based foundation for their work. Chapters address stigma reduction efforts at the individual, community, and national levels, and discuss what works and what doesn't. Others explore how holding different stigmatized identities compounds the burden of stigma and suggest ways to attend to these differences. Throughout, there is a focus on the current state of the research knowledge in the field, its applications, and recommendations for future research. The Handbook provides a compelling case for the benefits reaped from current research and intervention, and shows why continued work is needed.

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CAMBRIDGE
UNIVERSITY PRESS

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University Printing House, Cambridge CB2 8BS, United Kingdom

One Liberty Plaza, 20th Floor, New York, NY 10006, USA

477 Williamstown Road, Port Melbourne, VIC 3207, Australia

314–321, 3rd Floor, Plot 3, Splendor Forum, Jasola District Centre,
New Delhi – 110025, India

103 Penang Road, #05–06/07, Visioncrest Commercial, Singapore 238467

Cambridge University Press is part of the University of Cambridge.

It furthers the University's mission by disseminating knowledge in the pursuit of education, learning, and research at the highest international levels of excellence.

www.cambridge.org
Information on this title: www.cambridge.org/9781108843904
DOI: 10.1017/9781108920995

First published 2022

Printed in the United Kingdom by TJ Books Limited, Padstow Cornwall

A catalogue record for this publication is available from the British Library.

Library of Congress Cataloging-in-Publication Data
Names: Vogel, David L., editor. | Wade, Nathaniel G., editor.
Title: The Cambridge handbook of stigma and mental health / edited by David L. Vogel, Iowa State University, Nathaniel G. Wade, Iowa State University.
Description: 1 Edition. | New York, NY : Cambridge University Press, 2022. | Series: Cambridge handbooks in psychology | Includes bibliographical references and index.
Identifiers: LCCN 2021055098 (print) | LCCN 2021055099 (ebook) | ISBN 9781108843904 (hardback) | ISBN 9781108925488 (paperback) | ISBN 9781108920995 (epub)
Subjects: LCSH: Stigma (Social psychology) | Mental health. | BISAC: PSYCHOLOGY / Clinical Psychology
Classification: LCC HM1131 .C356 2022 (print) | LCC HM1131 (ebook) | DDC 362.196/89–dc23/eng/20220125
LC record available at https://lccn.loc.gov/2021055098
LC ebook record available at https://lccn.loc.gov/2021055099

ISBN 978-1-108-84390-4 Hardback
ISBN 978-1-108-92548-8 Paperback

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1 Introduction to the *Handbook of Stigma and Mental Health*

David L. Vogel & Nathaniel G. Wade

> I've had moments when I was talking to someone quite happily, mentioned the sheer fact that I suffer from mental health problems and I turned to talk to someone else and their back turned, they're heading for the door literally.
>
> –Participant in study on stigma by Dinos and colleagues (2004)

This Handbook is about the stigma associated with mental illness and seeking psychological help. Stigma is defined as a mark of shame associated with a specific condition or characteristic (Goffman, 1963). That mark of shame can lead people to do horrible things to others and themselves. As researchers and mental health professionals, we wanted to do something about that. We wanted to disrupt the processes that cause people to fear, intimidate, and shun or avoid others, and drive people to hate themselves for something they have little, if any, control over. One way we knew to do that is through our expertise as researchers. This book is the culmination of our vision to bring together the state-of-the-science regarding stigma and mental health into an accessible resource. We hope that by organizing this material, we might help future researchers, interventionists, and policy makers to effect change in the lives of millions of people throughout the world. Is it a vision too ambitious? Would it be a vision, if it weren't ambitious?

The field of stigma research has grown dramatically in the past two decades. In a PsychInfo search on May 27, 2021, we found that there were just under 900 books or journal articles related to mental health stigma published between 1890 and 1999. From 2000 to 2021 that number had mushroomed to over 12,000. In other words, publications on mental health stigma over the past 21 years is almost 15 times greater than in the previous 100 years.

Through this Handbook, we aim to summarize the findings on mental health stigma, which, building on Goffman's 1963 definition, we define as a mark of disgrace or shame related to having a mental illness or seeking psychological help. This comprehensive, single volume covers the most recent research in the field of mental health stigma and provides researchers and practitioners alike with an invaluable resource to drive stigma research and practice into the next decade. Across chapters, the authors present a review of each area including current research findings, describe consensus in the literature, and provide key questions for future research. Best practices in each area, based on the research findings, are presented. The chapters feature authors from a mix of established, expert voices and rising stars in the field who give their answers to the question: What do we know and where should we go from here?

The target readers of the Handbook are researchers, clinicians, educators, undergraduate and graduate students, policy makers, advocacy groups, and professionals seeking information on current mental health stigma trends and how to intervene to reduce stigma. This is an applied research handbook that draws broadly from professionals seeking to understand, address, and eliminate mental health stigma and increase well-being and utilization of mental health services. Those in many disciplines, including psychology, sociology, anthropology, medicine, nursing, counseling, and social work, may be interested in using this book as assigned reading for a graduate student course or for reference in their own research or practice.

What to Expect in the *Cambridge Handbook of Stigma and Mental Health*

Stigma can serve to maintain discrimination, oppression, and disparities and to reduce compassion and understanding. The authors of the Handbook's chapters have taken on the task of changing the impact of stigma and the barriers it creates to living our full lives and from reaching our potential by facilitating a deeper understanding of mental health stigma through answering four important questions: "What are the forms of mental health stigma?"; "What are impacts of mental health stigma?"; "How can we develop interventions to reduce mental health stigma across contexts?"; "How can we understand the specific ways that mental health stigma impacts different groups (e.g., racial minorities, veterans)?" As editors of the Handbook, we are extremely happy with the breadth of work covered across the chapters. We hope that you, the reader, will be inspired by this work and the authors, who have invested much of their professional time in understanding mental health stigma.

The Handbook is divided into four sections. Beginning in Part I (**Understanding Stigma and Mental Health**), chapter authors explore the different types of mental health stigma and address existing psychological models in the field. For example, in Chapter 2 (**Theoretical Models to Understand Stigma of Mental Illness**) Lindsay Sheehan, Carlo Vittorio Palermo, and Patrick Corrigan clearly lay out different types of mental illness stigma, including public stigma, self-stigma, associative stigma, and structural stigma, and the key theoretical models underlying our understanding into their development and propagation.

Section I also addresses key aspects related to stigma often missed or only briefly addressed in previous books that heavily focused on the stigma related to having a mental illness, missing significant work that has been done to broaden our understanding of the importance of help-seeking stigma. In Chapter 3 (**Disentangling Mental Illness and Help-Seeking Stigmas**) Rachel E. Brenner, Maddie M. Egli, and Joseph H. Hammer present a theoretical model that distinguishes between four stigmas related to mental illness and help seeking: (a) public stigma of mental illness, (b) public stigma of seeking help, (c) self-stigma of mental illness, and (d) self-stigma of seeking help. They discuss their most common measurements and how these different stigmas are related to each other and to mental health and help-seeking outcomes. In turn, in Chapter 4 (**Measurement of Mental Illness Stigma and Discrimination**) Elaine Brohan, Maria Milenov, Ioannis Bakolis, Sara Evans-Lacko, Brandon A. Kohrt, and Graham Thornicroft present up-to-date discussion of the measurement of mental illness stigma and discrimination, highlighting the importance of scale design, local and cross-cultural use, and present suggested directions for future measurement research.

In Part II (**Impact of Stigma on Mental Health)**, authors summarize the current empirical knowledge of mental health stigma. This section includes both reviews and new meta-analyses of the research on mental illness stigma and help-seeking stigma. These reviews focus on the correlates and outcomes associated with mental health stigma, such as psychological well-being and distress, attitudes toward and intentions to seeking psychological help, and other psychological and behavioral outcomes. For example, in Chapter 5 (**Time Trends in Public Stigma**) Georg Schomerus and Matthias C. Angermeyer report on changes in cultural conceptions of mental illness over the past decade. Their works shows increasing divides between “severe” and “less severe” types of mental illness and provides needed focus for anti-stigma efforts.

Building on this discussion of the changes in the perceptions of stigma over time, Section II also presents recent findings from two meta-analyses examining the effects of self-stigma (how people internalize stigma). In Chapter 6 (**Consequences of the Self-Stigma of Mental Illness**), Jennifer E. Boyd, Manuel Muñoz López, Clara González-Sanguino, J. Irene Harris, and Isaiah T. Sampson review the key findings of the two meta-analyses and present key similarities and differences in the findings over time. They also start our discussion, taken up further in Section III of the Handbook, on the need to understand the effects of self-stigma on people with a variety of intersectional identities. Then, in Chapter 7 (**Self-Stigma of Seeking Help: A Meta-Analysis**), Daniel G. Lannin and Jacqueline Bible provide a first-of-its-kind systematic review and meta-analysis on 145 studies into the consequences of help-seeking self-stigma. This key chapter provides compelling evidence into the effects of help-seeking self-stigma on help-seeking attitudes and intentions, decisions to seek online help-seeking information, and future help-seeking behaviors.

A growing research body has also started to distinguish important stigmas unique from mental illness stigma. In Chapter 8 (**Stigma and Suicide**), Philip J. Batterham, Alison L. Calear, and Ella Kurz discuss the unique measurement, associated demographics and cultural factors, and impacts of suicide stigma (influence on suicidality, depression, and help-seeking) for people with suicide ideation, people who have attempted suicide, and people bereaved by suicide. The authors also provide future directions into understanding the processes by which suicide stigma emerges and how to reduce suicide stigma and prevent suicide. In addition, in Chapter 9 (**Intellectual Disability Stigma: The State of the Evidence**) Shirli Werner and Katrina Scior discuss research on intellectual disability stigma. Examining the recent work in the area, they discuss the unique aspects of public stigma, professional stigma, self-stigma, and family/affiliate stigma associated with intellectual disabilities and report on stigma change interventions and directions for future research.

Next, in Part III (**Stigma and Mental Health in Specific Contexts**), authors focus on mental health stigma in specific contexts, discussing implications across culture, gender, age, religion, and sexual orientation. A key factor, often overlooked in mental health stigma research, is the role of intersecting stigmatized identities. People who experience mental illness and consider seeking professional help can also be part of other stigmatized groups. However, current mental health stigma research often ignores the potential effects of discrimination from multiple sources or assumes that stigmatization leads to additive effects on health outcomes. In Chapter 10 (**The Intersection of Mental Health Stigma and Marginalized Identities**), Courtney Andrysiak, Jennifer Cherry, Jessica Salmonsen, and Lauren Mizock discuss the qualitatively different ways that stigmatized social group identities and structural inequalities can intersect for each person, depending on their visible and invisible identities. Authors of the next two chapters then, specifically, discuss the state of knowledge and future needs in understanding intersectionality of stigmatized identities in ethnic minority populations (Chapter 11, **Stigma and Mental Health in Ethnic Minority Populations**, Lonnie R. Snowden, Genevieve Graaf, Latocia Keyes, and Amanda Ryan) and among LGBTQ+ populations (Chapter 12, **Mental Health Stigma among LGBTQ+ Populations**, Carlos A. Vidales and Ashley J. Macbeth).

Building on this, Chapters 13–17 focus on how mental health stigma emerges and plays out for different populations including across cultural groups (Chapter 13, **Unpacking Cultural Influences on Stigma of People with Mental Illness between Group-Oriented and Individual-Oriented Cultures**, Ben C. L. Yu and Winnie W. S. Mak); for men (Chapter 14, **All the World's a Stage: Men, Masculinity, and Mental Health Stigma**, Stephen R. Wester); within the military (Chapter 15, **Understanding and Reducing the Stigma of Mental Health Problems and of Treatment among Military Personnel**, Thomas W. Britt and Zachary P. Klinefelter); across age cohorts (Chapter 16, **Stigma of Seeking Mental Health Services and Related Constructs in Older versus Younger Adults**, Corey S. Mackenzie, Nicole Del Rosario, and Melissa Krook); and for individuals from different religious backgrounds (Chapter 17, **Stigma and Mental Health in the Abrahamic Religious Traditions**, Lily A. Mathison, Russell Jackson, and Nathaniel G. Wade).

In Part IV (**Reducing Stigma to Promote Mental Health)**, the authors provide a synthesis of what we know about the ways to reduce mental health stigma. Specifically, authors review commonly used interventions for both individuals and society and focus on cutting-edge interventions and their effectiveness for helping to increase service utilization. For example, in Chapter 18 (**Interventions to Reduce Mental Illness Stigma and Discrimination at the Person-Level for Individuals and Small Groups**) Sarah J. Parry, Elaine Brohan, Petra C. Gronholm, and Graham Thornicroft provide the current state of support for social contact and educational anti-mental illness stigma interventions. They also discuss the need to focus on specific target groups and provide the evidence currently known for three such groups – healthcare professionals, police, and students – and low- and middle-income countries (LMIC). In Chapter 19 (**Population-Based Interventions to Reduce the Stigma of Mental Illness**), Gaia Sampogna, Andrea Fiorillo, Lisa Giannelli, and Claire Henderson expand this discussion to review the population-level approaches to reduce mental illness stigma by presenting some of the recent population-level anti-stigma programs, evaluations of the programs that have been completed, and considerations for population efforts in terms of methods and content.

Subsequently, in Chapter 20 (**Interventions to Reduce Help-Seeking Stigma for Mental Health Conditions**) Jane Sungmin Hahn, Lina-Jolien Peter, Vanessa Juergensen, Georg Schomerus, and Sarah Evans-Lacko focus on systematic reviews of the interventions to reduce help-seeking stigma (i.e., remove the barriers to seeking help) including discussions of improving mental health literacy, psychoeducation, contact, and resource sharing and recent focus on online help-seeking interventions. Andrew J. Seidman, in Chapter 21 (**Self-Affirmation Interventions to Reduce Mental Health Stigma**), and Patrick J. Heath, in Chapter 22 (**Mindfulness and Self-Compassion Interventions to Address Mental Health Stigm**a), provide the theoretical and empirical support for two newer and innovative approaches that diversify how we may be able to reduce help-seeking stigma that have been receiving important attention.

Finally, in Chapter 23 (**What Is Left to Be Done: Key Points, Future Directions, and New Innovations**) we integrate and synthesize the chapters toward a broad understanding of both the current state of our understanding of mental health stigma and important future directions. Specifically, we conclude with a discussion of three broad and key lessons learned from the chapters in the Handbook: the expansion of theories to explain stigma, the intersectionality of stigma, and the effectiveness of interventions to reduce stigma. We then provide three broad areas for future work in this area. These include more explorations into the intersectionality of identities and stigma, further development and testing of interventions to reduce different forms of stigma among different people in different contexts, and an encouragement to push the boundaries of our work with creative and innovative research into new areas of exploration.

What You Should Look for as You Read the Following Chapters

Mental health stigma is a major obstacle to health and wellness (Mejia-Lancheros et al., 2021). Findings indicate that negative interactions from others, along with largely negative portrayals of mental illness in the media, lower an individual's self-esteem and self-efficacy (for discussion, see Corrigan, 2004). Internalized negative perceptions of mental health issues also appear have a negative impact on mental health and "adjustment and growth" (Mak et al., 2007, p. 256). Concerns about stigmatization also interfere both with the decision to seek help and with the continuing use of services (see Corrigan et al., 2014). In fact, greater stigma has been linked to lower intention to seek counseling for specific problems (Brenner et al., 2019; Hammer & Vogel, 2013; Lannin et al., 2015; Pattyn et al., 2014), lower rates of accessing online information about mental health and counseling services (Lannin et al., 2016), and decreased use of services over a two-year period (Seidman et al., 2019). It has also been linked with poorer follow-through with therapy (Sirey et al., 2001a), decreased willingness to return for subsequent counseling sessions (Wade et al., 2011), and with early termination of treatment (Sirey et al., 2001b). Accordingly, there is a clear need to better understand the role of mental health stigma in order to develop interventions designed to overcome these stigmas.

To address these needs, we have attempted to put together a cutting-edge examination of the topic. Importantly, the Handbook also offers important and unique understandings into the different types and possible routes of intervention. We can intervene at the individual, community, family, and societal levels to help people make the most informed and healthy choices for themselves. We believe that psychologists and allied health providers will be more effective at helping people overcome the effects of stigma if they are able to focus their efforts at these different levels.

Of course, no one handbook can cover all topics or perspectives, and so we hope that the current discussions inspire your own interests not only in what we cover but also what we have missed. You may ask yourself:

- "Are there topics not investigated in the Handbook that need to addressed?"
- "Are there stigmatized conditions that have not been covered?"
- "Are there consequences of stigma that have been overlooked?"

For example, although we have a chapter focusing on intersectionality of men and masculinity and mental health stigma, we do not have a separate chapter focused on mental health stigma and gender, or more specifically mental health stigma among women. Mental health stigma and gender are briefly discussed in several chapters (e.g., intersectionality; LGBTQ+), but those who identify as cis-gender women are not discussed at length. This might be both understandable and troubling, as cis-gender women are the single most likely group to seek out mental health services, at least in the United States (Kessler et al., 2005). As such, while our goal was to highlight not only what has been done and what needs to be addressed, and we believe the authors have done an excellent job of bringing to light a number of directions in which the field needs to go, we also encourage you as the reader to think about these and other topics and areas that have not been covered in an effort to decide what future work is needed. We hope that asking these questions will stimulate and drive more innovative research in the future.

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PART I

Understanding Stigma and Mental Health

2 Theoretical Models to Understand Stigma of Mental Illness

Lindsay Sheehan, Carlo Vittorio Palermo, &
Patrick Corrigan

Stigma has a profound impact on individuals who have a mental illness, their family members, treatment providers, and communities. The stigma of mental illness has been widely examined in an array of clinical, empirical, and theoretical contexts. Key foci of stigma research include understanding stigma's impact on the individuals and their social interactions, and how our society can change individual-level behaviors and organizational policies to reduce stigma. Theories provide an important framework for organizing research to achieve these goals. In this chapter we explore the theoretical underpinnings of various types of mental illness stigma, including public stigma, self-stigma, associative stigma, and structural stigma.

The theoretical orientations to stigma described herein, drawn from psychology, sociology, and various practice-based disciplines, ground the work on reducing stigma in a multitude of ways. First, theories help describe the phenomenon of stigma (Prewitt et al., 2012), which validates stigma-related experiences for those with mental illness, and allows others who might perpetuate stigma (e.g., healthcare providers, students, family members) to understand how stigma functions to marginalize people with mental illness. Viewing stigma through the lens of theory allows the learner to reflect on mediators and moderators of stigma and how these might relate to their own experiences. Thus, theories help organize isolated experiences of stigma into a more cohesive narrative that can be systematically understood and examined.

While scientific theories and models initially develop from observations of the natural world, the next step in the scientific process is evaluating theory-based hypotheses in experimental settings (Mortensen & Cialdini, 2010). Hypotheses based on models can be tested with different samples and in varying contexts to determine, for example, what conditions might exacerbate discriminatory behavior toward people with mental illness. Findings that are in line with a theory-driven hypothesis provide support for the theory, while findings that contradict a hypothesis may necessitate an amendment to the theory. In this way, theory and research evolve in tandem using an iterative process, with theoretical models serving as a framework and starting point for subsequent inquiry.

Finally, the testing of theories in real-world contexts beyond those of controlled laboratory experiments is essential (Mortensen & Cialdini, 2010), especially for those who hope to reduce the egregious impact of stigma. Here again, theories can provide the structure to develop and evaluate anti-stigma programs and policies meant to reduce stigma (Prewitt et al., 2012). When theory-based models are successfully implemented and tested, these can be more easily applied in other contexts or locations.

Definition of Key Terms

Goffman's (1963) seminal text defined stigma as "an attribute that is deeply discrediting" and that results in the stigmatized person being seen as "tainted" and subsequently disregarded by society (p. 3). This definition refers to *public stigma*, or the stigma directed from members of the community toward the person with the stigmatized condition (see Table 2.1). Sometimes referred to as *enacted stigma* or *experienced stigma*, public stigma results in acts of discrimination toward individuals with mental illness (Fox et al., 2018). These acts could be more overt, such as denying employment to a person with schizophrenia, or subtle, such as a condescending tone.

When people with a mental illness are aware of their membership in the stigmatized group of "mentally ill," they anticipate that stigma will be directed toward them if their status becomes known. This anticipation is often termed *felt stigma* or *anticipated stigma* (Fox et al., 2018). People with a mental illness who anticipate stigma may engage in *label avoidance*, whereby they stay away from environments or situations in which they are identified as a person who has a psychiatric diagnosis (Corrigan & Wassel, 2008). In contrast to more visible health conditions (e.g., cerebral palsy), individuals with mental illness can often conceal their membership in the stigmatized class, thereby forgoing opportunities for treatment or support through the label avoidance process. Thus, people with schizophrenia might choose not to participate in a supported housing or employment program so that others in the community will not inadvertently learn about their illness.

Some individuals who have a mental illness internalize negative societal attitudes by engaging in *self-stigma*, also called *internalized stigma* (Corrigan et al., 2006a) Self-stigma occurs when a person with a marginalized status agrees that the public's negative views of them are true, with harmful results. For example, a person who believes the common stereotype that depression is a result of personal weakness may feel even worse about themselves if they become depressed. Shame, feelings of low self-worth, and depression are all connected with the internalization of stigma (Corrigan et al., 2006a).

Family members, friends, and mental health clinicians can be tainted through their relationship with a stigmatized individual. This concept, which Goffman termed *courtesy stigma*, now commonly referred to as *associative stigma* (Sheehan et al., 2017), can lead to the acquaintance being blamed, discredited,

Table 2.1 *Key stigma terms*

Term	Definition	Example
Public Stigma	Stereotypes, prejudice, or discrimination directed toward a person with mental illness. Also called "enacted stigma" or "experienced stigma."	Employer denies hiring a person with mental illness.
Anticipated Stigma	Person with mental illness anticipates that stigma will be directed toward them if their status becomes known. Also called "felt stigma."	Person with mental illness fears that an employer will not hire them if they know they have a mental illness.
Label Avoidance	Person with mental illness avoids activities (such as care seeking) that will label them as having a mental illness.	Person with mental illness does not seek services at the mental health clinic for fear of being labeled "crazy."
Self-Stigma	Person with mental illness applies negative stereotypes about mental illness to themself. Also called "internalized stigma."	Person with mental illness feels ashamed and depressed when they internalize negative stereotypes.
Associative Stigma	Stereotypes, prejudice, or discrimination directed toward associates (friends, family members, healthcare providers) of a person with mental illness. Also called "courtesy stigma" or "stigma by association."	Father of person with mental illness is ostracized by their neighbors.
Structural Stigma	Unfair treatment against people with mental illness that is perpetrated by social institutions or organizations.	Lack of insurance coverage for people with mental illness.

or devalued (Goffman, 1963). In *family stigma*, a subtype of associative stigma, family members affected by associative stigma may encourage the individual with mental illness to conceal their condition or withhold needed support to evade the stigma. Just as people with mental illness might suffer from self-stigma, family members can internalize stigma and feel ashamed by their connection to mental illness (Corrigan & Miller, 2004).

In a related phenomenon, families or other loved ones experience *vicarious stigma* when they are hurt by witnessing or anticipating unfair treatment toward their child, parent, or sibling with a mental illness (Corrigan & Miller, 2004). In vicarious stigma, the family member does not apply stereotypes about mental illness to their loved one (public stigma) or to themselves (self-stigma) or directly experience stigma by association (associative stigma); rather, they experience distress from society's view of their loved one. For example, a father experiences vicarious stigma in the form of anger when he hears that his daughter is being teased about her mental illness at school.

Finally, *structural stigma* is unfair treatment against people with mental illness that is perpetrated by social institutions or organizations on a wider scale (Corrigan et al., 2004). Structural stigmas may be intentional or unintentional, and carried out via cultural practices, policies, legislation, or structural barriers. Examples of structural stigma for mental illness include deficiencies in insurance coverage for mental health, lack of funding for people with psychiatric disabilities in community living settings rather than institutions, and deficiencies in enforcement of Americans with Disabilities Act for people with mental illness.

Review of the Literature

We review the theoretical literature on mental illness stigma based on the aforementioned definitions of public stigma, self-stigma, associative stigma, and structural stigma, describing the conceptual underpinning of each type, then reviewing multi-level theories of stigma.

Public Stigma

Goffman (1963) described three categories of stigma: (1) "tribal identities" such as race or ethnicity, (2) physical characteristics such as body disfigurement, and (3) "defects of character" such as mental illness or addiction. Goffman suggested that these categories result in worse outcomes when the attribute is visible to others. Mental illness is generally considered a concealable stigmatized identity; however, some severe symptoms of mental illness (e.g., disorganization and responding to auditory hallucinations) may indicate mental illness to society. Link and Phelan (2001) suggest that in order for public stigma to ensue, five conditions should be met: (1) people perceive differences between groups, (2) negative stereotypes about the group form on a societal level, (3) people begin separating others into distinct groups, whereby an "us versus them" mentality forms, (4) people in one group experience discrimination and loss of status from being labeled, and (5) there are disparities in power (social, economic, or political) between the labeled group and the labelers (Link & Phelan, 2001). These conditions bolster the five theories related to public stigma that are discussed in this section: (1) modified labeling theory, (2) social cognitive model, (3) stereotype content model, (4) implicit stigma, and (5) attribution theory. Table 2.2 provides an overview of these theories.

Modified Labeling Theory (MLT). Labeling theory is an important framework for understanding the effects of stigma associated with psychiatric conditions. Labeling theory suggests that majority group members view and label those with minority group status as deviations from the "normal," leading to their devaluation. This perception of being labeled as deviant will then impact the ways that minority groups view themselves and how they behave in social situations. According to Link and colleagues (1989), modified labeling theory

Table 2.2 *Overview of theories and models of public stigma*

Theory	Description
Modified Labeling Theory	People with mental illness expect rejection based on stigma and therefore respond by keeping their illness a secret, withdrawing from social relationships, *or* changing the label and educating others about their experiences.
Social Cognitive Model	Stereotypes, prejudice, and discrimination are three components of stigma.
Stereotype Content Model	Social groups are viewed on continuums of warmth and competence.
Implicit Stigma	Unconscious bias is a subtle form of stigma that drives prejudice and discrimination
Attribution Theory	People attribute mental illness to different factors, leading to blame of others for being responsible for their illness or for failing to recover.

(MLT) explains how individuals are socialized to adopt negative attitudes toward individuals with mental illness. During socialization with in a specific culture, individuals learn about the social differences that exist between oneself and the stigmatized person/group (Link & Phelan, 2001). Once a person acquires a mental illness, these attitudes become personally relevant and they expect devaluation and social rejection. In turn, they can respond in several ways: (1) maintain secrecy regarding their symptoms and diagnosis, (2) withdraw from social situations wherein they can be labeled, or (3) educate others about mental illness. Negative outcomes may derive directly from a person's own beliefs about the community's attitudes, or they may derive from attempts to protect themselves by engaging in avoidant and isolative behaviors. In support of this theory, expectations of rejection are associated with unpleasant and negative outcomes, such as unemployment, low earnings, feelings of shame and guilt, social exclusion, and demoralization (Link et al., 1989). In addition, meta-analyses find that higher perceptions of stigma by people with mental illness are associated with reduced social support, suggesting that people are withdrawing to avoid the label (Livingston & Boyd, 2010). While MLT provides a foundational understanding of the labeling process that underlies many theories discussed in this chapter, it is limited to explaining individual-level rather than multi-level interactions such as structural stigma.

Social Cognitive Model. The social cognitive model builds on the basic premise of MLT to explain how thoughts, emotions, and behaviors connect to the perpetration of stigma. According to the social cognitive model, stigma is a complex phenomenon composed of three social psychological constructs: stereotypes, prejudices, and discrimination (Sheehan et al., 2017). Public stigma unfolds through a cognitive-behavioral process whereby cognitions lead to emotions and behaviors. Stereotypes are the widespread generalizations about a group, and so are considered cognitive. For example, “People with schizophrenia are dangerous” is a stereotype. Prejudice is the emotional reaction resulting from agreeing with the stereotype (“Yes, they are dangerous and I’m uncomfortable around them”), whereas discrimination is the behavior deriving from stereotypes and prejudices (“I won’t hire someone like that”).

With mental illness, social cues such as eccentricity, the presence of a symptomatology, or obvious labeling (e.g., “I know that person: he’s crazy”) provide the foundation for the cognitive-behavioral process. In fact, when an individual is identified as a member, or potential member, of a stigmatized group, the stereotypes associated with that particular group are activated, and then prejudice and discrimination ensue. In accordance with MLT, the person in the stigmatized group may engage in *label avoidance*, and sacrifice opportunities for treatment and support. For example, people with mental illness may skip taking psychiatric medication in front of others to avoid revealing their illness. Similarly, people may not seek out counseling or other services to avoid being seen entering the mental health clinic. The social cognitive approach to public stigma provides structure for the progressive model of self-stigma (described later in the chapter), but is also limited to describing interactions on the social and individual levels of stigma.

Stereotype Content Model. The stereotype content model, as an extension of the social cognitive approach, posits that people engage in stereotyping behavior based on perceived *warmth* and *competence* of social groups (Fiske et al., 2002). Stereotypes about groups can fall into four categories within the warmth-competence matrix: (1) low for both warmth and competence; (2) high for both warmth and competence; (3) low in warmth, high in competence; and (4) high in warmth, low in competence (Fiske, 2018; see Figure 2.1). Stereotype content about social groups subsequently leads to either positive or negative reactions toward people in that group. Low-warmth and low-competence groups arouse feelings of contempt, while high-warmth and high-competence groups elicit

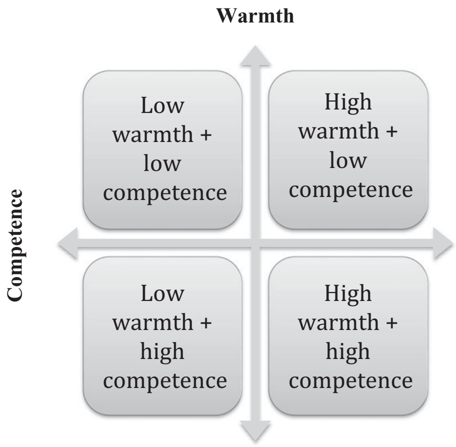

Figure 2.1 *Stereotype content model. Adapted from Fiske (2018)*

admiration. Low-warmth and high-competence groups are often envied, while high-warmth and low-competence are pitied (Fiske, 2018). Groups that are viewed as warm but incompetent include elderly, people with disabilities, and young children. Groups seen as low in warmth, but high in competence include the rich, businesspeople, and technical experts.

People with mental illness are stereotyped as relatively low in both warmth and competence; however, this varies based on diagnosis (Boysen, 2017). People with mood disorders fall in the moderate range of competence and warmth, whereas people with schizophrenia are viewed as low on both. Research on the stereotype content model has explored stereotypes of more masculine mental health disorders (e.g., substance use disorder, antisocial personality disorder) versus more feminine disorders (e.g., eating disorders, borderline personality disorder), finding that people with masculine disorders are viewed as lacking warmth and competence (Boysen, 2017). Masculine disorders also elicit more negative emotions and behavioral intentions than feminine disorders (Boysen, 2017). The stereotype content model allows for comparisons among various disorders and predictions about emotional and behavioral responses based on stereotype content of warmth and competence.

Implicit Stigma. Most research on the stigma of mental illness has viewed stigma as a conscious and intentional process. However, according to the *dual process model*, stigma originates through both automatic and deliberate mental processing (Reeder & Pryor, 2008). Whereas deliberate processing involves cognitive effort and control, automatic or implicit processing uses mental heuristics such as stereotypes to guide reactions. Social cues (e.g., person's appearance) may automatically activate stereotypes, and deliberate processing is required to override initial impressions. Dual processing sometimes results in a contradiction between emotional and behavioral responses (Reeder & Pryor, 2008). For example, someone might have an implicit reaction of fear upon meeting a person with schizophrenia, but nevertheless treat that person with kindness. In some situations, such as under time constraints or high-pressure situations, people rely more on implicit processing, while in other situations there is an opportunity and motivation for reflection and deliberation about social groups (Reeder & Pryor, 2008). Since people may not be aware of implicit bias, they cannot accurately convey such beliefs and feelings on self-report measures of prejudice or other diagnostic tests aimed at investigating stigma toward those who experience a given health condition (Mannarini & Boffo, 2014). Consequently, implicit bias is often measured using the Implicit Association Test (IAT; Greenwald et al., 1998). Originally designed to evaluate implicit forms of racial prejudice, the IAT is a computerized task that assesses the strength of automatic associations between target categories (e.g., faces, names, objects) and positive/negative evaluations (e.g., adjectives such as good and bad) by measuring the speed with which people classify stimuli.

Teachman and colleagues (2006) showed that the general public and even those diagnosed with mental illness had somewhat more implicit AND explicit bias toward people with mental illness than physical illness. However, individuals who had personally experienced a mental illness in themselves or a family member showed lower implicit bias than those who had no personal familiarity with mental illness (Sandhu et al., 2019). In support of the dual process model, some findings show no relationship between scores on implicit and explicit bias measures (Sandhu et al, 2019), suggesting that implicit and explicit bias may be independent of each other. Mental health professionals who do not explicitly express prejudicial attitudes on self-report measures can show higher scores on implicit bias measures (Brener et al., 2013). Moreover, mental health professionals and graduate students were more likely to over-diagnose patients when they scored highly on an implicit bias task (Peris et al., 2008). Implicit bias in mental health workers has also predicted support for more controlling practices, such as involuntary treatment of people with mental illness (Stull et al., 2013). Further research has shown that while explicit attitudes of mental health workers were not related to behavioral intentions to help patients, negative implicit attitudes were connected to reduced intentions to help (Brener et al., 2013). Taken together, these findings imply that implicit bias may be an important factor in healthcare discrimination.

Attribution Theory. Attribution theory is a useful orientation to help explain stigma development toward various disorders. Attribution theory posits that perceived cause of a stigmatized identity will determine the stigmatizer's response (Weiner, 1995). Attribution theory describes three factors: (1) internal versus external locus of control for the condition, (2) stability of the cause of the condition, and (3) controllability over the condition. Those who are perceived as being personally responsible for their condition may be subject to higher levels of stigma. Weiner (1995) also makes a distinction between onset and offset responsibility. Whereas onset responsibility refers to the person's agency for the development of the condition or belonging to a group, the offset responsibility is the perceived ability to manage recovery (Sheehan et al., 2017). Those who experience obesity, for example, are considered to possess high levels of both onset and offset responsibility because: (1) they are viewed by society as responsible for becoming overweight through overeating and/or lack of exercise (onset) and (2) they are perceived as having the ability to lose weight through changing their lifestyle (offset). Therefore, people with obesity may be subject to greater stigmatization than other health conditions in which onset and offset responsibilities are lower (Malterud & Ulriksen, 2011). Similarly, individuals with a mental illness may find themselves feeling a strong sense of guilt for their mental health condition, given how society blames and assigns responsibility for the illness (Schomerus et al., 2014). Biogenetic explanations of mental illness (e.g., schizophrenia is a disease of the brain) appear to challenge conceptions about personal responsibility for the disorder, thereby reducing stigma. Paradoxically, however, biogenetic attributions threaten to emphasize differences between those with and without a mental illness (e.g., their brain is just damaged), and to undermine potential for recovery, when people assume that because the etiology is biological, recovery efforts are futile (Kvaale et al., 2013). Prejudices based in biogenetic explanations can increase stigmatizing behaviors such as paternalism. Thus, attribution theory suggests fruitful avenues for research focused on measuring and changing the public's attributions about both the etiology of onset and recovery from mental illness.

Self-Stigma

Self-stigma (or internalized stigma) occurs when a person with a mental illness applies negative public attitudes to themselves (Corrigan & Watson, 2002). Self-stigma is experienced by many people with severe mental illness, with more than one fifth of people with affective disorders and half of people with schizophrenia or other psychotic disorders reporting self-stigma at moderate to high levels (Brohan et al., 2011). A higher level of self-stigma in people with mental illness is inversely related to self-esteem, self-efficacy, and quality of life, while positively correlated with psychiatric symptoms (Corrigan et al., 2011; Picco et el., 2016; Pearl et al., 2017). A person with mental illness who has internalized stigma risks experiencing the *why try effect*, wherein they give up pursuit of life goals such as work, school, or relationships (Corrigan et al., 2009). In the why try effect, people with a mental illness may think, "Why should I try to reconnect with my family? I'm worthless anyway" or "Why even try applying for that job? I'm disabled." Research also suggests that implicit bias toward self is vital in understanding self-stigma; in people with mental illness, an implicit measure of self-stigma predicted reduced quality of life, independent of the explicit, self-report measure (Rüsch et al., 2010). Thus, understanding the nature of self-stigma is essential to prevent and overcome potential consequences (Göpfert et al., 2019).

Progressive Model of Self-Stigma. The progressive model of self-stigma offers a social cognitive theoretical basis for the process of self-stigmatization (Corrigan et al., 2006a). The progressive model describes four phases of stigma internalization: awareness of stereotypes, personal agreement with stereotypes, application of the stigma to self, and resulting harm. In the progressive model, much as Link and colleagues (1989) suggest in MLT, awareness of stereotypes about people with mental illness results from a socialization process. A person with mental illness who is aware of a specific stereotype (e.g., "People with bipolar are crazy") might go on to agree with that stereotype ("I guess they are crazy") and then apply it to themselves ("I've got bipolar, so I must be crazy"). In the final stage of the progressive model, harm manifests in the form of shame, low self-esteem, or depression, which may further complicate recovery from psychiatric symptoms. There are two main assumptions postulated by the model: (1) a "trickle down" process such that the highest levels of endorsement are for stereotype awareness, followed by lower endorsements for each subsequent stage and (2) proximal stages that are more strongly associated with one another than more distant stages. Thus, although many people with mental illness express awareness of stereotypes, many fewer will actually endorse them as valid, apply those stereotypes to their own identity, and experience the negative consequences of this endorsement.

Stigma Management

Self-stigma does not impact all people with mental illness equally; despite awareness of public stigma, some individuals are relatively impervious to self-stigma. For example, research suggests that trait resilience might be an important factor in maintaining resistance to self-stigma such that characteristics that comprise resilience, such as flexibility, balance, perseverance, and independence, could protect individuals from the harmful effects of self-stigma (Hofer et al., 2019). Given that mental illness is oftentimes a concealable identity, people with mental illness may also manage the effects of stigma through stigma resistance strategies, including strategically disclosing their mental health status, the implications of which can vary by person and context. Here we explore a theoretical model on stigma resistance and two conceptual models describing disclosure-related decision-making.

Stigma Resistance Model. Firmin and colleagues (2017) describe stigma resistance as a continuous process by which individuals with stigmatized conditions use their lived experiences and capacities to reduce the impact of stigma. This theory, based on qualitative interviews with individuals living with mental illness, describes three levels of resistance: (1) personal, (2) peer, and (3) public. On the personal level, a person with a mental illness can simply choose not to agree with stigma or cognitively challenge stigma. Alternately, they might learn information about recovery from mental illness, thereby experiencing a sense of empowerment in which the stigma no longer seems as relevant. To personally address stigma, some individuals may focus on their own efforts toward recovery with the goal of proving society's negative attitudes about them as false, while others may forge an identity separate from one of "person with a mental illness." On a peer level, people with mental illness resist stigma by helping mental health peers challenge stigma in their lives. Finally, on the public level, people with mental illness may educate others, challenge stigma publicly, disclose their status, or engage in advocacy activities.

Disclosure Process Model. The disclosure process model (DPM; Chaudoir & Fisher; 2010) explains how individuals with stigmatized identities decide to share (i.e., disclose) their identities within social contexts. This model recognizes that two processes, a decision-making process and an outcome process, interact to produce a feedback loop for future disclosure. The model predicts that disclosure will result in either harm or benefit, depending on a variety of contextual factors, including the disclosure goals, disclosure contents, and confidant reactions. If the person with a stigmatized identity initiates disclosure with the goal of a positive result (e.g., getting healthcare), this is an *approach goal*. Disclosure goals that center on evading negative results (e.g., avoiding people calling me crazy) are termed *avoidance goals*. The DPM model predicts that approach goals will be more effective than avoidant goals and that breadth, depth, and emotional content of the disclosure, along with confidant response, will combine to determine both outcomes and future disclosure behaviors. For example, if Maria just briefly mentions to her friend that she was depressed in the past (low breadth, depth, and emotional content), she will be less likely to benefit from her friend’s emotional support, since her friend will assume her depression is in the past and she does not seem amenable to talking about it now. Similarly, if the friend responds to the disclosure in an unsupportive way (e.g., “Really? You were depressed??”), Maria is less likely to talk with her friend about depression in the future.

Furthermore, the model recognizes that while disclosure can produce feelings of relief from revealing the stigmatized identity (i.e., reduction of inhibition), the person who discloses experiences either provision or withdrawal of social support, and a subsequent change in the dynamic of their social interaction with the confidant. While the DPM has been applied to other concealable stigmatized identities, it has not been well studied in the field of mental illness (Chaudoir et al., 2011). Thus, the DPM provides a useful framework for testing hypotheses about mental illness disclosure to support people with mental illness in strategic decision making.

Disclosure Decision-Making Model (DD-MM). The disclosure decision-making model (DD-MM) was developed to apply across health conditions and reflects how individuals with concealable health conditions balance individual and contextual factors during the decisional process (Greene et al., 2012). First, individuals with the health condition evaluate aspects of the health condition itself, which includes five characteristics: (1) amount of stigma attached to the condition, (2) prognosis associated with the condition, (3) symptoms of the condition, (4) how prepared the person with the condition is for acquiring the condition (i.e., whether was it expected or anticipated in some way), and (5) relevance of the condition for others (i.e., how much other people may be impacted by the condition). Second, persons with the health condition consider information related to the receiver or confidant, which includes the relationship quality between discloser and confidant, the confidant’s anticipated reaction, and how assured the person is that the confidant will respond in the anticipated manner. If Jim is considering telling his new girlfriend about his depression, he will think about whether the relationship is close enough yet, will try to predict how she might react, and will determine whether he knows her well enough yet to predict her reaction. Third, persons with the health condition consider their own confidence level in executing the actual disclosure. At this stage in the disclosure decision, Jim will be thinking about how he might approach the topic and how well he thinks he will be able to explain his depression to his girlfriend. This model has considerable potential for developing and testing hypotheses related to stigma and disclosure of mental illness. For example, if a person with mental illness believes family members might have to take care of them for an extended period of time due to a diagnosis of schizophrenia (prognosis and relevance), how will that connect with the anticipated reaction from family members? This model has been examined using a structural equation modeling approach in people with a variety of concealable conditions, resulting in considerable support for the hypothesized pathways (Greene et al., 2012). Additionally, Pahwa and colleagues (2017) used the

DD-MM to explore disclosure of mental health, finding that lower perceptions of social support were connected with reduced disclosure preferences.

Associative Stigma

Associative stigma happens when those affiliated with the stigmatized individual are "tainted" by their association and have public stigma applied to them. Associative stigma applies to family, friends, neighbors, employers, service providers, or other individuals who appear connected to the stigmatized group (van der Sanden et al., 2013). For example, psychiatric nurses are less likely than other specialty nurses to be described as skilled and respected (Halter, 2008). However, associative stigma has particular implications for families (Corrigan & Miller, 2004). This *family stigma* varies by relationship to the stigmatized individual and can result in family members feeling shame and isolation and being alienated from their communities (Corrigan et al., 2006b). Research has shown that parents of a child with mental illness are blamed for onset of the illness, whereas children of parents with mental illness are seen as contaminated. More distal family members such as spouses and siblings may be blamed for failing to provide adequate supports to help the person with mental illness in their recovery. Family members who anticipate stigma directed at their loved one have increased psychological distress and may attempt to separate themselves from the family member with mental illness (van der Sanden et al., 2013). Families may sacrifice opportunities for treatment or support when they hide a diagnosis or delay care out of stigma-related fears (Corrigan et al., 2014). Consistent with the progressive model of self-stigma, family members can internalize public stigma, feel shame, and blame themselves for the illness (Moses, 2013). In *vicarious stigma*, families also experience pain because of stigmatizing treatment toward their loved one (Corrigan & Miller, 2004). Only a few research studies have examined associative and vicarious stigma of mental illness, and these have been mostly descriptive. Researchers can explore how the larger theoretical frameworks presented later in this chapter can incorporate associative and vicarious stigma, and determine how best to design and evaluate anti-stigma interventions in this area.

Structural Stigma

Regardless of whether or not an individual experiences stigma within the interpersonal sphere, they may be subject to environments that restrict their rights. Structural stigma occurs when prejudice and discrimination become embedded in social policies and practices (Hatzenbuehler, 2016). Structural stigma can be explicit and intentional, such as a policy to restrict firearm rights for people with a history of mental illness, or can be unintentional, such as restructured funding mechanisms for mental health services (Sheehan et al., 2017). Structural stigma arises from the same stereotypes and assumptions that drive public stigma, but results in broader and systematic consequences.

Another example of intentional structural stigma is statutes that restrict parental rights because of past history of mental illness (Corrigan et al., 2004). In addition, some states restrict those with a mental health diagnosis from voting, serving on juries, or holding public office (Corrigan et al., 2004). These laws stem from stereotypes of incompetency, violence, and treatment-resistance of mental illness and become especially problematic when enforced without regard for reinstatement of rights upon recovery or remittance of disability (Corrigan et al., 2004).

Examples of unintentional structural stigma may involve biased media characterizations (Corrigan et al., 2004), lack of access to care (Link & Phelan, 2001), or exclusion from community participation (Zubritsky et al., 2006). Those with mental illness and other disabilities sometimes reside in institutionalized care such as nursing homes, despite the capacity to live in more integrated community housing if provided the support and opportunity (Cremin, 2012).

Protest and advocacy efforts to challenge structural stigma led to the passage of the Americans with Disabilities Act (ADA) and the subsequent *Olmstead* v. *L.C.* (1999) court decision. This decision directed U.S. states to offer individuals with disabilities, including those with serious mental illness, who were living in nursing homes to have access to community rather than institutional living (Zubritsky et al., 2006). Advocacy efforts have also led to the passage of laws requiring health insurance to cover mental health services at the same level as physical health services (Barry et al., 2010).

While the ADA, *Olmstead* decision, and mental health parity laws provide evidence that advocacy strategies can change laws, policies, and discriminatory behaviors, the field lacks theory-informed research on *how* to most effectively address structural stigma. Future research could use theoretical orientations to explore which characteristics of advocacy campaigns are most appealing to key decision makers and which implementation science strategies should be employed for wide-scale stigma reduction. Research could also examine how mandatory behavior changes to reduce structural stigma (e.g., workplace anti-discrimination laws) influence the endorsement of prejudicial attitudes on an interpersonal level (e.g., perceptions of coworker with a disability).

Multi-Level Frameworks

Several recent theories have recognized multi-level frameworks that describe the development and impact of stigma using an ecological structure. We review two of these here: the Mental Illness Stigma Framework and the Health Stigma and Discrimination Framework.

Mental Illness Stigma Framework (MISF). The Mental Illness Stigma Framework (MISF), proposed by Fox and colleagues (2018), differentiates between perceived stigma and personal stigma. Perceived stigma refers to an individual's perception of stigma in society (what someone believes about how society views members of a stigmatized group), which is formed in a cultural context and results in a marginalized identity for individuals with mental illness.

Perceived stigma is the only type of stigma that is experienced by persons both with and without a mental illness. In contrast, personal stigma describes the person's own stigmatizing beliefs – in other words, their own stereotypes, prejudices and discriminatory behavior toward people with mental illness.

The MISF model separately reflects the perspective of the stigmatizer and the stigmatized. The stigmatizer perpetrates stereotypes, prejudice, and discrimination, resulting in outcomes such as reduced funding for mental health and restricted employment opportunities. The stigmatized person with a mental illness, in contrast, is most affected by internalized stigma, experienced stigma, and anticipated stigma. In this model, internalized stigma happens when a person with mental illness applies negative stereotypes to themselves and experiences negative feelings as a result. Experienced stigma is the person's encounters with people or social institutions that restrict their rights or exhibit prejudice toward them, whereas anticipated stigma refers to the expectation that the person will encounter experienced stigma from others. Together these three types of stigma result in personal outcomes such as treatment engagement, mental wellness, social support, and physical health. For example, a person with a high level of internalized stigma might feel too ashamed to seek care, might avoid care because they anticipate poor treatment, or might directly experience unfair treatment when they participate in an under-resourced treatment system.

Importantly, this model also recognizes the impact of intersectional characteristics of both the stigmatizer and the stigmatized. Intersectionality refers to how multiple stigmatized identities of an individual combine with one another to further complicate the impact of stigma. Intersectional characteristics could include gender, race, sexual orientation, socioeconomic status, or mental illness type. For example, a stigmatizer with the intersectional identity of "young Latinx male" may perceive and perpetrate stigma in a different way than "older White female." Conversely, a stigmatized identity of "older Black male with schizophrenia" may experience or anticipate stigma much differently than "young White female with depression" (for more on stigma and intersectionality, see Chapter 10 this volume).

Although this model can help differentiate between types of stigma and how each type impacts the individual, it fails to explicitly include concepts such as associative stigma and structural stigma. Associative stigma (the stigma directly experienced by friends, family, or healthcare providers of people with mental illness) is important to acknowledge within stigma frameworks, given that it is influenced by societal perceptions (i.e., public stigma), has direct impact on associates of people with mental illness through their devaluation (e.g., low wages for mental health workers), and has indirect impact on support for people with mental illness (e.g., high turnover of mental health workers due to low wages and devalued status of profession). Although MISF includes public policy support as an outcome of personal stigma, it does not indicate how changes in structural stigma might impact the other types of stigma in the framework.

Health Stigma and Discrimination Framework (HSDF). Theoretical frameworks from other health conditions can provide insight into mental illness stigma as well. Stangl and colleagues (2019) have developed an overall health stigma model, the Health Stigma and Discrimination Framework (HSDF), that explicitly avoids the dichotomy of stigmatizer-stigmatized, choosing instead to accentuate larger contextual factors that influence stigma. They argue that viewing stigma as an act perpetrated by one individual against another reduces the emphasis on environmental factors that can promote broader stigma changes. In this model, drivers and facilitators of stigma interact with personal identities to result in stigma experiences, practices, and outcomes. The drivers of health stigma include factors such as stereotypes about the health condition, social and economic threats, and fear of illness contagion. The model recognizes that drivers of stigma will vary by culture and health condition. Whereas drivers of stigma are negative in that they increase stigma, facilitators of stigma influence stigma in either a positive or negative direction. Facilitators include factors like health policy, cultural norms, and legislation. Together, drivers and facilitators lead to whether or not an individual with a stigmatized condition will be identified or "marked," leading to the manifestations of stigma. Like the MISF, HSDF recognizes that the mark of stigma can occur based on health conditions *and* simultaneously on other intersectional characteristics such as gender, age, and sexual orientation. Manifestations consist of stigma experiences and stigma practices. Stigma experiences comprise experienced stigma, self-stigma (i.e., internalized stigma), perceived stigma, anticipated stigma, and associative (i.e., secondary) stigma. In contrast, stigma practices describe how stigma is perpetrated in society through stereotypes, prejudice, and discrimination. Finally, the outcomes of stigma can be for either the affected individuals or for organizations and institutions, and ultimately lead to larger societal impacts such as morbidity, mortality, and quality of life in the population. Thus, HSDF combines several theoretical orientations to stigma change and identifies key areas for research, monitoring, and intervention at each level of the model (Stangl et al., 2019).

Future Research Recommendations

Conceptual models help researchers to clarify overlapping concepts, select study measures, and guide research hypotheses on stigma (Stangl et al., 2019). While ideally interventions to reduce stigma are theory based, in reality, many are not (Fox et al., 2018). Advocates, researchers, and other stakeholders can use theoretical frameworks outlined here to develop and evaluate anti-stigma programs and test hypotheses about essential components of stigma change interventions. Importantly, research and program development should also involve those most impacted by stigma – people living with a mental illness. Community-based participatory research (CBPR) describes a philosophy and framework toward research that encourages the involvement of end-users of healthcare in the research process (Minkler & Wallerstein, 2011). CBPR involves community members with a mental illness and other stakeholders working together throughout the research process and engaging in bidirectional learning. In bidirectional learning, the researcher collaborates with and learns from individuals with mental illness about their needs, perspectives, and daily realities. In turn, individuals with mental illness learn about research and ensure that research studies are relevant and consumer centered.

Both qualitative and quantitative research might be done to examine how explicit and implicit stigma might operate in conjunction with each other. Future stigma research can use theoretical models to further examine the intersectionality of stigma, discover how race, gender, and stigma interact to affect the individual. Research using these theoretical models can also explore how individuals can build resistance to stigma, and how they can make decisions about disclosure of mental illness. Furthermore, there is a need to understand how self-stigma and experienced stigma might lead to anticipated stigma and label avoidance, thereby preventing healthcare engagement and access.

Conclusion

As we have highlighted throughout this chapter, stigma is a socially constructed phenomenon that occurs on multiple levels and has broad implications for both individuals with mental illness and society as a whole. We have discussed theoretical models related to public, self, associative, and structural stigma of mental illness, as well as multi-level stigma frameworks. These theoretical approaches to understanding stigma are essential to guiding future anti-stigma programming and research.

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3 Disentangling Mental Illness and Help-Seeking Stigmas

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Stigma is the adverse beliefs and discriminatory views against someone based on personal traits and behaviors that are considered undesirable (Blaine, 2000). Mental health stigma plays a meaningful, deleterious role for those experiencing mental health concerns, interfering with treatment seeking, compliance, and engagement, exacerbating depression, and lowering self-esteem (Conner et al., 2010; Fung & Tang, 2010; Lannin et al., 2015; Seidman, Wade et al., 2019). Having a mental illness is stigmatized, as is the act of seeking psychological help (Ben-Porath, 2002; Corrigan, 2004; Vogel et al., 2006). Historically, researchers have often lumped these forms of stigma together (Lannin et al., 2015). Researchers have also identified several forms of stigma related to mental illness as well as seeking psychological help at external levels (i.e., stigma held by members of the public; Corrigan, 2004; Komiya et al., 2000), and internal levels (i.e., stigma held by oneself; Corrigan, 2004; Vogel et al., 2006). This research raises an important question – are stigmas toward those with mental illness and stigmas toward seeking psychological help theoretically distinct? That is, there may be unique stigmas related to mental health based on who is stigmatizing (e.g., public, self) and what is being stigmatized (i.e., having a mental illness, seeking psychological help). Table 3.1 provides a graphic illustrating these conceptual differences by highlighting the source of stigma (the public or the self) and the target of stigma (mental illness or help seeking). Disentangling these stigmas is essential to understanding the pathways through which they interfere with mental health and help seeking and, in turn, to developing effective, targeted interventions that increase help seeking and improve mental health.

Recently, researchers have taken a more active role in defining the unique forms of stigma related to mental illness and seeking help (Corrigan, 2004; Lannin et al., 2015; Vogel et al., 2006, 2009), understanding how they uniquely relate to each other and relevant help seeking and mental health outcomes (e.g., Lannin et al., 2015; Vogel et al., 2017), and examining evidence to test these theoretical distinctions (Brenner et al., 2019; Lannin et al., 2015; Tucker et al., 2013). This evolving research currently indicates that mental illness and help-seeking stigmas operate with theoretical distinction and demonstrate meaningfully unique relationships to clinically relevant outcomes; however, this research continues to grow.

As such, this current chapter has two central aims: (1) outline these different forms of stigma, including how they relate to each other and mental health and

Table 3.1 *Different types of stigmas related to having a mental illness and help seeking*

	Target of stigma	
Source of stigma	Mental illness	Help seeking
Public	Public stigma of mental illness	Public stigma of help seeking
Self	Self-stigma of mental illness	Self-stigma of help seeking

help-seeking outcomes and (2) report the current state of the science regarding the theoretical and applied distinctions between the help-seeking and mental illness stigmas. We provide an overview of the internalized stigma model (ISM; Lannin et al., 2015), which provided the first framework for the theoretical delineation of the four major stigmas and their unique relationships with mental health and help-seeking outcomes. Then we discuss each form of stigma and the extant support for the relationships outlined by the ISM, explore new research findings that further test the delineation of these mental illness and help-seeking stigmas, and looke to related future directions.

Internalized Stigma Model

Building upon prior work (e.g., Corrigan 2005; Corrigan & Watson, 2002; Link et al., 1989; Link & Phelan, 2001; Vogel et al., 2007), Lannin et al. (2015) proposed the *internalized stigma model* (ISM; see Figure 3.1), which aimed to explain the development of internalized stigma as well as its impact on relevant mental health and help-seeking outcomes. This model provided the first simultaneous consideration of the four major stigmas at once: public stigma of help seeking, public stigma of mental illness, self-stigma of help seeking, and self-stigma of mental illness. Although we will expand upon each of these stigmas in this chapter, we briefly provide definitions of each form of stigma now.

The *public stigma of mental illness* refers to the societal stigma toward those who have or are perceived to have mental illness (Corrigan, 2004; Corrigan & Watson, 2002). The *self-stigma of mental illness* is the reduction in self-worth one experiences for having a mental illness or anticipates experiencing if they were to have a mental illness (Corrigan, 2004; Corrigan & Watson, 2002). The *public stigma of help seeking* denotes the societal stigma toward individuals who seek psychological help (Vogel et al., 2006). The *self-stigma of help seeking* refers to the reduction in self-worth one experiences for seeking professional help or anticipates experiencing if they were to seek professional help for mental health concerns (Vogel et al., 2006). In other words, the public stigmas of mental illness and seeking help represent perceptions of societally held stigmas targeted toward having mental health concerns or for seeking help, respectively. Both of these public stigmas are internalized as their respective self-stigma of

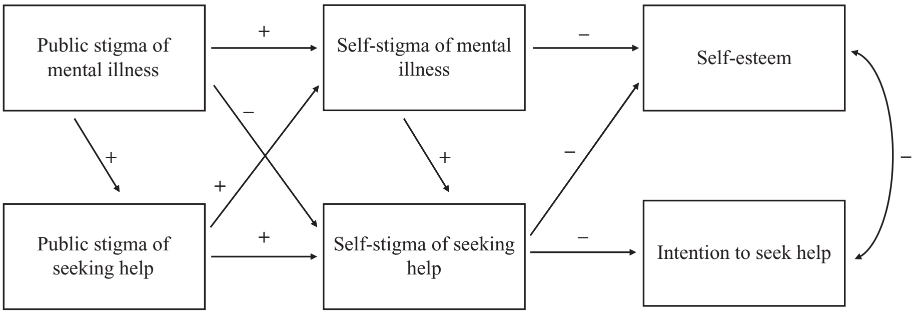

Figure 3.1 *The internalized stigma model. (Lannin et al., 2015)*

mental illness or self-stigma of seeking help, in which the individual acts as their own society, turning the perceived public stigma inward toward themselves.

Rooted in modified labeling theory (Link et al., 1989) and the social cognitive model of stigma (see Corrigan, 2004), the ISM makes several assertions that this chapter will explore. First, implied in the model framework, the ISM posits that the stigmas of seeking help and of mental illness are theoretically distinct from each other. Second, a central assertion is that each public stigma is internalized as its respective self-stigma. Third, the self-stigmas mediate the relationships between public stigmas and recovery variables such as self-esteem and intent to seek psychological help. That is, as illustrated in Figure 3.1, the model highlights two parallel paths, where public stigma of mental illness is linked to greater self-stigma of mental illness, and public stigma of seeking help is linked to greater self-stigma of seeking help, and both self-stigmas are detrimentally linked to relevant help-seeking and mental health outcomes. The ISM also posits that self-stigma of seeking help mediates the public stigma of mental illness, and self-stigma of mental illness mediates public stigma of seeking help; nascent research findings support this claim (Lannin et al., 2015), and also suggest that the unique strengths of these relationships may be smaller than with their respective stigmas (Brenner et al., 2019; Lannin et al., 2015; Tucker et al., 2013).

Finally, based in previous research (e.g., Tucker et al., 2013), the ISM proposed a unique pattern of relationships with help-seeking outcomes. Because self-stigma operates by eliciting negative self-evaluations (Lannin et al., 2015), the ISM posits that both the self-stigma of mental illness and the self-stigma of seeking help are uniquely linked to lower self-esteem; however, only the self-stigma of seeking help is uniquely linked to intentions to seek help – the self-stigma of mental illness is not. The ISM reasons that because the self-stigma of seeking help directly devalues seeking psychological services, the self-stigma of seeking help will be more proximally related to intention to seek help than the self-stigma of mental illness. Thus, the self-stigma of seeking help should mediate the relationship between self-stigma of mental illness and intention to seek help, with the only self-stigma of seeking help uniquely linked to this intention.

Stigma of Mental Illness. According to modified labeling theory (Link et al., 1989), mental illness carries devaluing, denigrating, and discriminatory labels, or stereotypes toward individuals "labeled" with mental illness. Indeed, those with mental illness face societal stereotypes (e.g., dangerous, incompetent), prejudices (e.g., endorsing these stereotypes, fearing those with mental illness, viewing people with mental illness as incompetent), and discrimination (e.g., not hiring someone with mental illness; Corrigan, 2004).

Ben-Porath (2002) conducted an experimental study in which 422 college students in the United States read one of four vignettes in which "Tom" was either depressed after a breakup or injured his back. These vignettes were identical except for manipulation of the disorder type (mental versus physical health) and mental health treatment. That is, "Tom" either had been (1) depressed after a breakup three months ago and sought mental health treatment, (2) depressed after a breakup three months ago, (3) injured his back three months ago and sought treatment from the university health center, or (4) injured his back three months ago. All vignettes ended saying that Tom is doing better now. After reading the vignette, participants rated "Tom" on scales that captured dimensions: Warm, Emotional Instability, Interpersonally Interesting, Competence, and Confidence. Demonstrating the existence of stigma toward those with mental illness, participants who read the vignette in which "Tom" was depressed rated him as more emotionally unstable, less interpersonally interesting, less competent, and less confident compared to those rating the vignette in which "Tom" suffered from a physical injury.

Indeed, the existence of societal stigma toward those with mental illness is well documented. A systematic review of stigma of mental illness in the United States indicates that there is a pervasive societal stigma toward individuals with mental health concerns; across studies and age groups, adults and children endorsed the beliefs that those with mental illnesses are violent, dangerous, and incompetent. These beliefs are tied to the tendency to desire to keep social distance from such people (Parcesepe & Cabassa, 2013). Moreover, individuals with mental illness experience disproportionate rates of homelessness, housing discrimination, and employment discrimination when compared to individuals without mental health concerns. For example, in a study on job acquisition among individuals with severe mental health issues, only 56% of participants were able to find competitive employment (Corbiere et al., 2011). The level of stigma varied between groups – for example, those with substance use disorder and other drug dependence as well as children with depression were among the most stigmatized – nonetheless, stigma toward those with mental illness appeared to be present to some degree for all mental health concerns (Parcesepe & Cabassa, 2013). This stigma may be on the rise. For example, in 2006 people with mental illness were 2.3 times more likely to be perceived as violent compared to perceptions in 1950, which indicates that over time people are increasingly perceiving individuals with mental illness as dangerous (Parcesepe & Cabassa, 2013; see Chapter 5 in this Handbook for additional discussion of changes in stigma over time).

Public Stigma of Mental Illness. Unsurprisingly, people are aware of the stigma society holds toward those with mental illness. While some studies, such as those discussed above, assess the existence this societal stigma, awareness of it can also lend psychological and behavioral consequences (e.g., Link et al., 1989; Vogel et al., 2007). Thus, most researchers have assessed awareness of the *public stigma of mental illness* (i.e., societally held stigma toward those who have or appear to have mental illness). This includes awareness of the stereotypes (e.g., dangerous, incompetent), prejudices (e.g., endorsing these stereotypes, fearing those with mental illness, viewing people with mental illness as incompetent), and discrimination (e.g., not hiring someone with mental illness; Corrigan, 2004) mentioned above. Public stigma of mental illness is most often measured using the Beliefs about Devaluation-Discrimination (BDD; Link, 1987) scale.

Self-Stigma of Mental Illness. Link and colleagues' modified labeling theory (1989) and those of other theorists (Corrigan, 2004; Corrigan & Watson, 2002) also suggest that those labeled as mentally ill may turn the stereotypes and prejudice held by society inward toward themselves and experience an internal degradation of self-worth. While the research on mental illness stigma existed for decades earlier (e.g., Freeman, 1961; Link et al., 1989), Corrigan and colleagues (e.g., Corrigan, 2004; Corrigan & Watson, 2002) formally delineated public stigma of mental illness from the self-stigma of mental illness. Self-stigma is the internalized shame associated with a specific condition or characteristic (Corrigan, 2004). The *self-stigma of mental illness* is the reduction in self-worth one experiences due to having a mental illness or anticipates experiencing if they were to have a mental illness (Corrigan, 2004; Link & Phelan, 2001). That is, in addition to the negative impacts of others' stigma toward those with mental illness (e.g., lost job opportunities, viewed as socially undesirable), people may apply these stereotypes and prejudices to themselves (Corrigan, 2004). Internalizing this external, public stigma, people may view themselves as incompetent and unworthy, or carry out those same forms of discrimination in themselves, believing they should not even pursue a job because of their incompetence (Corrigan, 2004). Self-stigma of mental illness is most-often measured using the Internalized Stigma of Mental Illness Scale (Ritsher et al., 2003) or the application subscale of the Self-Stigma of Mental Illness Scale-Short Form (Corrigan et al., 2012).

Further, this process can result in decreased self-esteem (Link et al., 1987) and hinder one's interpersonal relationships (Farina et al., 1971). This may then lead to increased vulnerability for mental health issues in the future (Link et al., 1989). Hughes and colleagues (2020) examined the impact of the self-stigma of mental illness on intentions and behaviors to seek psychological help in a sample of people who previously received mental health care as well as a general community sample. For individuals who previously sought help for mental health concerns, endorsing high rates of self-stigma was linked with fewer intentions to seek psychological help for themselves. Further, the results indicated that stigma has the greatest influence on behavioral outcomes (e.g., making an appointment for therapy) when actions are psychologically proximal (e.g., seeking treatment in 2 days) compared to psychologically distant (e.g., 3 months). That is, self-stigma impacted participant's treatment decisions more when the behavioral outcome was in the near future compared to several weeks away.

Stigma of Seeking Help. As the research examining the stigma of mental illness continued to flourish, a similar, parallel line of research began to gain momentum. Researchers applied modified labeling theory (Link et al., 1989) to contend that a comparable but distinct process can occur for seeking psychological help. A person who seeks psychological help may be labeled or label themselves as a help seeker, and help seeking carries its own stigma (Vogel et al., 2006). That is, researchers began to distinguish between the stigma of seeking help and the stigma of having a mental illness. In the "Tom" vignette study mentioned earlier, Ben-Porath (2002) also examined help-seeking behavior. Participants rated "Tom" as more unstable and less confident when he sought help than when he didn't, regardless of whether it was for depression or physical injury (Ben-Porath, 2002). In other words, there is a stigma for seeking help that is different from the presence of a mental illness, specifically. Indeed, help seekers are associated with labels such as awkward, defensive, insecure, inadequate, inferior, not in control of one's emotions, weak, or disturbed (King, et al., 1973; Sibicky & Dovidio, 1986; Vogel et al., 2006, 2009). Similar to mental illness stigma, the stigma of seeking help also entails its own unique set of stigmas, which we outline below.

Public Stigma of Seeking Help. Paralleling the public stigma of mental illness, the *public stigma of seeking help* refers to the societal stigma toward seeking psychological help. This stigma entails the view that those who seek help are socially unacceptable or undesirable (Vogel et al., 2006). Indeed, those who have sought psychological help in the past report higher perceived discrimination relative to those who have not sought psychological help (Jorm & Wright, 2008). Public stigma of seeking help is most often measured as to the extent to which people perceive or are aware of this societal stigma using such scales as the Stigma Scale for Receiving Psychological Help (Komiya et al., 2000). This public stigma has been found worldwide (see Vogel et al., 2017), in Australia (Mellor et al., 2013), Brazil (Sartorius & Schulze, 2005), Canada (Cook & Wang, 2010; Mackenzie et al., 2019), China (Lee et al., 2005), Hong Kong (Lam et al., 2015; Mak & Cheung, 2010), Israel (Shechtman et al., 2018), Portugal (Evans-Lacko et al., 2012; Gonçalves et al., 2013), Romania (Evans-Lacko et al., 2012), Taiwan (Mellor et al., 2013), Turkey (Güneri & Skovholt, 1999; Topkaya, 2011; Topyaka et al., 2017; Towle & Arslanoglu, 1998), the United Arab Emirates (Al-Krenawi, et al., 2004; Heath et al., 2016), and the United States (Brenner, Cornish et al., 2020; Komiya et al., 2000; Vogel et al., 2017).

Self-Stigma of Seeking Help. In parallel to Corrigan and colleagues' public stigma and self-stigma of mental illness model (Corrigan, 2004; Corrigan & Watson, 2002) and modified labeling theory (Link, 1989), help-seeking researchers propose that there is a self-stigma of seeking help. Whereas the self-stigma of mental illness denotes the reduction in self-worth one experiences if they have a mental illness (Link & Phelan, 2001), the *self-stigma of seeking help* is the reduction in self-worth if one were to seek professional help for mental health concerns (Vogel et al., 2006). Self-stigma of seeking help is most often measured as an anticipated reduction in self-worth (as this anticipation can be a barrier to even considering seeking help) via the Self-Stigma of Seeking Help (SSOSH) scale (Vogel et al., 2006), of which screener (SSOSH-3) and brief versions (SSOSH-7) have recently been published (Brenner, Colvin et al., 2020). The original SSOSH has received psychometric support across six countries (i.e., England, Greece, Israel, Taiwan, Turkey, and the United States; Vogel, Armstrong et al., 2013), and the items retained in the SSOSH-3 were included in analyses supporting five of the SSOSH items across ten countries (Australia, Brazil, Canada, Hong Kong, Portugal, Romania, Taiwan, Turkey, United Arab Emirates, and the United States; Vogel et al., 2017).

Self-stigma of seeking help has become a major area of research focus due to its harmful relationship with help-seeking outcomes. It is consistently linked with worse attitudes toward seeking psychological help (e.g., Brenner, Colvin et al., 2020), lower intentions to seek psychological help (e.g., Brenner, Colvin et al., 2020; Brenner, Cornish et al., 2020), as well as greater perceived risk and lower anticipated benefit of self-disclosing to a therapist (e.g., Heath, Brenner et al., 2017; Seidman, Lannin et al., 2019; Vogel et al., 2006). Self-stigma of seeking help has been associated with help-seeking related behavior and can even interfere with learning about mental health and help seeking. Among participants with relatively higher levels of distress, studies have found that those with high self-stigma were less likely to seek information about counseling when given the option (Lannin et al., 2016), and they spent less time reading a brochure designed to decrease self-stigma (Cornish et al., 2019). Self-stigma of seeking help has predicted a lower likelihood of participants electing to receive their mental health score (Brenner et al., 2019). Although direct longitudinal examination of self-stigma to behavioral outcomes is limited, self-stigma of seeking help has been linked to attending fewer behavioral healthcare sessions over a 2-year period among active duty service members (Seidman, Wade et al., 2019), and lower likelihood of engaging in inpatient, outpatient, or medication treatment for mental health concerns over 1.5 years among post-9/11 veterans (Fox et al., 2018).

Disentangling Mental Illness and Help-Seeking Stigmas

Thus far, we have provided an overview of the four major types of mental illness and help-seeking stigma. The first assertion of the ISM model is that the stigmas of seeking help and of mental illness are theoretically distinct from each other. Next, we discuss the empirical evidence surrounding the theoretical distinction of these stigmas.

Disentangling Public Stigma. Evidence thus far has generally supported the distinction among the two types of public stigma: mental illness and help seeking. For example, earlier we discussed Ben-Porath's (2002) findings. This study provided the first examination of this distinction. As a reminder, students read one of four vignettes in which "Tom" was depressed or injured, and either sought treatment or did not. If mental illness and help-seeking stigmas were the same, there would be similar results across the depression/no help-seeking and depression/help-seeking conditions. However, as mentioned earlier, participants rated Tom as more emotionally unstable, less interpersonally interesting, less competent, and less confident when he experienced depression compared to a physical injury, and more unstable and less confident when he sought help for depression or physical injury (Ben-Porath, 2002). This demonstrates a unique pattern of responses. Moreover, Ben-Porath found a significant interaction between disorder type and help-seeking behavior; participants rated Tom as more emotionally unstable when he was depressed and sought psychological help compared to when was depressed (with no mention of seeking help).

The Ben-Porath (2002) study examines existing stigmas that others hold rather than perceptions of societally held stigmas. If these stigmas operate uniquely among people who are part of society, it follows that others would perceive these stigmas as distinct and, in turn, public stigma of mental illness would function independently from public stigma of seeking help. Although the distinction of these external stigmas has received less attention than self-stigmas, there does appear to be support for this distinction. For example, an exploratory factor analysis of items from five stigma measures, including the public stigma of seeking help and public stigma of mental illness, found that the public stigma of help-seeking items loaded onto a separate factor from the public stigma of seeking mental illness items (Vogel et al., 2009). Similarly, in a direct test of the ISM using structural equation modeling (SEM) the researchers found a good fit of the measurement model (i.e., testing whether the conceptualization of the model constructs demonstrated a good fit to the data), which included a distinction of these public stigmas (Lannin et al., 2015).

Disentangling Self-Stigmas. Several studies have also directly examined the theorized distinctions between the self-stigmas of mental illness and help seeking. As with public stigma, one avenue used to assess the theorized distinction was through testing competing measurement models using SEM. Tucker et al. (2013) developed the Self-Stigma of Mental Illness (SSOMI) scale by altering the wording of the SSOSH (Vogel et al., 2006) scale items to refer to mental illness rather than to seeking help. They then used confirmatory factor analysis (CFA) with a clinical undergraduate sample and a community sample with a reported history of mental illness to demonstrate that the self-stigma of mental illness (SSOMI items) and self-stigma of seeking help (SSOSH items) are best modeled as separate factors. Building on this study, Brenner et al. (2019) used a series of CFAs across two community and student samples to determine whether the high correlations observed between the SSOSH and SSOMI across multiple samples (Lannin et al., 2015; Tucker et al., 2013) indicated a general self-stigma factor (Reise, Moore, & Haviland, 2010), or simply represented method variance shared between the SSOSH and SSOMI that prior studies had not accounted for. They determined that an oblique (i.e., correlated) two-factor model with additional method factors best fit the data. This reinforced the conclusion offered by Tucker et al. (2013): that the self-stigma of mental illness and the self-stigma of seeking help are independent constructs and should be treated as such in future theorizing and empirical research.

Unique Relationships with Self-Report Outcomes. Another avenue through which researchers can test the theoretical distinction between constructs is by examining distinct relationships with clinically relevant outcomes. If the constructs are theoretically distinct, they should demonstrate unique patterns of relationships with other variables. Indeed, the ISM proposed unique patterns of relationships with mental health and help-seeking outcomes such that both self-stigmas directly contribute to mental health, whereas only self-stigma of seeking help would relate to help-seeking behavior. Using self-esteem and intent to seek help to represent the mental health and help-seeking outcomes, respectively, Lannin et al. (2015) found initial support for this assertion. While both self-stigmas were inversely related to self-esteem, only self-stigma of seeking help was inversely related to intent to seek help. Tucker et al. (2013) also found that each self-stigma accounted for unique variance in help-seeking variables such as public stigma of seeking help and public stigma of mental illness, whereas in both samples only self-stigma of seeking help consistently accounted for unique variance in intentions to seek professional help. Using university and community samples, Brenner et al. (2019) likewise found that the self-stigma of seeking help was uniquely associated with lower intention to seek help and greater public help-seeking stigma, whereas the self-stigma of mental illness was uniquely associated with greater self-coldness, less self-compassion, and lower life satisfaction.

Essential to delineating these self-stigmas is demonstrating differences in predicting behavior. Accordingly, Brenner et al. (2019) determined that self-stigma of seeking help was associated with unwillingness to receive feedback on their current level of psychological distress as measured by the K6 screening scale (Kessler et al., 2002), whereas the self-stigma of mental illness was (surprisingly) associated with willingness to receive this score.

Internalization of Public Stigma as Self-Stigma

Having now provided evidence for the first assertion of the ISM model (i.e., the stigmas of mental illness and help seeking as distinct), we will next review the evidence for the second assertion of the ISM model, that the two types of public stigma are internalized as their respective self-stigmas.

Mental Illness Stigma. The assertion of the ISM that the public stigma of mental illness is internalized as the self-stigma of mental illness has been supported in a number of cross-sectional studies. Public stigma of mental illness has been linked to greater self-stigma of mental illness, for example, among clinically distressed community adults (Tucker et al., 2013), clinically distressed college students (Tucker et al., 2013), and general samples of university students (Brenner et al., 2019; Lannin et al., 2015). However, one study examining a sample of 75 people in Chicago diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder, or recurrent unipolar major depressive disorder demonstrated small but nonsignificant correlations between public stigma and self-stigma of mental illness (*r*s = .20, .19), measured by the Aware and Apply subscales of the Self-Stigma of Mental Illness Scale (SSMIS; Corrigan et al., 2006; Watson et al., 2007), respectively. Given the consistency of findings in other samples, there is need for researchers to rule out whether this finding reflects a true nonsignificant relationship rather than an artifact of a smaller sample size, or due to differences in measurement approaches.

In addition, longitudinal research is needed to fully realize the extent of internalization between public stigma of mental illness and self-stigma of mental illness, as a major limitation of the cross-sectional research is that correlation does not imply causation. To our knowledge, only one study examined public stigma and self-stigma of mental illness stigma longitudinally (Corrigan et al., 2011). Yet, internalized stigma in this study was not examined as an outcome because the study aims focused on self-esteem and hopelessness leaving this question still open.

Help-Seeking Stigma. The internalization of public stigma of seeking help as self-stigma of seeking help has been examined in both cross-sectional and longitudinal research. The extant literature reveals robust bivariate correlations between public stigma of seeking help and self-stigma of seeking help among clinical community and clinical university student samples (e.g., Tucker et al., 2013), general samples of college students (e.g., Brenner, Colvin et al., 2020; Brenner, Cornish et al., 2020; Heath et al., 2018), college student women and men (e.g., Lannin et al., 2015), community adults (e.g., Brenner, Colvin et al., 2020), and military personnel (e.g., Seidman, Wade et al., 2019; Wade et al., 2015). Cross-sectional studies examining these relationships within a larger theoretical model (i.e., controlling for covariates) and denoting public stigma of seeking help as a predictor of self-stigma of seeking help have consistently found support for this relationship, including among a clinical sample of military personnel (Wade et al., 2015); college students in the United States within the context of career counseling (Ludwikowski et al., 2009); as well as college students in the United States (e.g., Brenner, Cornish et al., 2020; Heath et al., 2018; Lannin et al., 2015; Mathison et al., 2021), Turkey (Topkaya et al., 2017), Hong Kong, Australia, Brazil, Canada, Romania, Taiwan, and the United Arab Emirates (Vogel et al., 2017). One exception should be noted: this path was nonsignificant in Portugal (Vogel et al., 2017).

Although these robust cross-sectional studies provide initial support for this internalization, longitudinal testing is essential given the causal nature of this theorized relationship. In further support of this internalization, a cross-panel analysis from a longitudinal study indicated that public stigma is internalized as self-stigma over time (Vogel, Bitman et al., 2013). Specifically, Vogel, Bitman et al. (2013) collected responses to measures of public stigma and self-stigma of seeking help at two time points (3 months apart), from 448 undergraduate students. They compared four nested models, one of which included only autoregressive paths (i.e., T1 public stigma → T2 public stigma, T1 self-stigma → T2 self-stigma). The three other models included these autoregressive paths, as well as the proposed cross-lag, internalization path (i.e., T1 public stigma → T2 self-stigma), the addition of a T1 self-stigma → T2 public stigma path, or the addition of both of these paths. The cross-lag model that reflected the hypothesized internalization process (i.e., T1 public stigma → T2 self-stigma), demonstrated the best, most parsimonious fit to the data. Therefore, this study provided longitudinal support for the notion proposed by Link and colleagues (Link et al., 1989; Link & Phelan, 2001), Corrigan and colleagues (Corrigan, 2004; Corrigan & Watson, 2002), and the internalized stigma model (Lannin et al., 2015) that public stigma is internalized as self-stigma over time.

Indirect Relationships of Public Stigma through Self-Stigma

Having provided evidence for the first two assertions of the ISM model, we will now review the evidence for the third assertion – that the different self-stigmas will mediate the relationships between their respective public stigmas and clinically relevant outcomes variables (e.g., self-esteem and intent to seek psychological help). This assertion is one of the most commonly examined among mental illness and help-seeking stigma theorists (e.g., Corrigan, 2004; Lannin et al., 2015; Link et al., 1989). This mediation framework has been tested cross-sectionally with stigma of mental illness, in which self-stigma of mental illness mediated the relationship between public stigma of mental illness and attitudes toward mental health treatment (Brown et al., 2010). In this study of 449 African American (n = 220) and White adults (n = 229), Brown et al. found that public stigma demonstrated an indirect effect on mental health treatment attitudes through self-stigma. Lannin et al. (2015) also found support for indirect effects for both public stigmas and self-stigmas. Namely, in a college student sample, public stigma of mental illness was indirectly linked with self-esteem through self-stigma of mental illness. Public stigma of seeking help was indirectly linked with self-esteem and intentions to seek help through self-stigma of seeking help. However, as noted earlier, longitudinal research is needed to truly test the mediation and causal nature of these proposed relationships.

This mediation model has also received cross-sectional support internationally across at least 11 countries, such as Israel (Shechtman et al., 2018), Turkey (Topkaya et al., 2017; Vogel et al., 2017), Australia, Brazil, Canada, Hong Kong, Portugal, Romania, Taiwan, United Arab Emirates, and the United States (see Vogel et al., 2017). The majority of work in this area has focused on the stigma of help seeking in the United States, demonstrating an indirect effect of public stigma of seeking help on help-seeking outcomes (e.g., attitudes toward seeking help, intention to seek help) through self-stigma among college students (Brenner, Cornish et al., 2020; Lannin et al., 2015; Vogel et al., 2017) and veterans (Wade et al., 2015), as well as with unique forms of psychological services such as career counseling (Ludwikowski et al., 2009) and group counseling (Shechtman et al., 2018). However, these studies typically collected data cross-sectionally. Longitudinal research should be used to test this model with appropriate rigor, and more research outside the United States is needed.

Internalization across Stigma Targets

In delineating the stigmas, the internalized stigma model asserts that this cross-target internalization is weaker than same-target internalization. That is, public stigma of mental illness is more strongly linked to self-stigma of mental illness than self-stigma of seeking help, and vice versa. When testing the internalized stigma model, Lannin et al. (2015) found relationships between public stigma of mental illness and public stigma of seeking help demonstrated medium to large effect sizes with self-stigma of mental illness and self-stigma of seeking help, respectively (i.e., $\beta \geq .42$), and small effect sizes with self-stigma of seeking help and self-stigma of mental illness, respectively (i.e., $\beta \leq .20$; Lannin et al., 2015). Statistical differences in the strengths of these relationships were not empirically examined. Interestingly, when examining all four major stigmas in the same model, Lannin et al. (2015) found that public stigma of mental illness demonstrated a small inverse relationship with self-stigma of seeking help (i.e., $\beta = -.12$, $p < .05$), which was significant among women ($\beta = -.14$, $p < .05$) but not men ($\beta = -.06$, $p > .05$). This finding contradicts previous research examining this relationship, (e.g., Tucker et al., 2013; Vogel et al., 2007), but this was the first study to test the four major forms of stigma at once and thus warrants further examination.

The ability to draw conclusions from these study findings is limited in that these studies mostly gathered responses at once point in time, did not include all four stigmas, and/or did not statistically examine differences in relationship strengths. Future research should be conducted to test this to further strengthen (or challenge) the trending findings that public stigmas are more strongly related to their respective self-stigma, and also examine these relationships over time to truly support the assertion of this temporal development. A similar examination to Vogel, Bitman et al. (2013) that includes all four major stigmas could strengthen evidence for this mixed-target internalization process, including the assertion of the temporal development, as well as provide support for the delineation of these stigmas over time. For now, Lannin et al. (2015) appears to lend initial support for the theoretical distinction of these stigmas.

Future Directions

Taken together, this research supports a clear distinction between the self-stigma of seeking help and the self-stigma of mental illness. Veteran health administration agencies, psychotherapy clinics, behavioral health units in hospitals, and university counseling centers hoping to increase help seeking might benefit from focusing their interventions on reducing the self-stigma of seeking help to increase help seeking, to focus on the self-stigma of mental illness to improve mental health and well-being, and to cultivate a willingness to learn about psychological functioning (Brenner et al., 2019). In this vein, identifying interventions that uniquely impact each form of self-stigma would be an important focus of future work. For example, the finding that self-stigma of mental illness but not self-stigma of seeking help was uniquely linked to life satisfaction and lower self-compassion (Brenner et al., 2019) may suggest that positive psychology interventions may be more effective in addressing mental illness stigma and may explain why findings have been mixed regarding the potential for self-compassion to reduce self-stigma of seeking help or buffer its internalization (Heath et al., 2018; Heath, Brenner et al., 2017; Hilliard et al., 2019). Perhaps these findings would be consistent if tested with self-stigma of mental illness (Brenner et al., 2019). Researchers could compare the effects self-compassion and related interventions, such as self-affirmation (e.g., Lannin et al., 2013; Seidman et al., 2018) or acceptance (Brenner, Cornish et al., 2020) on reducing both self-stigmas. Moreover, Brenner, Cornish et al. (2020) called for testing interventions that moderate the impact of self-stigma rather than reduce it. Thus, moderating each self-stigma's impact on behavior, the true outcome researchers are trying to shift, should be a point of focus as well.

As mentioned throughout the chapter, there is a strong need for longitudinal research. As experimental and longitudinal research is expanded, researchers might consider using briefer measures. Recently, researchers developed the SSOSH-3 (Brenner, Colvin et al., 2020), an ultra-brief, three-item version of the SSOSH (Vogel et al., 2006) to make longitudinal research more accessible, particularly to harder-to-reach populations. Because most clients seek initial help for mental health from primary care physicians compared to mental health specialists (Druss et al., 2008), briefer measures can make it feasible to assess stigma during intake in applied medical settings and use tailored interventions that increase the likelihood that a person follows through on their physician's referral to psychological services (Brenner, Colvin et al., 2020). In addition, briefer outcome measures can provide a more valid assessment of intervention effects. Using briefer measures in these projects, and developing similarly brief measures for self-stigma of mental illness, could help researchers conduct such work on a larger scale more accessibly.

Marginalized Populations

As the field continues to expand this work, it is imperative that researchers examine the unique ways these stigmas develop and relate to outcomes among those at greater need for services. Extant work predominantly focuses on White heterosexual samples; yet, people of color (see Maura & de Mamani, 2017), sexual minorities, and transgender and gender nonconforming (TGNC) individuals (Borgogna et al., 2019), among other marginalized individuals, experience mental health disparities and are thus in greater need of such services. Researchers should also be inclusive when considering factors that contribute to the development of self-stigmas. This may include breaking the tendency to exclude women and TGNC individuals from research examining masculinity and self-stigma, especially given how masculine norms (e.g., self-reliance) overlap with other subcultures such as military norms (Heath, Seidman et al., 2017).

Social Network Stigma of Seeking Help

Given the importance of close relationships within collectivists cultures (Cross, Gore, & Morris, 2003; Markus & Kitayama, 1991; Yeh, 2002), we want to bring attention to another form of help-seeking stigma that falls outside the scope of the delineation debate as outlined by the internalized stigma model (Lannin et al., 2015). Vogel et al. (2009) introduced the notion that perceptions of societally held stigma (i.e., public stigma) is not the only form of external stigma that should be measured. *Social network stigma of seeking help* involves the perceived stigma toward seeking psychological help held by those within one's direct social circle (Vogel et al., 2009). This stigma is most often measured using the Perceptions of Stigmatization by Others for Seeking Help (PSOSH) scale (Vogel et al., 2009). Social network stigma has been linked to greater public stigma, greater self-stigma, and worse attitudes toward seeking psychological help (Ludwiskowi et al., 2009; Topkaya et al., 2017; Vogel et al., 2009). Although moderately correlated with public stigma, there is evidence that social network stigma is unique from public stigma. For example, an exploratory factor analysis using items from measures including the PSOSH scale and a measure of public stigma of seeking help found that they loaded onto separate factors (Vogel et al., 2009). In addition, social network stigma has predicted self-stigma of seeking help over and above the public stigma of seeking help among U.S. clinical and general college student samples (Ludwikoswki et al., 2009; Vogel et al., 2009), and Turkish college students (Topkaya et al., 2017). Results from these preliminary studies suggest that social network stigma may demonstrate a smaller unique effect than public stigma; however, more studies are needed to further elucidate this, as well as determine any cross-cultural differences.

This has also received consideration within the realm of mental illness stigma. For example, Fox and colleagues (2018) inadvertently considered social network stigma of mental illness in a study mentioned earlier in the chapter. They found that a one-item measure, "If friends and family knew I had a mental health problem, they would think less of me" (p. 17, Fox et al., 2018), predicted an item that captures self-stigma of seeking help. Indeed, this was taken from the Concerns about Stigma from Loved Ones subscale of the Endorsed and Anticipated Stigma Inventory (EASI; Vogt et al., 2014). This social network stigma of mental illness has been linked with a person's own beliefs toward those with mental health concerns, negative beliefs toward oneself seeking treatment, and negative beliefs toward mental health treatment itself (Vogt et al., 2014). As the debate regarding the theoretical distinction of these stigmas continues, researchers should also consider delineating these forms of social network stigma.

Given the importance of close relationships within collectivists cultures (Cross, Gore, & Morris, 2003; Markus & Kitayama, 1991; Yeh, 2002), researchers have suggested that social network stigma might be particularly relevant within these populations (Topkaya et al., 2017). We found one non-U.S. study examining social network stigma, with this research using a sample of college students in Turkey (Topkaya et al., 2017). Social network stigma demonstrated significant bivariate correlations with greater public stigma of seeking help, greater self-stigma of seeking help, and worse attitudes toward seeking counseling. Interestingly, although public stigma and social network stigma were moderately to strongly correlated with self-stigma of seeking help, in a structural model, social network stigma demonstrated a visibly smaller unique relationship with self-stigma ($\beta = .17$) than did public stigma ($\beta = .57$), and only public stigma demonstrated a unique relationship with intentions to seek counseling. This mirrors Ludwikowski and colleagues' (2009) finding among U.S. college students (βs = .22, .63). This raises questions for future research regarding the cultural meaning of social network stigma. Turkey represents a hybrid of collectivist and individualistic values (İmamoğlu, 2003; Kağıtçıbaşı, 2012; Mocan-Aydin, 2000); therefore, it is plausible that these unique relationships may differ if examined among more strongly collectivist cultures, such as those within China or Taiwan, or among older generations within Turkey, which may be less influenced by social media and intergenerational cultural shifts.

Researchers are starting to pay attention to these cross-cultural questions, which begins by examining the cross-cultural validity of the tools that may help answer them. A study examining the social network stigma measure used by Topkaya et al. (2017), the Personal Stigma of Seeking Help (PSOSH) scale (Vogel et al., 2009), across 11 countries found that the PSOSH items capture the same one-factor structure across countries and supported cross-country comparisons of the strengths of these relationships (Vogel et al., 2019). Although support for mean-difference comparisons were mixed based on the specific countries (Vogel et al., 2019), the bigger questions center less on comparing the extent to which social network stigma exists in these countries, but rather comparing the level of influence of social network stigma (i.e., the strengths of these relationships), which received cross-cultural support. Moreover, these findings raise the question of whether there are other forms of unmeasured stigma that may be more prominent in collectivist cultures. For example, is there a form of self-stigma in which a person experiences a reduction in self-worth for bringing shame to their family as a result of seeking help? Indeed, additional research is needed to more fully understand the impact and cultural variations of social network and other forms of help-seeking stigma, as well as delineate social network stigma of seeking help from social network stigma of mental illness.

Conclusion

This chapter aimed to serve two purposes: (1) to provide distinct definitions of the four prominent forms of mental illness and help-seeking stigma and (2) to discuss the current state of the science regarding the delineation of these stigmas from each other and their relationships with clinically relevant constructs. Current evidence research lends support for the delineation of these stigmas with theoretically distinct relationships with clinically meaningful outcomes. However, future research (e.g., examining help-seeking behavior longitudinally) is needed to replicate, extend, and strengthen these findings.

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4 Measurement of Mental Illness Stigma and Discrimination

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It is over 20 years since Liz Sayce highlighted the importance of considering the power inherent in how mental illness stigma and discrimination are measured (Sayce, 1998). This chapter considers how the differential attention placed on aspects of stigma and discrimination shape the narratives presented in public and scientific discourse. The central question is whether this prioritization reflects the experiences of individuals with a mental illness globally and helps to eliminate the social exclusion, disability discrimination, and human rights violations that are still being experienced by a large proportion of those who experience mental illness. By considering the importance of what we measure, and introducing key principles to define and evaluate the appropriateness of existing measurement approaches, this chapter offers a framework for considering current and future measurement priorities.

Definitions of Stigma and Discrimination

Discrimination has been defined as the behavioral aspect of stigma: the enactment of problems of knowledge (ignorance or misinformation) and problems of attitudes (prejudice) (Thornicroft et al., 2007). Public stigma is defined as public endorsement of prejudice and discrimination toward a minority group such as people with mental illness (Sheehan et al., 2017). Public stigma can be distinguished from personal stigma, which reflects the stigma and discrimination reported by individuals who have experienced mental illness.

Three elements of personal stigma and discrimination are proposed: (1) perceived stigma and discrimination; (2) experienced stigma and discrimination; and (3) self-stigma or internalized stigma and discrimination (Brohan et al., 2010). Perceived stigma is the belief that the public holds negative attitudes toward people with a particular health condition and the fear or expectation

GT and IB are supported by the National Institute for Health Research (NIHR) Applied Research Collaboration South London at King's College London NHS Foundation Trust, and by the NIHR Asset Global Health Unit award. The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health and Social Care. GT is also supported by the Guy's and St Thomas' Charity for the On Trac project (EFT151101), and by the UK Medical Research Council (UKRI) in relation the Emilia (MR/S001255/1) and Indigo Partnership (MR/R023697/1) awards. IB is supported by the NIHR Biomedical Research Centre at South London and Maudsley NHS Foundation Trust

that others will behave in a discriminating way toward them, while experienced stigma refers to instances of unfair treatment or discrimination due to having a mental illness (Corrigan, 1998) and also the experience of actual discrimination and/or participation restrictions on the part of the person affected (Van Brakel, 2006). Self-stigma is a personal response to perceived or experienced stigma. It can be considered a transformative process wherein a person loses their previously held or desired identities (e.g., as a parent, employee, friend, partner) to adopt a stigmatized and devalued view of themselves (Yanos et al., 2008).

This chapter will consider the measurement of personal stigma and discrimination including these three aspects (perceived stigma and discrimination; experienced stigma and discrimination; and self- or internalized stigma and discrimination). These aspects of stigma and discrimination are not independent constructs but rather overlap and influence each other (e.g., experiences of discrimination may influence not only how much future discrimination people with mental illness anticipate but also how much they internalize negative self-stigmatizing feelings; Quinn et al., 2015). For example, the Discrimination and Stigma Scale (DISC), which is an experienced discrimination measure, demonstrated a moderate correlation with aspects of the Internalized Stigma of Mental Illness scale ($r = 0.31$), suggesting that they are assessing related, but distinct, constructs (Brohan et al., 2013). Additional aspects of mental illness stigma and discrimination (e.g., the stigma and discrimination related to seeking psychological help/therapy) are not considered here.

Stigma and Discrimination Measurement: Why Does Measurement Matter?

Stigma and discrimination against people with mental illness is a global problem with considerable public health significance (Evans-Lacko et al., 2012; Hatzenbuehler et al., 2013; Kane et al., 2019; Vistorte et al., 2018). There is a treatment gap in conditions such as major depressive disorder where only 1 in 5 people in high-income and 1 in 27 in low-/lower-middle-income countries receive a minimally appropriate level of treatment (Thornicroft et al., 2017). A mortality gap of 15–20 years of excess mortality has also been observed for individuals with a mental disorder (Wahlbeck et al., 2011).

Discrimination at the macro- (societal factors), meso- (social networks and organizational level factors), and micro-levels (psychological and sociological individual level) represents a pervasive global violation of the human rights of individuals who are experiencing disability due to mental illness (Drew et al., 2011; Pescosolido & Martin, 2015; Pescosolido et al., 2008). Stigma and discrimination have also been reported across many areas of life including employment, education, housing, parenthood, and dating (Brouwers et al., 2016; Jeffery et al., 2013; Thornicroft et al., 2009; Webber et al., 2014).

In considering how to ameliorate the global burden of stigma and discrimination, robust measurement approaches are required that produce high-quality evidence on the impact of implementing discrimination and stigma reduction interventions at the macro-, meso-, and micro-levels of society. These are also important in (1) understanding the socioeconomic determinants of stigma and discrimination; (2) understanding the different mechanisms of stigma and discrimination at the macro-, meso-, miso-levels; and (3) capturing global and culturally specific stigma and discrimination constructs.

As personal stigma and discrimination, including perceived, experienced and self-stigma, and discrimination, are not observable at the point of assessment and concern an individual's beliefs, feelings, or behaviors, then a measurement that comes directly from the individual, without interpretation by a clinician or other party, will provide the most accurate approach (De Vet et al., 2011; Patrick et al., 2007). The remaining sections of this chapter will present measurement considerations for a self-reported assessment such as this. Much of the aspects presented come from the literature on measures of patient-reported outcomes (PROs); however, the terminology of person-reported outcome measures may be more appropriate here, as globally not all individuals with a mental health problem will be patients (Fayers & Machin, 2013).

Aims of This Chapter

The aims of this chapter are to do the following:

1. Highlight the importance of using an appropriately targeted measurement strategy in mental illness stigma and discrimination research
2. Introduce principles of good measurement including content validity, context of use, and psychometric properties (reliability, validity, ability to detect change)
3. Highlight considerations for global and local measurement (translation and cross-cultural adaptation)
4. Summarize the most used measures of perceived, experienced, and self-stigma and discrimination with an emphasis on context of use and available measurement properties
5. Present suggested directions for future measurement research in mental illness stigma and discrimination

Measuring What Matters: Using Appropriately Targeted Measurement Strategies

The way in which the concepts of personal stigma and discrimination are defined and how these concepts are operationalized through the creation of questionnaires will now be discussed. A glossary of key measurement terms from the patient-reported outcomes literature is presented in Table 4.1. This is intended to orient the reader to the terminology and the main aspects that are considered when developing a measure of personal stigma and discrimination, or in selecting an existing measure for use.

Table 4.1 *Glossary of measurement terms*

Term	Definition
Ability to detect change	Evidence that an instrument can identify differences in scores over time in individuals or groups who have changed with respect to the measurement concept. Effect sizes and 95% confidence intervals can be used to assess this property.
Cognitive debriefing	A qualitative research technique used to determine whether concepts and items are understood by intended participants in the way that instrument developers intend. Cognitive interviews involve incorporating follow-up questions in a field-test interview to gain a better understanding of how patients interpret questions asked of them. In this method, respondents are often asked to think aloud and describe their thought processes as they answer the instrument questions (Cappelleri et al., 2013).
Concept	The specific measurement goal (i.e., the thing that is to be measured by a PRO instrument). In clinical trials, a PRO instrument can be used to measure the effect of a medical intervention on one or more concepts. PRO concepts represent aspects of how patients function or feel related to a health condition or related aspect (e.g., stigma).
Conceptual framework	Defines the concepts measured by the instrument in a diagram that presents a description of the relationships between items, domains (subconcepts), and concepts measured and the score produced by a PRO instrument
Construct validity	Evidence that relationships among items, domains, and concepts conform to a priori hypotheses concerning logical relationships that should exist with other measures or characteristics of patients and patient groups.
Content validity	Evidence from qualitative research demonstrating that the instrument measures the concept of interest including evidence that the items and domains of an instrument are appropriate and comprehensive relative to its intended measurement concept, population, and use. Testing other measurement properties will not replace or rectify problems with content validity.
Convergent validity	An aspect of construct validity. Evidence that relationships between results gathered using the instrument and results gathered using other measures are consistent with preexisting hypotheses concerning those relationships. Correlations can be used to assess this property.
Domain	A subconcept represented by a score of an instrument that measures a larger concept composed of multiple domains. For example, psychological function is the larger concept containing the domains subdivided into items describing emotional function and cognitive function.

Table 4.1 (*cont.*)

Term	Definition
Floor and ceiling effects	These are an observed distribution in categorical item responses where item variance is limited by a large proportion of respondents achieving the highest (ceiling) or lowest(floor) possible scores, suggesting a uniform distribution. The thresholds used for flagging floor and ceiling effects for consideration are dependent on the expected pattern of responses within the construct of interest, as a high endorsement of the floor or ceiling is a desirable indicator in some circumstances (e.g., in a pre- and post-evaluation of an intervention).
Instrument	A means to capture data (i.e., a questionnaire) plus all the information and documentation that supports its use. Generally, that includes clearly defined methods and instructions for administration or responding, a standard format for data collection, and well-documented methods for scoring, analysis, and interpretation of results in the target patient population.
Internal consistency	An aspect of reliability. A measurement of the extent to which items comprising a scale measure the same concept. This can be assessed using Cronbach's alpha coefficient (α) or KR-20.
Inter-rater reliability	An aspect of reliability for interview-based or observation-based measures. It assesses the proportion of agreement among interviewers or rates when the PRO is administered by two or more different individuals. This can be assessed using the intra-class correlation coefficient (r) or weighted kappa.
Item	An individual question, statement, or task (and its standardized response options) that is evaluated by the patient to address a particular concept.
Known-groups validity	An aspect of construct validity providing evidence that the instrument can differentiate between distinct groups (e.g., clinically different subgroup). This can be assessed by comparing difference in mean scores between subgroups (e.g., a parametric t-test).
Measurement properties	All the attributes relevant to the application of an instrument including the content validity, construct validity, reliability, and ability to detect change. These attributes are specific to the measurement application and cannot be assumed to be relevant to all measurement situations, purposes, populations, or settings in which the instrument is used.
Minimal important difference	The smallest difference in score in the domain of interest that patients perceive as beneficial and that would mandate, in the absence of troublesome side effects and excessive cost, a change in a patient's management (Jaeschke et al., 1989).
Questionnaire	A set of questions or items shown to a respondent to get answers for research purposes. Types of questionnaires include diaries and event logs.

Table 4.1 (*cont.*)

Term	Definition
Recall period	The period of time that participants are asked to consider in responding to an item or question. Recall can be momentary (real time) or retrospective of varying lengths.
Reliability	The ability of an instrument to yield consistent, reproducible estimates of the construct.
Responder definition	A score change in a measure, experienced by an individual patient over a predetermined time period that has been demonstrated in the target population to have a significant treatment benefit.
Scale	The system of numbers or verbal anchors by which a value or score is derived for an item. Examples include visual analog scales, Likert scales, and numeric rating scales.
Score	A number derived from a person's response to items in a questionnaire. A score is computed based on a prespecified, validated scoring algorithm and is subsequently used in statistical analyses of clinical trial results. Scores can be computed for individual items, domains, or concepts, or as a summary of items, domains, or concepts.
Test-retest reliability	An aspect of reliability. Assessment of stability of scores over time when no change is expected in the concept of interest. Most informative when the time interval chosen between the test and retest is long enough in stable patients to minimize memory effects. This is typically assessed using the intra-class correlation coefficient (r) or weighted kappa.
Translation and cross-cultural adaptation	The process of modifying an instrument if used in a linguistic or cultural context outside the parameters of the original development study. Evidence that the content validity and other measurement properties are adequately similar between any new version and the original is required before versions can be considered equivalent from a conceptual and/or measurement perspective (Van Ommeren et al., 1999).

Source for measurement terms: Food and Drug Administration, 2009.

Principles of Good Measurement: Content Validity, Context of Use, and Evaluation

One of the most important aspects of measurement is *content validity*. This is a foundational principle; if the questionnaire or instrument does not contain items that are relevant and well understood and comprehensively cover the aspect of personal stigma under consideration (be it perceived, experienced, or self-stigma), then other measurement properties cannot supplement this fundamental problem. Content validity is a qualitative measurement property that involves exploring the concept of interest through open-ended questioning. Particular attention is paid to the language used by patients to describe these concepts. The insights from these interviews are used to develop a *conceptual framework*, which is then further developed into a draft questionnaire/instrument. A *cognitive debriefing* process should then be used to assess the conceptual relevance of the items as well as the consistency of understanding and interpretation of the items, instructions, response options, and recall period. Prinsen and colleagues (2018) have developed the consensus-based standards for the selection of health measurement instruments (COSMIN) criteria and rating scale to allow a structured evaluation of the content validity of PROs.

Once content validity has been established, then quantitative or psychometric measurement properties can be established, including *reliability*, *construct validity*, and *ability to detect change*. *Reliability* concerns the ability of an instrument to yield consistent, reproducible estimates of the construct under consideration across time (test-retest reliability); raters (inter-rater reliability); and across item responses (internal consistency). *Construct validity* assesses the ability of the instrument or questionnaire to yield consistent, reproducible estimates of the construct by assessing hypothesized relationships with similar constructs (convergent validity) and within distinct groups, such as clinically different subgroups (known groups). *Ability to detect change* considers whether the instrument can identify differences in scores over time in individuals or groups who have changed with respect to the measurement concept. Each of these properties contributes to an overall understanding of the functioning of the instrument. The COSMIN guideline and risk of bias checklist for systematic reviews of PROs provide a thorough resource for researchers who are interested in a more detailed understanding of how to assess the methodological quality of stigma and discrimination measures (Mokkink et al., 2018; Prinsen et al., 2018).

Considerations for Global and Local Measurement (Translation and Cross-Cultural Adaptation)

Context of use is another fundamental principle of measurement. The Discrimination and Stigma Scale (DISC) offers an example of a measure that has been developed in a globally collaborative way including conducting qualitative work to establish content validity in 28 countries. For measures that are not developed cross-culturally in the first instance, a process of *translation and cross-cultural validation* is recommended (Knudsen et al., 2000). This process can be challenging due to difficulties resulting from the differences in language, tradition, and history that are seen when using work from anglophone countries as a basis for global work (Gaebel et al., 2017). The process of translation and cross-cultural adaption may produce something that is linguistically appropriate and understood by participants but not relevant or comprehensive in its expression of the concept. Moreover, the behaviors, cognitions, and feelings associated with personal stigma and mental health may vary widely (Lauber & Rössler, 2007), shaped by what anthropologists refer to as "local moral worlds." Therefore, instrument items may not be relevant in some contexts (Kleinman, 1999). A systematic review in 2014 suggests that cross-cultural adaptation is not a common process with the vast majority of studies (77%), which in this review meant using existing Western-developed stigma measures in a new cultural group without adapting to include culture-specific forms of stigma. An example of how to develop a *culturally sensitive measurement* approach is provided by Yang and colleagues in their development of an integrative framework that places the stigma experiences of Chinese immigrants in the context of structural discrimination, cultural engagement, and "what matters most," or individual's ability to maintain meaningful participation in the community through activities such as work (Yang et al., 2014).

The importance of considering socioeconomic as well as cultural differences is also emphasized in the literature (Koschorke et al., 2017). This includes consideration of aspects such as poverty and access to healthcare, as well as differences relating to cultural beliefs and norms. The ability to distill a longer instrument into a short form that retains the core aspects of the conceptual framework and demonstrates appropriate psychometric properties is highly advantageous when using measures in lower-resource settings. Bakolis and colleagues provide an example of the process of developing a short-form experienced discrimination measure (Dyskinesia Identification System Condensed User Scale; DISCUS) and the psychometric considerations in this process (Bakolis et al., 2019).

The next section will present and discuss key measures of personal stigma and discrimination.

Most Commonly Used Measures of Perceived, Experienced, and Self-Stigma

A review in 2010 identified 14 scales that assessed aspects of perceived, experienced, and self-stigma in 57 studies (Brohan et al., 2010). Perceived stigma was most frequently assessed in 79% of studies, followed by experienced stigma in 46% of studies and self-stigma in 33% of studies. Since this review was published, five additional reviews have been published that use a similar methodology to consider aspects of personal stigma. Three reviews considered perceived, experienced, and self-stigma and discrimination (Fox et al., 2018; Van Brakel et al., 2019; Wei et al., 2018); one considered perceived and experienced stigma and discrimination (Cardoso et al., 2020); and one considered internalized or self-stigma (Stevelink et al., 2012). This section will review the measures that have been identified by at least three of these five reviews (Brohan et al., 2010; Cardoso et al., 2020; Fox et al., 2018; Stevelink et al., 2012; Wei et al., 2018). This is not intended to be an exhaustive review but rather to provide a snapshot of the most frequently used measures of personal stigma and discrimination. Table 4.2 provides a summary of key information and measurement considerations when using the nine measures that met this criterion.

Table 4.3 then presents a summary of the psychometric properties of each measure, as reported in the five review papers and initial development paper. This table is a modified version of the format suggested by Terwee and colleagues (2007) and focuses on four properties: content validity, internal consistency, construct validity and test-retest reliability, and floor or ceiling effects. It should be noted that although floor or ceiling effects are included as a criterion, a skewed distribution is not unexpected in stigma and discrimination measurement, particularly in intervention studies, and as such the utility of this as an indicator of psychometric quality is uncertain in this field. Information on three further properties (acceptability, responsiveness, and interpretability) is not included, as this was not available for most located measures.

Directions for Future Measurement in Mental Illness Stigma and Discrimination

The mental illness stigma and discrimination field has grown rapidly in the past 15 years, with a large number of measures having been developed. For example, a 2018 review calculated that an average of 36 measures of stigma have been developed per year since 2004 (Fox et al., 2018). In this chapter, we have focused on nine commonly used measures of perceived, experienced, and self-stigma and discrimination. We have summarized measurement considerations in mental illness stigma and discrimination research, introduced key measurement terms, and presented quality criteria to evaluate the measurement properties and establish whether a measure is suitable for the intended context of use (Prinsen et al., 2018; Terwee et al., 2007).

These considerations are particularly key as mental illness stigma and discrimination research evolves to further serve the priorities of the individuals that most experience it. If we consider that the global disease burden of mental illness is largely experienced in low- and middle-income countries (LMICs; Murray et al., 2012), and that most people with mental illness experience stigma and discrimination, then it is imperative that the current disparity wherein measurement properties are not established for this context of use is redressed. The evidence presented affirms the urgent need for evidence on cross-cultural validity and measurement invariance in established personal stigma measures. This requires qualitative methods for transcultural adaptation. A systematic qualitative method for conducting and documenting transcultural translation and adaptation captures five domains that correspond with different types of equivalence: understandability (semantic equivalence – the meaning of each item is the same in each culture), acceptability and other response set issues

Table 4.2 *Key stigma and discrimination measures*

Scale	Measures perceived stigma	Measures experienced stigma	Measures self-stigma	Measures other
1. Perceived Devaluation and Discrimination (PDD) (Link, 1987). **Reviews citing:** (Brohan et al., 2010; Cardoso et al., 2020; Fox et al., 2018; Wei et al., 2018)	Perceived discrimination (6 items) Perceived devaluation (6 items)	No	No	No
	12-item self-complete measure. Each item is rated on a 6-point Likert scale anchored at 1=strongly disagree and 6 = strongly agree. The internal consistency of the scale ranges from α = 0.86 to α = 0.88 (Link et al., 2001). Used by 37/101 studies (Cardoso et al., 2020).			
2. Internalized Stigma of Mental Illness (ISMI) (Ritsher et al., 2003). **Reviews citing:** (Brohan et al., 2010; Fox et al., 2018; Stevelink et al., 2012; Van Brakel et al., 2019; Wei et al., 2018)	No	Discrimination experience (5 items)	Alienation (6 items) Stereotype endorsement (7 items) Social withdrawal (6 items)	Stigma resistance (5 items)
	29-item self-complete measure. Each item is rated on a 4-point Likert scale anchored at 1=strongly disagree and 4 = strongly agree. Internal consistency (α = 0.90), test–retest reliability (r = 0.92). A short-form version is also available (Boyd, Otilingam, et al., 2014). A review of ISMI properties is available (Boyd, Adler, et al., 2014).			

Table 4.2 (*cont.*)

Scale	Measures perceived stigma	Measures experienced stigma	Measures self-stigma	Measures other
3. **Self-Stigma of Mental Illness Scale (SSMIS)** (Corrigan et al., 2006). **Reviews citing:** (Brohan et al., 2010; Fox et al., 2018; Stevelink et al., 2012; Wei et al., 2018)	Stereotype awareness (10 items)	No	Stereotype agreement (10 items) Stereotype self-concurrence (10 items) Self-esteem decrement (10 items)	No
	40-item self-complete measure. Each item is rated on a 9-point Likert scale anchored at 0=strongly disagree and 9 = strongly agree). Internal consistency for subscales range α = 0.72 to α = 0.91. Test-retest reliability for subscales ranged from 0.68–0.82. The stereotype awareness items were adapted from the PDD (Link, 1987). A short-form version is also available (Corrigan, Michaels, et al., 2012).			
4. **Consumer Experiences of Stigma Questionnaire (CESQ)** (Wahl, 1999). **Reviews citing:** (Brohan et al., 2010; Cardoso et al., 2020; Fox et al., 2018; Wei et al., 2018)	No	Experiences of stigma (9 items) Experiences of discrimination (12 items)	No	No
	21-item self-complete postal survey. Each item is rated on a 5-point Likert scale anchored at 1 = never and 5 = very often. Has also been used as an interview. Psychometric properties not reported. Used by 32/101 studies (Cardoso et al., 2020)			
5. **Depression Self-Stigma Scale (DSSS)** (Kanter et al., 2008). **Reviews citing:** (Brohan et al., 2010; Fox et al., 2018; Stevelink et al., 2012; Wei et al., 2018)	Public stigma (4 items)	Stigmatizing experiences (6 items)	General self-stigma (9 items) Secrecy (9 items)	Treatment stigma (4 items)
	32-item self-complete measure. Each item rated on a 7-point Likert scale anchored at 1=completely agree and 7=completely disagree. Internal consistency for subscales range α = 0.78 to α = 0.95 (Rusch et al., 2008)			

6. **Stigma Scale (SS)** (King et al., 2007). **Reviews citing:** (Brohan et al., 2010; Cardoso et al., 2020; Fox et al., 2018; Wei et al., 2018)	No	Discrimination (12 items)	Disclosure (11 items)	Positive aspects (5 items)
	28-item self-complete measure. Each item is rated on a 4-point Likert scale anchored at 0=strongly disagree and 4 = strongly agree. Test-retest reliability (kappa range 0.49–0.71) and internal consistency α = 0.87. Used by 14/101 studies (Cardoso et al., 2020).			
7. **Inventory of Stigmatizing Experiences (ISE)** (Stuart et al., 2005). **Reviews citing:** (Brohan et al., 2010; Cardoso et al., 2020; Fox et al., 2018)	Perceived stigma (2 items)	Experienced stigma (2 items)	Social withdrawal (1 item)	Impact of stigma (5 item)
	10-item interview-based measure with qualitative components. Each item is scored on a 5-point Likert Scale anchored at 1 = never and 5 = always. The scale is intended as a measure of "the extent and impact of stigma." Stigma experiences scale KR-20 = 0.83, stigma impact scale α = 0.91. Used by 10/101 studies (Cardoso et al., 2020).			
8. **Discrimination and Stigma Scale (DISC)** (Thornicroft et al., 2009). **Reviews citing:** (Brohan et al., 2010; Cardoso et al., 2020; Fox et al., 2018; Wei et al., 2018)	Anticipated discrimination (4 items)	Experienced discrimination (32 items)	No	No
	36-item interview-based measure. Each item is scored on a 7-point Likert scale anchored at -3 = strong disadvantage and 3=strong advantage. Psychometric properties are reported in a follow-up paper (Brohan et al., 2013). A short-form version DISCUS is also available (Bakolis et al., 2019). Used by 30/101 studies (Cardoso et al., 2020).			
9. **Self-Stigma Scale Short-Form (SSS-S)** (Mak & Cheung, 2010). **Reviews citing:** (Fox et al., 2018; Stevelink et al., 2012; Wei et al., 2018)	No	No		No
	9-item self-complete measure. Each item is rated on a 5-point Likert-type scale from (1) strongly disagree to (4) strongly agree. Internal consistency was demonstrated α = 0.87. Convergent validity was established (*r* = 0.33–0.54). Test-retest reliability for subscales ranged from 0.68–0.82. self-stigma was significantly related to their current depression and anxiety levels further establishing construct validity.			

Table 4.3 *Assessment of measurement properties of key stigma and discrimination measures*

Scale	Content Validity[1]	Internal Consistency[2]	Construct Validity[3]	Test-retest Reliability[4]	Floor/ceiling effects[5]
1. PDD (Link, 1987)	?	?	+	0	0
2. ISMI (Ritsher et al., 2003)	+	+	+	+	0
3. SSMIS (Corrigan et al., 2006)	+	?	+	+	0
4. CESQ (Wahl, 1999)	+	0	0	0	–
5. DSSS (Kanter et al., 2008)	?	+	+	0	0
6. SS (King et al., 2007)	+	+	+	+	0
7. ISE (Stuart et al., 2005)	+	?	0	0	0
8. DISC (Thornicroft et al., 2009)	+	+	+	+	0
9. Self-stigma scale (SSS) (Mak & Cheung, 2010)	?	+	+	0	?

+ = positive rating of property, ? = indeterminate rating of property, – = negative rating of property, 0 = no information available for property

For each property, a positive rating of the property was made if the below criteria were met (Terwee et al., 2007). Ratings are particularly informed by reviews that used this rating system (Brohan et al., 2010; Stevelink et al., 2012; Wei et al., 2018).

[1] Clear description is provided of the measurement aim, the target population, the concepts that are being measured, and the item selection, target population and (investigators or experts) were involved in item selection.

[2] Factor analysis performed on adequate sample size and Cronbach's alpha calculated per dimension and Cronbach's alpha between 0.70 and 0.95.

[3] Specific hypotheses were formulated and at least 75% of results are in accordance with the hypothesis.

[4] ICC or weighted kappa $\geq$ 0.70.

[5] $\leq$15% of respondents achieved the highest or lowest possible scores.

(technical equivalence – the method of assessment [e.g., interview] is comparable in each culture with respect to the data that it yields), relevance (content equivalence), and completeness (semantic, criterion, and conceptual equivalence; Van Ommeren et al., 1999). However, this approach has been designed and used when the construct is a mental illness. It will be important to explore how this approach works with stigma, which can be a more heterogeneous and contextually specific construct. One approach to employ a conceptual framework to guide cross-cultural adaptation is the use of a "what matters most" framework (Yang et al., 2014). The use of short-form instruments and establishment of item banks are also key considerations in resource-limited settings. Three of the measures reviewed in this chapter have associated short-form versions (ISMI, SSMIS, DISC), and special consideration of these measures is recommended when a short-form measure is most appropriate. The methods used to derive short-form instruments and evaluate them for measurement equivalence also requires further attention, such as innovative factor analytic techniques that have been used to derive the DISC short-form DISCUS (Bakolis et al., 2019).

Intersectionality has been defined as the consideration of the meaning and consequences of membership in multiple stigmatized social groups (Oexle & Corrigan, 2018). This is increasingly recognized in relation to a range of other legally protected characteristics (e.g., age, gender, race, disability, religion, sexuality) that impact on stigma and discrimination measurement, such as ethnic minority populations (Eylem et al., 2020); Hispanic populations (Eghaneyan & Murphy, 2020); comorbid illnesses (Jackson-Best & Edwards, 2018); LGBTQ communities (Morrison et al., 2016); and cross-illness consideration of stigma (Van Brakel et al., 2019). Intersectionality influences group expectations of how one will be treated in society and can potentially overshadow or hide stigma due to mental illness when one is a member of a marginalized group (see Chapters 10–12 in this Handbook for additional discussions of intersectionality). For example, the intersectionality of mental illness stigma and caste discrimination in South Asia can complicate the measurement of stigma, especially when caste identity is associated with mental health–related behaviors such as alcohol use (Kohrt & Harper, 2008; Trani et al., 2015). The consideration of measurement invariance, as well as construct validity if differences are expected for certain groups, is also key in intersectional measurement. There is also a fundamental need to ensure that content validity is established when measures are used in populations that differ from the original context of use.

Beyond content validity considerations, there is a wider question on ownership of the mental illness stigma and discrimination research agenda – researchers must ensure that research priorities reflect the aspects that are of key concern to individuals with a mental illness and that funding is available to facilitate meaningful leadership and co-creation by service users and grassroots organizations outside of academia. Within academia, there is a need to ensure that distribution of research funding is equitable in recognizing institutions based in the LMICs that are receiving an increased research focus. This chapter has emphasized discrimination and stigma measurement, as further linking stigma to discrimination will facilitate the situating of research within a human rights framework and draw focus to measuring what matters and ensuring that the dignity, safety, privacy, and opportunities for full societal participation (healthcare, education, housing, relationships, etc.) are at the forefront of the mental illness stigma and discrimination measurement.

A final key measurement consideration is the need to ensure that measures are suitable for use in interventional contexts if this is the intended context of use. For example, if a measure is to be used in stigma reduction, then it is likely that the intended population will have high stigma at the start and that the measure will detect meaningful changes in stigma. Responsiveness and interpretability were not included in the assessment of the properties of the nine included measures as evidence on these properties was lacking, though available in some cases (e.g., Chang et al., 2014). However, further consideration of responsiveness and interpretability (i.e., whether change is meaningful at the individual and group levels) would help to ensure that mental illness stigma and discrimination measurement is detecting meaningful change (Brohan & Chan, 2019).

There are many other aspects of stigma and discrimination in which measurement considerations abound, including public stigma (Corrigan, Morris, et al., 2012); structural discrimination (Gaebel et al., 2017; Stuart, 2017); implicit stigma (West et al., 2014); associative or courtesy stigma (Angermeyer et al., 2003); and stigma resistance (O'Connor et al., 2018). These areas are beyond the scope of this chapter, although the measurement considerations outlined for personal stigma may offer a roadmap for measurement aspects to consider.

Conclusions

Mental illness stigma and discrimination measurement has evolved over the past 20 years and there are many measures now available. Considerations of content validity, context of use, and psychometric properties are key in evaluating the methodological quality of these measures and appropriateness for use in future studies. Complexity and variation in the experience of stigma and discrimination are now more recognized, with a focus on cross-cultural measurement and intersectionality of experience. This chapter is a call to ensure that we are measuring what matters most and focusing research proportionately on communities who experience the most stigma and discrimination, for example, LMICs. It highlights the value of measurement science in achieving this aim.

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PART II

Impact of Stigma on Mental Health

5 Time Trends in Public Stigma

Georg Schomerus & Matthias C. Angermeyer

Time-Trend Studies of Public Attitudes toward Persons with Mental Illness

Attitudes of the general population about mental illness and people with mental illness are by no means static; they change. Changes in population attitudes are relevant, because what is changing is the cultural conception of mental illness, the social reality defining what it means to have a mental illness in a given place at a particular time. As Link and coworkers (2011) have pointed out, "as a context this cultural conception becomes an external reality, something that individuals must take into account when they make decisions and enact behavior" (p. 255). Any changes in the cultural conception of mental illness have immediate consequences for someone developing or living with a mental illness, particularly in terms of stigma, self-stigma, and structural stigma. Thus, our efforts to alleviate the burden of mental illness need to adjust to these changes.

A systematic review and meta-analysis of time-trend studies in 2012 showed that since the beginning of the 1990s, several broad trends in attitudes toward mental illness and help seeking over time were visible across different countries (Schomerus et al., 2012). First, mental health literacy improved considerably. The share of people who were able to correctly identify disorders presented in unlabeled case vignettes had grown: In Australia, for example, 40% of respondents were able to identify depression in 1995, and 67% in 2004. Across several countries, the proportion of respondents agreeing with biological causes of depression and schizophrenia, such as being inherited or a brain disease, increased by about 20% between 1990 and 2006. Seeking professional help and, specifically, using psychotherapy or medication for mental disorders also became more popular.

At the same time, however, several measures of mental illness stigma did not improve. The most striking finding of the 2012 meta-analysis was an increase in the desire for social distance, specifically with regard to vignettes of a person with schizophrenia. Readiness to accept someone with schizophrenia as a neighbor or as a colleague at work steadily decreased by about 1% annually over 16 years, while no changes occurred with regard to someone with depression. These findings were remarkable for two reasons: First, they were based on studies from different countries covering different, overlapping time frames.

Hence, they showed an overarching common trend regardless of country-specific developments (with the important limitation that all studies were from high-income countries, since no time-trend data were available from low- and middle-income countries). Second, findings seemed to be specific for schizophrenia, since the reaction to someone with depression did not change, thus ruling out other general reasons for changes in responses to the type of questions employed in these surveys. What we were seeing was not growing reluctance to interact with neighbors in general, for instance, but a specific deterioration of attitudes toward people with schizophrenia. The review thus opened up a pertinent question: Why is the desire for social distance toward someone with schizophrenia growing? And, related: Is this time trend continuing up to today, and have attitudes toward persons with other mental disorders also changed? In this chapter, we will examine evidence on time trends in public attitudes that have emerged after the initial review, looking for answers to these questions. We will first summarize findings from studies relying on case vignettes, similar to the studies analyzed in the 2012 meta-regression analysis. These studies use short descriptions of someone with current mental illness, usually without mentioning the diagnosis, so-called unlabeled case vignettes. Hence, these studies elicit reactions to a specific situation, which is described identically over the time period covered. We will then contrast these studies to findings from time-trend studies on reactions to specific terms like "a mental health problem," which have yielded somewhat different results. Here, the stimulus is usually not defined further, but refers to what individual respondents are associating with the term used. From these contrasting findings, we explore whether there is evidence of a broadening of the concept of mental illness among the public, and whether there are any indications for a widening gap between attitudes toward common mental disorders and toward severe mental illness.

But first, we briefly consider some general methodological issues with time-trend studies. To establish valid time trends of population attitudes, repeated cross-sectional surveys are far more suitable than panel studies. Panel studies monitor attitude change in defined cohorts, but attrition over long follow-up periods results in samples that are no longer representative of the population at the end of the study. With repeated cross-sectional surveys, "snapshots" of population attitudes are compared to identify any changes that have occurred on a population level in the interim. For this purpose, however, the methodology of all surveys needs to be identical: The surveys need to study the same population, use identical item wording and response formats, employ identical sampling methods, and, ideally, use the same interview mode at all time points (face-to-face, telephone, online, mail), so that any observed differences in attitudes on a population level represent true changes and not methodological artifacts (Angermeyer & Schomerus, 2017). Studying time trends thus relies on surveys that have been done years, often decades, ago, which need to be replicated identically. A prime example is a study by Phelan and colleagues (2000), who in 1996 did an identical replication of a study done by Shirley Star in 1950, asking about the popular meaning of the term "mental illness." Reliance on previous surveys also comes at a cost: aspects of mental illness stigma that could be of particular interest today, but have not been of interest in earlier surveys, can only be introduced into surveys for present assessment and with respect to future time-trend studies. All time trends we report in this chapter have been found to be statistically significant at least at the 95% confidence level.

Vignette Studies: Evolution of Help-Seeking Recommendations

A recent meta-analysis of studies using vignettes to assess attitudes toward psychiatry and psychiatric treatment showed that, on average, recommendation of both psychotherapy and of medication for a person with schizophrenia or depression increased by about 1% per year over a time period of 21 years from 1990 to 2011 (Angermeyer et al., 2017). The strongest increase was found for recommending medication for schizophrenia (1.5%/year). Similar trends were observed for recommending a general practitioner, a psychiatrist, and a psychologist/psychotherapist. Across several countries and continents, medication was recommended by 49% for depression on average, and by 67% for schizophrenia, while psychotherapy was even more popular, being recommended by 76% for depression and 85% for schizophrenia (Angermeyer et al., 2017). Overall, time trends show solid and growing support for professional treatment of mental disorders.

Evolution of Causal Attributions

For schizophrenia, surveys in Australia and in Germany in 2011 corroborated the trends observed earlier, showing further increases in endorsement of biological, specifically genetic, causes (Angermeyer et al., 2013a; Reavley & Jorm, 2014a). In a recent trend study from Austria, however, different developments for schizophrenia were observed, yielding a declining endorsement of heredity as a cause for schizophrenia from 76% to 70% between 1998 and 2018 (Angermeyer et al., 2021). Different trends were also observed for depression, in which endorsement of biological causes declined (Germany) or did not increase further (Australia). For example, while in Germany 40% had agreed that "heredity" was a cause of depression in 1990, this percentages dropped to 29% in 2011 (Angermeyer et al., 2013a). In Australia, 68% considered depression to have genetic causes in 2004, and 66% did so in 2011 (Pilkington et al., 2013).

Psycho-social causes like "stress" have always been endorsed by large proportions of the population. From high baselines, slightly different trends have emerged over the past years. In Australia, starting at 82% to 90% in 1995, even more respondents (90% to 97%) endorsed causes like "a recent traumatic event" or "problems from childhood" in 2011 to be a likely cause for both depression (with and without suicidal thoughts) and schizophrenia, demonstrating near ubiquitous belief in both present and past psychosocial stressors as causes of mental disorders (Pilkington et al., 2013; Reavley & Jorm, 2014a). In Germany, while belief in "work-related stress" as a cause for depression increased from 70% in 1990 to 80% in 2011, agreement with a "stressful life-event" slightly decreased for schizophrenia (from 71% in 1990 to 66% in 2011) and for alcohol dependence (from 80% to 71%; Angermeyer et al., 2013a). While belief in "bad housing conditions" and "excessive lifestyle" as a cause for schizophrenia increased in Austria between 1998 and 2018, belief in occupational stress as a cause decreased (from 57% to 51%; Angermeyer et al., 2021).

Comparing trends in attitudes from 1996 to 2011 between the public and psychiatrists with regard to depression, Jorm observes that "the public have become much more like psychiatrists in their thinking" (Jorm, 2021, p. 135). This can be said about the beliefs of the public on causes and treatment of mental disorders in general: in line with a bio-psycho-social model of mental disorders, both biological and psycho-social factors are seen as causing mental disorders, and professional help is widely recommended.

Evolution of Stigma: Social Distance and Negative Stereotypes

But how have stigmatizing attitudes evolved? We first look at the desire for social distance and the most pervasive negative stereotypes the general public has been found to hold toward people with mental illness, namely, that they are dangerous and unpredictable. An Australian study compared reactions to different vignettes in 2011 to those in 2004. It showed that perceptions of dangerousness and unpredictability had *increased* for both schizophrenia and depression, while the desire for social distance had *decreased*, particularly toward someone with depression and suicidal thoughts, and remained largely unchanged with regard to the other vignette characters (Reavley & Jorm, 2012). In the United States, a survey in 2018 showed that since 1996, the belief a person with schizophrenia would likely be violent toward themselves and toward others had increased from 47% to 57%. For depression, it remained stable and just over 30% (Pescosolido, Manago, & Monahan, 2019). Perceptions of violence of persons with alcohol dependence were high, but remained also largely unchanged at 60%. In Germany, a 2011 survey showed an increase in the desire for social distance toward a person with schizophrenia. Compared to 1990, the percentage of people indicating reluctance to engage in hypothetical situations increased by double digits for 6 out of 7 situations examined. For example, the proportion being unwilling to have someone with schizophrenia as a neighbor increased from 19% to 29%, being unwilling to work together increased from 20% to 31%, being unwilling to rent them a room increased from 46% to 58%, and unwillingness to introduce them to a friend increased from 39% to 53%. For people with depression, and with alcohol dependence, no consistent changes were observed (Angermeyer et al., 2013a). A time-trend study of negative stereotypes regarding alcohol dependence also showed no meaningful change between 1990 and 2011 in Germany (Schomerus, Matschinger, & Angermeyer, 2014a).

An important hypothesis explaining the increase in social distance toward people with schizophrenia links growing social distance to the increasing popularity of biogenetic illness models. Genetic essentialism (Nelkin & Lindee, 1995) describes the belief that our genes are fundamental to our personal identity, determining who we are and how we behave. Attributing mental illness to biogenetic causes thus risks enhancing a perceived fundamental difference between people with and without mental illness (Kvaale et al., 2013; Phelan, 2005). In fact, a cross-sectional population study of causal attributions and social distance supported this hypothesis particularly for schizophrenia: stronger biogenetic causal beliefs were associated with stronger rejection of someone with schizophrenia, and this relation was mediated by increased perceived differentness and dangerousness (Schomerus et al., 2014b).

A trend study from Austria lends further support to this hypothesis. Here, different to other trend studies, the desire for social distance from a person with schizophrenia decreased between 1998 and 2018. Interestingly, this change was also accompanied by a reduction of genetic causal attributions (Angermeyer et al., 2021). Although the 2012 review and later time-trend studies found a parallel increase of biological causal attributions and desire for social distance, and established a cross-sectional statistical association between them (Schomerus et al., 2014b), the Austrian time-trend study found a parallel development in the opposite direction. This singular finding from Austria thus lends further support to the hypothesis that biogenetic causal attributions increase stigma by showing that a reduction of biogenetic beliefs is accompanied by less stigma.

Emotional Reactions and Approval of Coercion

Other developments could add to the explanation of why attitudes particularly toward someone with schizophrenia have worsened. A study from Germany examined time trends of emotional reactions toward persons with schizophrenia, depression, and alcohol dependence between 1990 and 2011. Again, distinct developments for all three conditions emerged, for example, with regard to pro-social reactions: although the desire to help the person *increased* for depression (from 61% to 68%), it *decreased* for schizophrenia (from 65% to 60%). Reactions of *fear* developed in the opposite direction: feeling uncomfortable increased from 40% to 49% for schizophrenia, and decreased for depression (from 37% to 30%); More people stated they were scared by the person with schizophrenia in 2011 than 1990 (37% versus 30%), while this did not change for depression. The only consistent changes affecting someone with alcohol dependence, which were largely absent in depression and schizophrenia, were increasing expressions of annoyance and anger, the latter growing from 15% to 24%.

Overall, the increase in fear could explain the rising reluctance to deal with someone with schizophrenia in everyday situations. The 2018 survey in the United States added another aspect to this argument: in parallel to the growing anticipation of violence toward others from someone with schizophrenia, *support for coercion* also grew, although no mention of violence was made in the case vignette: 42% supported involuntary hospitalization in 2018, up from 36% in 1996. There was no significant change in preferences for coercion with regard to alcohol dependence and depression (Pescosolido et al., 2019). In Germany, while many negative stereotypes about psychiatric hospitals seemed to diminish, more people in 2011 than in 1990 sustained that psychiatric hospitals are necessary "to protect society from the mentally ill" (Angermeyer et al., 2013a). The impression that growing uneasiness with people who behave in strange and unpredictable ways translates to lower tolerance for these people in daily life was also corroborated by findings from a trend study in eastern Germany (Angermeyer et al., 2014). When asked under which circumstances someone with a mental illness should be hospitalized against their will, a growing proportion agreed with reasons that were not directly linked to violence, such as appearing as a public nuisance (1993: 37%; 2011: 61%) or rejecting medication (1993: 29%; 2011: 40%).

Overall, we found mixed developments with regard to stigma. It appears that notions of dangerousness, expression of fear, and desire for social distance have further increased, particularly when people are confronted with someone with schizophrenia. Developments regarding depression seem more benevolent, with growing pro-social reactions and at least some indicators of reductions of social distance. Little change has been observed in the stigma of alcohol dependence.

Returning to the initial question on reasons for these disparate developments, we have seen two possible explanations: First, a growing notion of seemingly fundamental, biological differentness could increase the perceived "otherness" of people with severe mental disorders like schizophrenia and could increase stigma. Second, a generally lower tolerance for unpredictable, strange behavior, together with growing assumptions about possible violence, could also be responsible for the observed increase in social distance toward people with schizophrenia. Both explanations are not mutually exclusive. Furthermore, they are not exhaustive, since, for example, increases in the perception of violence in Australia have not been accompanied by increases in social distance (Reavley & Jorm, 2012). The relationship between perceptions of violence, fear, and desire for social distance, which has been firmly established in cross-sectional studies (Corrigan et al., 2001; Link et al., 1999), could thus be more complex from a long-term population perspective and would warrant further investigation.

A Different Approach: Attitudes toward "Mental Health Problems"

Parallel to developing and implementing the English national anti-stigma campaign Time to Change (TTC; Henderson & Thornicroft, 2009), Thornicroft and his group compiled a set of concise instruments to monitor public attitudes in England and thus evaluate any effects of TTC (Evans-Lacko et al., 2013). Instead of presenting respondents with a case vignette, they used scales asking about "people with mental health problems" (the Mental Health Knowledge Schedule [MAKS], and the Reported and Intended Behavior Scale [RIBS], a measure of contact and desire for social distance) and "people with mental illness" (the Community Attitudes toward the Mentally Ill [CAMI] scale). Annual population surveys in representative quota samples of the English population were conducted face-to-face from 2008 onward, the latest published results at the time of writing this chapter are from 2017 (Robinson & Henderson, 2019). Over the course of 9 years (or 8 years, since some instruments were introduced only in 2009), they showed significant and meaningful changes in public attitudes that show not only parallels but also relevant differences from time trends elicited in other countries using vignette studies.

From 2009 to 2017, mental health literacy in England improved, as demonstrated by increasing agreement with true statements and decreasing agreement with false statements of the MAKS. For example, agreement with the statement "People with severe mental health problems can fully recover" increased from 60% to 67%, and agreement with "Most people with mental health problems want to have paid employment" increased from 69% to 75%. Agreement with "Medication can be an effective treatment for people with mental health problems," however, slightly decreased from 79% to 73% (while approval of psychotherapy increased from 79% to 83%). Overall, the MAKS score had increased by a standardized effect size of 0.17 in 2017 compared to 2009.

Similarly, attitudes as measured with the CAMI improved. By 2017, its standardized mean score was 0.25 standard deviations (SD) higher than it was 9 years earlier. For example, while 12% stated in 2008 that they would not want to live next door to someone who had been mentally ill, this proportion fell to 7% in 2017. Likewise, 70% agreed in 2008 that "the best therapy for many people with mental illness is to be part of a normal community"; this percentage rose to 81% in 2017.

Social distance was measured with the four-item Intended Behavior subscale of the RIBS. In all four hypothetical relations, live with, work with, live nearby, and continue a relationship, agreement increased by 6% to 15%. For example, in 2009, 57% indicated willingness to live with a person with mental health problems, increasing to 72% in 2017. Furthermore, 69% agreed to work with someone with mental health problems in 2009, rising to 80% in 2017. Remarkably, the Reported Behavior subscale of the RIBS also showed improvement. While 19% reported having lived nearby someone with mental health problems, this number was 26% in 2017. Regarding work, 27% reported contact in 2009, rising to 36% in 2017. Overall, intended behavior had increased by 0.29 SD in 2017, and the odds ratio of reporting contact in 2017 (compared to 2009) was 1.47 (Robinson & Henderson 2019).

These results indicate that a sustained, well-funded, and evidence based anti-stigma campaign like TTC may indeed have long-term effects on population attitudes (Henderson et al., 2016). Changes, however, seem to occur on many levels. Growing mental health literacy and decreasing stigma toward someone with unspecified mental health problems seem accompanied by changes in how people talk about mental health problems and, more importantly, how willing they are to disclose their own mental health problems. The rise in reported contact in fairly stable situations that presumably are not guided by considerations of people's mental health (work with, live nearby), for example, likely reflects a more open conversation about mental health issues and more frequent disclosure in existing social networks, rather than changes in these networks. People seem to be better able to appreciate contact with someone with mental health problems that previously might have occurred unnoticed.

An increase in willingness to disclose personal mental illness was also observed in Australia between 1995 and 2011 (Reavley & Jorm, 2014b). The growing openness about personal mental health issues seems to be a broader trend that is not exclusively tied to anti-stigma campaigns: in Austria (Moosbrugger et al., 2018), where national anti-stigma efforts were lacking, 36% of respondents stated in 2007 they knew someone with depression in their family or among their close friends, and 19% in their neighborhood. These numbers had risen to 50% (family/close friends) and 24% (neighborhood) in 2018. With a stable prevalence of depression (Bretschneider et al., 2018), increases in reported contact are most likely due to increases in disclosure.

Broadening of the Concept of "Mental Illness"

A more open conversation about mental health problems likely also alters the significance of the term "mental health problems." In fact, the scale used to monitor mental health literacy in England, MAKS, also contains a list of six conditions, asking whether they constitute a type of mental illness (depression, schizophrenia, bipolar disorder, and drug addiction, and, as potentially false answers, grief and stress). The definition as mental illness increased for the mental disorders listed, for example for depression from 82% to 88%. It also increased, however, for grief (from 49% to 57%) and stress (from 58% to 66%). Hence, as Robinson and Henderson (2019) discuss, parallel to improving attitudes toward "people with mental health problems," there is evidence that the very definition of mental health problems has changed, that "the public's concept of what constitutes a mental illness has widened" (p. 2723). So, when being asked about whether they would accept living next to someone with mental health problems, respondents might today have different conditions and stories in mind than 10 years ago. This widening of the concept of mental illness is also reflected in international comparisons of reactions to "people with mental health problems." A comparison of reported contact and social distance toward someone with a mental health problem between England and the Czech Republic, where mental health care was characterized by "institutionalization, low awareness among public about mental health issues, and structural discrimination" with regard to funding, showed dramatically lower willingness to interact with someone with mental health problems, and considerably lower reported contact in the Czech Republic (Winkler et al., 2016, p. 802). For example, while 68% in England were willing to work with someone with a mental health problem, this was 20% among the Czech population. Conversely, 26% reported they had actually worked with someone with mental illness in England, while this was stated by only 13% in the Czech Republic. Quite conceivably, the term "mental health problem" had a different, more severe significance in the Czech Republic at the time of the study, since generally in this country, in an underfunded, institutionalized mental health–care system, only severe cases of mental illness were identified and treated.

So, a broadening of the concept of mental health issues and a normalization of mental illness have likely improved awareness of and attitudes toward common mental disorders. This is very much in line with the goals of anti-stigma campaigns like TTC and should be regarded as indicating their success. But again, they may also indicate broader trends that occur similarly in other countries. For example, using Link's Perceived Devaluation and Discrimination (PDD) scale (Link et al., 1989), a trend study in Germany demonstrated that perceived stigma of a "a former mental patient" improved considerably between 1990 and 2011, although acceptance of someone with schizophrenia declined over the same time period (Angermeyer et al., 2014). Again, a change in significance of the label "former mental patient" due to a more open conversation about mental health care could explain this finding, but also, having recovered from mental illness seems less stigmatized than it was in 1990.

A widening of the concept of mental illness was first observed by Phelan and coworkers in their 1996 replication of parts of a study conducted by Shirley Star in 1950 (Phelan et al., 2000). While in 1950, the public's definition of mental illness as elicited by an open-ended question was dominated by mentions of psychosis, anxiety, and depression, in 1996 significantly more people referred to other, non-psychotic diagnostic categories. However, contrary to expectations, more respondents mentioned violent symptoms or other frightening characteristics of mental illness in 1996 compared to 1950. This change was entirely driven by a more violent image of psychosis in 1996 that overshadowed any possible improvements caused by the apparent normalization of mental health problems.

Common versus Severe Mental Health Problems

From the early findings of Phelan and colleagues, and from the present time-trend studies of mental illness stigma, the question arises whether the observed normalization of mental health problems and mental health care today does translate to less stigma toward persons with severe mental health problems like schizophrenia, or whether the divide between reactions to schizophrenia and depression, which has been observed for three decades now, is signifying a growing divide between attitudes toward common mental disorders and severe mental disorders. To establish whether normalizing of common mental health problems comes at the cost of more stigma toward severe mental illness, or whether common mental disorders are normalized and de-stigmatized first, leading the way for the de-stigmatization of severe mental disorders, is certainly a task for future time-trend studies.

So far, two other trends seem to corroborate this diverging development: The growing familiarity with depression observed in Austria between 2007 and 2018 was not accompanied by any increases in reported contact to someone with schizophrenia. While the proportion stating they did not know anybody with depression declined from 50% in 2007 to 33% in 2018, the proportion of not knowing someone with schizophrenia remained high at about 80% and did not change significantly (Moosbrugger et al., 2018). Differences became also apparent when people were asked about where they had obtained information about either disorder. In depression, the percentage of respondents recounting that they had talked to someone with personal experience of depression, or to a family member of someone with depression, increased from 35% (2007) to 52% (2018), while it remained stable at 18% for schizophrenia. Information about schizophrenia was primarily gathered through the media, while in depression, both media information and personal conversations were recalled with equal frequency (Moosbrugger et al., 2018). Hence, a decidedly more open conversation about mental illness in Austria with regard to depression contrasts with little personal exchange about schizophrenia.

Another trend that has shown diverging dynamics for depression on the one side and schizophrenia and alcohol use disorder on the other side is related to resource allocation preferences of the public. Over a period of 19 years, in 2001, 2011, and 2020, samples from the general population in Germany were asked about their funding preferences in healthcare. Under the assumption that in general, costs need to be contained, they were instructed to choose three disorders from a list of nine that should be, in their opinion, protected from any spending cuts (see Figure 5.1). Although in 2001, mental disorders like schizophrenia, alcohol dependence, and depression were least frequently chosen by the public, depression ranked fourth in 2020 (after cancer, diabetes, and cardiovascular diseases), with 25% of respondents prioritizing funding for this disease over other mental and physical disorders, while alcohol dependence and schizophrenia remained at the bottom of the list (Schomerus et al., 2021). However, the share of respondents choosing schizophrenia more than doubled from 8% in 2011 to 17% in 2020, offering at least some hope that in fact gains in public preferences regarding depression might trickle down to schizophrenia. On the other side, a broadening of the concept of mental disorders among the public, and lowering the threshold for using mental health care, could have the unwanted consequence that people with severe mental illness compete with even

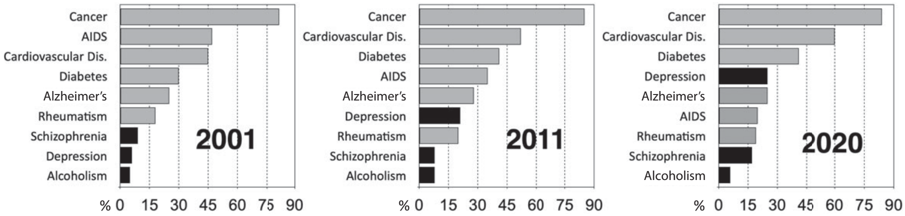

Figure 5.1 *Spending preferences for healthcare among the public in Germany. Instruction: Please chose from the list those three conditions where, in your opinion, spending should on no account be reduced. Representative population surveys in Germany (2001:* n *= 5,025; 2011:* n *= 1,232; 2020:* n *= 1,200), percentage of respondents choosing each condition. Data from (Schomerus et al., 2021)*

more people with minor mental health complaints for scarce mental health–care resources, such as psychotherapy. Only future time-trend studies will show whether the trend of normalizing common mental disorders and mental health treatment continues, and whether it extends to diminishing stigma of severe mental disorders, or whether it amounts to more discrimination for the most vulnerable group of people with severe mental illness.

Attitude Change and Social Context: Beyond Anti-Stigma Campaigns

Larger trends of public opinion, and events that affect society as a whole, are likely to interfere with attitudes toward people with mental illness. We have seen that many of the changes observed in countries with large anti-stigma campaigns were, at least in part, also observable in countries without such campaigns. In England, attitudes as measured with the CAMI started improving *before* the Time to Change campaign was launched, illustrating that anti-stigma campaigns are simultaneously the result *and* the driver of attitude change (Evans-Lacko et al., 2014). The above-mentioned study on time trends of resource allocation preferences was conducted to see whether willingness to secure funding for mental health care was reduced under the unique conditions of the COVID-19 pandemic (which seemed not to be the case), a cause of social disruption with huge consequences in many areas of life. In the United States, the increase in perception of potential violence and approval of involuntary treatment, which also extended to "troubled persons," has been attributed not only to media coverage of mass shootings, but also to a medicalization of social problems, where "psychiatry and medicine are called upon to serve as institutions of social control" (Pescosolido et al., 2019, p. 1741). Other studies have examined the influence of the economic crisis in 2008 on stigma in a region of Greece (Economou et al., 2019). However, no negative effects were observed. Still, in Germany reluctance to recommend someone with depression for a job grew between 2001 and 2011, but not between 1990 and 2001 (Angermeyer et al., 2013b). Altogether, trend studies need to be aware of societal change, and in studies reporting on more than two time points, elaborate analyses like age-period-cohort analyses might help to identify period effects, that is, effects due to developments that affect society as a whole during a specified time period (Angermeyer et al., 2016; Schomerus et al., 2015).

Future Directions

Currently, public attitudes seem to change profoundly in many areas of life: in many countries, we are witnessing a surge in nationalism, xenophobia, and populism. Social media are fueling the "othering" of people outside our own social group, connecting and dividing people at the same time (Aral, 2020). Discussions on social injustices have become closely linked to definitions of personal identity. Future time-trend studies will show how these developments impact how we deal with mental illness, and whether a perspective on population attitudes has to be complemented by a perspective on cultural differences of mental illness stigma within societies, between different groups being driven apart by polarization (Schomerus & Angermeyer, 2021). To make the trajectories of attitudes toward people with mental illness visible, however, and to be able to address both expected and unexpected future developments, we need to continue monitoring these attitudes in future time-trend studies.

Conclusion

Time-trend studies reveal several developments, and from this brief narrative review it has become clear that they do not follow a simple pattern such as a general increase or decrease of stigma. Acknowledging the chief limitation of time-trend studies so far, namely, that they are all from a limited set of high-income countries, they nevertheless seem to yield at least two distinct broad trends: the public seems to have become more accepting and open-minded with regard to mental health problems in general and with regard to mental health care. Studies that use case vignettes and thus compare reactions to identical situations over long time periods show, however, that people with severe mental illness, in particular when showing strange, incomprehensible behavior, still face considerable, even growing, reservations among the public. Support for restrictions and involuntary treatment also seems to have grown, and in particular, developments regarding schizophrenia and depression seem to be disconnected to some extent, with more positive developments regarding depression. Notwithstanding the successful efforts to enable more open conversations about mental health issues and mental health care, stigma toward people with severe mental disorders such as schizophrenia is pertinent. Destigmatizing common mental illness should not come at the cost of deepening a divide toward severe mental illness. Future anti-stigma efforts thus need to find ways to increase tolerance and improve the way the public is interacting with people most severely affected by mental illness.

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6 Consequences of the Self-Stigma of Mental Illness

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The stigma of mental illness is ultimately a societal problem, as stereotypes about people with mental illness engender acts of discrimination and oppression that impede their life chances and deprive society of their potential contributions (Corrigan & Watson, 2002a; Link & Phelan, 2001; Thornicroft, 2006). There are several types of stigma of mental illness, which may be differentiated based on whether they affect the stigmatizing agents or the stigmatized (Fox et al., 2018). Stigma may be found at the level of public policies (*structural stigma*); the media, social and family groups (*social or public stigma*); or at the individual level (*personal stigma*) (Livingston & Boyd, 2010; Stangl et al., 2019). One particularly tragic sequela of social or public stigma is that people with mental illness can internalize it and turn it against themselves, compounding the burden of the illness itself (Corrigan & Watson, 2002b). This inward type of stigma is called *internalized stigma* (also known as self-stigma). It is the psychological point of contact of stigma, where it does damage to the person's very self (e.g., decreased self-esteem and self-efficacy [Watson et al., 2007]). While structural, social, public, and personal stigma can create obstacles and experiences that impede recovery, internalized stigma causes people with mental illness to hold themselves back, also known as the "why try" effect (Corrigan et al., 2016). Internalized stigma insidiously erodes morale and undermines setting and striving for goals and dreams (Corrigan et al., 2016; Ritsher [Boyd] & Phelan, 2004). Simply put, it works against recovery (Yanos et al., 2008). The consequences of the internalized stigma of mental illness are the subject of this chapter.

The empirical literature on the internalized stigma of mental illness has been expanding rapidly in recent years, including examinations of internalized stigma's prevalence, composition, sequelae, treatment, and prevention. The present chapter reviews the key findings of two meta-analyses of the correlates and consequences of internalized stigma that occurred a decade apart.

To highlight the importance of intersectional identities, our review of the meta-analyses is followed by a focus on three contrasting types of subgroups with marginalized identities in terms of gender (women and transgender people), race (African Americans), and profession (mental health professionals with a lived experience of mental illness, also known as prosumers [Manos, 1993]). It is our hope that giving examples of some of the nuances that may remain hidden in meta-analyses will serve to encourage the field to study these and other subgroups with intersectional identities more intentionally and in greater depth.

2010 and 2020 Meta-Analyses

Overview

Studies investigating the internalized stigma associated with mental illness have increased over time, especially in recent decades. This increase reflects the importance of the issue and created the possibility for meta-analyses to compile the main studies and establish general conclusions about the phenomenon and its consequences. One of the most important of these is the work of Livingston and Boyd, carried out in 2010, which reviewed 127 articles, of which 45 were eligible to be included in the meta-analysis. The impact of this meta-analysis was significant, becoming a reference for research in recent years, showing the correlation and consequences of internalized stigma with a large number of variables.

A decade has now passed since the publication of this study, time enough for changes to occur at the societal level and in the research examining the internalized stigma associated with mental illness. Consequently, this chapter will review the evolution of research on the internalized stigma of mental illness in the past 10 years. To achieve this, we will compare the Livingston and Boyd (2010) work with the main results found by a recent scoping review and meta-analysis focusing on the correlations and consequences of internalized stigma associated with psychosocial, clinical, and sociodemographic variables (Del Rosal et al., 2020). This recent scoping review and meta-analysis focus on the correlations and consequences of internalized stigma from 2010 to 2020 assessed by the Internalized Stigma of Mental Illness scale (ISMI; Ritsher [Boyd] et al., 2003). The ISMI is one of the most widely used scales for internalized stigma, is available in many languages and versions, and was developed in collaboration with people with mental illness (Boyd et al., 2014; Ritsher [Boyd] et al., 2003). It contains 29 items, such as "Having a mental illness has spoiled my life." The 2020 meta-analysis research was published as an article in the journal *Stigma and Health* and included a total of 61 studies in the review and 52 for the meta-analysis (Del Rosal et al., 2020).

In this chapter, we review the current state of research on the internalized stigma of mental illness, comparing the results obtained by both reviews, and summarizing the study trends on internalized stigma over time. The following are the main results found by the recent meta-analysis on the correlations and consequences of the internalized stigma associated with psychosocial, clinical, and sociodemographic variables, as well as the differences found in comparison with the previous work. The main variables studied in both meta-analyses, and the statistical results obtained, as well as the variables that were only included in one or the other of them can be seen in Table 6.1. The complete set of references

Table 6.1 *Comparison between 2010 Livingston & Boyd meta-analysis (1) and 2010–2020 Del Rosal et al. meta-analysis (2) results*

	Number of studies (k)		Sample size (*N*)		Random effect size (95% CI)		Q		I	
	1	2	1	2	1	2	1	2	1	2
Variables studied in both meta-analyses										
Hope	4	7	390	1,065	–.58 (–.67, –.48)	–.43 (–.61, –.26)	5.77	43.64***	47.99	86.25
Self–esteem	19	22	2,366	3,534	–.55 (–.62, –.46)	–.50 (–.61, –.39)	129.42***	242.26***	86.09	91.33
Empowerment	7	11	764	5,241	–.52 (–.63, –.39)	–.31 (–.51, –.11)	30.98***	426.54***	80.63	97.66
Quality of Life	12	16	1,583	2,969	–.47 (–.56, –.36)	–.47 (–.54, –.40)	79.54***	54.038***	84.91	72.24
Variables studied only in the 2010–2020 meta-analysis (2)										
Subjective recovery		5		517		–.51 (–.60, –.43)		3.18		0
Stigma resistance		7		2,927		–.27 (–.36, –.18)		21.33***		71.88
Personal functioning		8		1,194		–.29 (–.39, –.18)		22.8***		69.3
Depressive symptoms		12		2,116		.46 (.36, .55)		52.42***		79.01
Experienced stigma		6		666		.45 (.36, .54)		7.01		28.7
Perceived stigma		14		5,948		.26 (.13, .40)		312.79***		95.84
Insight		11		1,659		.12 (–.08, .31)		136.11***		92.65
Variables studied only in the 2010 meta-analysis (1)										
Social support	3		306		–.28 (–.50, –.03)		10.08**		80.15	
Self-efficacy	7		698		–.54 (–.72, –.29)		94.98***		93.68	
Symptom severity	22		2,453		.41 (.33, .49)					
Treatment adherence	7		949	314	–.38 (–.47, –.28)					

1 = Livingston & Boyd meta-analysis (2010); 2 = Del Rosal et al. (2020) meta -analysis; CI = Confidence Interval; Q = Homogeneity index; I = Between-study variability; * = $p < .05$; ** = $p < .01$; *** = $p < .001$.

for each one of the included studies for both meta-analyses can be found at the original sources (Del Rosal et al., 2020; Livingston & Boyd, 2010). Toward the end of the present chapter, the main limitations of both studies are described, commenting on certain aspects that we consider to deserve special attention, and suggesting future lines of research.

Internalized Stigma and Psychosocial Variables

Psychosocial variables have been those most studied in relation to internalized stigma over time. Perhaps, as Livingston and Boyd (2010) state in their research, this is because internalized stigma is itself a psychosocial variable, and research often includes several variables from the same field of study.

The most frequently studied psychosocial variable over time is self-esteem, which tends to show a strong negative relationship with internalized stigma in the past decade ($r = -.504$; CI = –.619, –.388), and in the studies previous to 2010 ($r = -.55$; CI = –.62, –.46). The internalization of stigma and its relationship to self-esteem may be understood in the sense that people with lower self-esteem tend to internalize stigma more easily. Alternatively, internalized stigma could result in lowered self-esteem. The importance of this variable is also demonstrated by its inclusion in most of the theoretical explanatory models of internalized stigma (Corrigan et al., 2010; Drapalski et al., 2013; Lannin et al., 2015; Mashiach-Eizenberg et al., 2013; Yanos et al., 2010). In many cases, its decrease is presented as a consequence of internalized stigma (Corrigan et al., 2010; Lannin et al., 2015; Yanos et al., 2008), although in other approaches it acts as a mediator between internalized stigma and other variables such as rehabilitation, social interaction (Yanos et al., 2010), quality of life (Mashiach-Eizenberg et al., 2013), or symptoms (Drapalski et al., 2013). Regardless of the direction taken in relation to internalized stigma, the importance of self-esteem, involving the self-efficacy and self-concept in relation to internalized stigma, needs to be emphasized.

The other psychosocial variable to which special attention should be paid is quality of life, which has also shown a negative and moderate-high relationship with internalized stigma over the years ($r = -.472$; CI = –.544, –.4; $r = -.47$; CI = –.56, –.36) (Del Rosal et al., 2020; Livingston & Boyd, 2010, respectively). Quality of life refers to the individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals or concerns. It involves dimensions such as physical and mental health, psychological and social well-being, and the ability to carry out activities of daily life. People with mental illness often face problems in accessing or maintaining employment, difficulties accessing housing, and being discriminated against (World Health Organization, 2015), all of which have consequences that end up affecting their quality of life and well-being. In this sense, the internalization of stigma may represent an added problem with a reciprocal relationship with the quality of life, with both affecting each other. The nature of their relationship is not completely clear, as most research to date has been cross-sectional in design.

Additional relationships that have been found in research on internalized stigma include social variables, such as social integration, and social support or functioning. The 2020 meta-analysis found a significant and negative relationship between internalized stigma and personal functioning (r = –.287; CI =–.394, –.18), while the 2010 meta-analysis found a relationship with social support (r = –.28; CI = –.50, –.03). These are perhaps the most visible effects of stigma, as they translate into difficulties in social interactions and social avoidance strategies, affecting interpersonal relationships. These effects may end up increasing or producing a certain amount of social isolation, also aggravated by the habitual discrimination that people with mental illness must face.

Other important variables to refer to are empowerment and hope. Empowerment, understood as a concept from community psychology and developed from the movements of users and self-help (Hansson & Björkman, 2005), can be defined as the process of gaining control over one's life situation influencing the organizational and societal structure in which one lives (Segal et al., 2013). Research conducted in the past decade shows a negative and moderate relationship of this variable with internalized stigma (r = –.308; CI = –.505, –.111), which contrasts with the results found in the 2010 meta-analysis that showed stronger negative relationships (r = –.52; CI = –.63, –.39). These contrasting results may be due to several reasons, such as the differences between the two meta-analyses, with different samples and studies included. Additional potential explanations include the differential role of empowerment in different cultures studied, a change of perspective over time on this construct, and the lack of consensus on its definition and the variety of instruments used to measure it (Castelein et al., 2008). For example, the Empowerment Scale (Rogers et al., 1997) focuses on empowerment from the user's perspective at the interpersonal and social level, while the Personal Empowerment Scale (Segal et al., 1995) focuses on aspects more related to daily life such as housing, income, or the individual's ability to minimize unwanted events. On the other hand, regarding hope, results of both meta-analyses show negative moderate-high correlations of this variable with internalized stigma (r = –.434; CI = –.606, –.262; r = –.58; CI = –.67, –.48), showing the impact that the internalization of stigma can have on hopelessness and/or vice versa.

Other psychosocial variables found in the meta-analysis from the past decade in relation to internalized stigma are experienced stigma and perceived stigma, both of which had positive and moderate to high intensity (r = .449, CI = .356, .543; r = .264, CI = .127, .401), and also stigma resistance, which was negative and moderate (r = –.269, CI= –.356, –.181). These variables were not found in Livingston and Boyd's 2010 meta-analysis and might reflect the evolution over time of the concept of internalized stigma, with greater differentiation and precision in its definitions. An example of this evolution is the Mental Illness Stigma Framework (MISF) proposed by Fox et al. (2018). In this approach, they differentiate the stigmatized and the stigmatizer, finding in the perspective of the stigmatized the internalized *anticipated and experienced stigma*. From this approach, the *perceived stigma* would be a link between both perspectives, understood as the perceptions about social beliefs, feelings, and behaviors toward people with a mental illness problem both from people with mental health problems and others. The 2020 results show how experienced stigma seems to have a greater relationship to the internalization of stigma compared to the perception of it. Stressing the importance that experiences of discrimination seem to have, perhaps once stigma is internalized it can also affect the evaluation of experiences as more discriminatory, resulting in even more damage to those stigmatized.

Finally, it is worth mentioning that feelings such as shame or loneliness have shown a strong relationship with internalized stigma during the past decade (Chrostek et al., 2016; Hasson-Ohayon et al., 2012; Świtaj et al., 2014), although few studies have focused on studying specific emotions in relation to the internalization of stigma.

Considering stigma as a continuum (Corrigan et al., 2009), at one extreme would be damaged esteem (internalized stigma) and at the other extreme hope, resilience, or empowerment. This idea implies that a person can experience internalized stigma and feel incompetent but at the same time be resilient and empowered, so the two extremes of the continuum would not be mutually exclusive (Picco et al., 2017). This lack of linear correlation between variables can be the basis for an explanation of the internalization of stigma that integrates and takes into account the different variables mentioned and their relationship to internalized stigma.

Internalized Stigma and Clinical Variables

Among the clinical variables examined in relation to internalized stigma, the most studied over time have been the duration of the disorder, the number of hospitalizations, and the severity of mental health symptoms. Interestingly, neither the number of hospitalizations nor the duration of illness has shown significant relationships consistent with internalized stigma over time. However, the severity of psychiatric symptoms has shown a moderate-to-high, positive relationship with internalized stigma in the 2010 Livingston and Boyd meta-analysis ($r = .41$, CI = .33, .49). This relationship seems to hold whether severity is assessed by a professional or perceived by affected persons themselves. Furthermore, the relationship between the severity of the illness and internalized stigma has been found in different diagnoses, not being limited only to those cases considered as "severe mental disorders," such as in different diagnoses of anxiety (Curcio & Corboy, 2020). On the other hand, as a specific symptom, the role of depressive symptoms and internalized stigma has also received a fair amount of attention in the past decade with results indicating a positive relationship of moderate-to-high intensity ($r = .457$, CI = .361, .553).

Another clinical variable of importance is insight into the disorder, whose role in the relationship with internalized stigma is mixed; researchers have found significant relationships both positive and negative in different studies over time, and the 2020 meta-analysis did not show a significant relationship with internalized stigma. Perhaps this may be due to the instruments used for measuring it, which are usually focused mainly on serious mental disorders, or the differences that can be found in this variable depending on the type of diagnosis. For example, a lack of awareness of the problem may be a symptom in some diagnoses (e.g., manic episode or anorexia), while in other clinical cases it is not even usually considered (e.g., depression). Also, these mixed relations seem to be reflected in the "insight paradox" (described by Lysaker and colleagues in 2007) that exposes how awareness of the disease has been paradoxically linked both to better functional outcomes and to less hope and self-esteem, when in reality greater insight, along with stigmatizing beliefs about the disease and therefore internalized stigma, is often associated with worse outcomes.

Finally, it is necessary to comment on the variables of treatment adherence and subjective recovery. Treatment adherence showed a moderate negative relationship with internalized stigma in the 2010 meta-analysis conducted by Livingston and Boyd (r = .31, CI =.39, .23), but was not included in the 2020 analysis. On the contrary, subjective recovery is a variable that seems to have increased in importance over the past decade by not being present in Livingston and Boyd's 2010 meta-analysis, and showing the highest negative relationship with internalized stigma in the 2020 research (r = –.514, CI = –.601, –.426). These changes in the variables may reflect a paradigm shift in clinical care, where perhaps in recent years the importance of the person has become more central, focusing the study variables on their own opinions, such as subjective recovery, while perhaps previous studies were more focused on other, more externally observable variables, such as adherence to treatment, which generally refers to taking medications and following a treatment plan.

Internalized Stigma and Sociodemographic Variables

In relation to the sociodemographic variables, although these variables are often studied, no statistically significant correlations have been found between any of them and the internalized stigma in either meta-analysis. The most studied sociodemographic variables have been gender, age, education, and work situation, showing mostly inconsistent relationships with the internalization of stigma over the years. For example, in relation to gender, studies reveal mixed relationships, which will be discussed in depth later in this chapter. We also see mixed results with other sociodemographic variables, for example age, in which both positive and negative relationships with internalized stigma have been found. In general, although most studies include the evaluation and analysis of these measures and their study remains necessary, the results suggest that these variables do not seem to be key in explaining both the appearance of internalized stigma and its consequences, or at least scant attention has been paid to the specific aspects of sociodemographic variables that may have a greater weight in this area.

Consequences of Internalized Stigma in Marginalized Subgroups

Although the internalized stigma literature is global in scale and encompasses many types of participant groups, such as various nationalities and diagnostic categories (e.g., Boyd et al., 2014), relatively little is known about the nature or effects of internalized stigma of mental illness in specific marginalized subgroups. Summaries and meta-analyses by their very nature average across studies and may be unable to detect differences between subgroups, particularly as they may be contextualized and nuanced, or defined in different ways in different studies.

Both the 2010 and 2020 meta-analyses on the correlates and consequences of internalized stigma showed a lack of clear findings for psychosocial variables. In part, this is because different studies collected different psychosocial variables, making it harder to generalize across the entire body of work, and because the studies occurred in such disparate settings across the world. This means that clear relationships of internalized stigma with specific marginalized identities in specific contexts may be blurred by merging them in with others in the meta-analytic method. For the present chapter, we have selected just a few of the many potentially important types of intersectional identity factors for illustrative purposes: gender, focusing on those identifying as female or transgender; race/ethnicity, focusing on African Americans; and profession, focusing on mental health care providers with a personal lived experience of mental illness (prosumers, Manos, 1993).

These are important groups to consider because they also face internalized oppression, resulting in applying stereotypes to themselves and others in their group. This includes internalized misogyny, internalized homophobia/transphobia, and internalized racism (David et al., 2019; Szymanski et al., 2008, 2009). Similarly, in addition to stigmatizing themselves, prosumers may also stigmatize others with mental illness, even other prosumers (Harris et al., 2016). Thus, we review each subgroup in turn.

Consequences of Internalized Stigma and Gender

The issue of gender and its relationship to internalized stigma is complex. As previously mentioned, research results are often contradictory: some studies find no gender differences, while other studies report positive associations alternatively for women and men. Although this is a topic that will be addressed in depth in later chapters of this Handbook, we consider it necessary to make certain comments on this subject due to its great importance and consequence.

Studies that have found higher internalized stigma in women may be compatible with the intersectional discrimination hypothesis (Fredman, 2016; McCall, 2005). This approach suggests that multiple stigmatizing identities interact with each other, increasing the discrimination and stigma suffered by these people and leading to more negative outcomes. In this case, a woman with a mental disorder may have multiple stigmatizing experiences, such as being discriminated against as a woman and for having a mental disorder, which interact with each other and subsequently increase the likelihood of further negative outcomes. For example, internalized sexist attitudes could interact with the internalized stigmatizing attitudes of the illness and multiply the negative effects of them (e.g., women are more sensitive than men, so my problem probably is that I'm overreacting or just hormonal).

On the other hand, some studies have found that internalized stigma is higher in men, or at least the effects of it on attitudes/behavior is stronger. One possible explanatory hypothesis is that men more readily assume aspects of public stigma (e.g., associating depression with weakness or over-sensitivity) that apply to themselves. In other words, experiencing mental illness may conflict with traditional male gender roles that support stoicism, self-sufficiency, and lack of emotional expression (e.g., boys do not cry; Vogel et al., 2011; see also Chapter 10 this volume). So a man who agrees with these traditional beliefs may be more likely to internalize the stigma associated with mental illness, as having a mental illness may be seen as a failure to be a "man," and subsequently lead to, for example, seeking less professional help or support (Hammer et al., 2013; Vogel et al., 2014). Both explanations for stigma in men and women are probably adequate, and the results also depend on other variables such as culture, education, or socioeconomic level, which still need to be studied in depth in order to clarify the role of gender in this issue (see Chapter 14 in this Handbook for additional discussion).

In relation to perspectives not based merely on cisgender approaches, studies on internalized stigma of mental illness in people with transgender or non-binary gender identities are difficult to find (see Chapter 12 in this Handbook for additional discussion). In general, research conducted with samples of transgender people indicates the presence of internalized anti-transgender stigma (King et al., 2020). It is also possible to cite studies that indicate that trans people experience high rates of prejudice and discrimination, with these experiences being related to poorer mental health and even greater likelihood of suicide (Tebbe & Moradi, 2016). The relationship between internalized anti-trans stigma and mental health impairment can be explained by the "minority stress theory," which identifies perceived experiences of discrimination, internalized prejudice, and fear and vigilance regarding potential stigmatization as minority stressors that can contribute to negative mental health outcomes (Meyer, 1995, 2003). However, there does not seem to be any research that combines anti-trans stigma with the internalized stigma associated with mental illness.

This lack of research can be attributed to the relatively recent emergence of these concepts, which are often not legally recognized in many countries, or even illegal, reflecting the existing structural stigma in society. More studies on stigma and gender are needed, with a greater inclusion of variables and not only conducted from a cisgender perspective. Knowing the implications of gender from an intersectional approach, in which the presence of different stigmas accumulates, can help to achieve a more realistic understanding of the real impact of the issue (e.g., will a trans person with a severe mental illness experience more internalized stigma compared to a cisgender person with the same diagnosis?).

Consequences of Internalized Stigma among African Americans

As discussed above, there is a host of common consequences to mental health internalized stigma. In this section, we explore whether those consequences vary in either type or severity when other social identities such as race and ethnicity are considered (see also Chapter 11 in this Handbook for additional discussion). We chose to focus on African Americans due to the research showing a clear underutilization of mental health services within this group (Briggs et al., 2014). However, how closely correlated is this underutilization with internalized stigma? Unfortunately, we found that the literature exploring the African American experience with mental illness was fairly inconclusive in that it scarcely explored the dualities of having two intersecting stigmatized identities – being Black and a person with mental illness. Although the literature is limited in this regard, there are some hints that may point to substantial differences in how African Americans experience mental health internalized stigma compared with other races/ethnicities. In this section, we hope to point toward the additional research required in order to have a more thorough understanding of these differences by highlighting some seemingly relevant and potentially impactful conclusions from current research. Current research seems to suggest that African Americans may experience both protective factors and risk factors *unique to their subculture* that render them either more or less likely to experience internalized stigma as compared to other American ethnicities.

One line of research suggests that racism and discrimination on the basis of race may be positively correlated with an increased mental health internalized stigma, not only in African Americans, but in Asian and Latinx Americans as well (Cheng et al., 2013). Racial minorities, because they experience racism and discrimination more often than European Americans, may be more likely to have increased internalized stigma (Cheng et al., 2013; Forrest-Bank & Jenson, 2015). More specifically, Cheng and colleagues suggest that although macro-level influences like racism and discrimination don’t directly affect internalized stigma, they are positively correlated with a heightened anticipated public stigma for psychological help, which, in turn, is positively correlated with greater internalized stigma. In summary, this study found that anticipated public stigma serves as a mediator between racism/discrimination and internalized stigma (Cheng et al., 2013).

In the African American population, specifically, there may be a unique set of protective and risk factors that may render them either more or less likely than even other racial minorities to experience mental health internalized stigma on account of racism and discrimination. One risk factor is that research suggests African Americans experience more racism and discrimination than Asians, Latinx/Hispanic, or European Americans in that they report more microaggressions, are more likely to feel like second-class citizens, and are more likely to be assumed criminals (Forrest-Bank & Jenson, 2015). Thus, the greater intensity of racism and discrimination that African Americans report comparatively merits further investigation into whether this may relate to greater internalized stigma, being that research seems to support racism and discrimination as a medium to increased internalized stigma (Cheng et al., 2013).

Despite this unfortunate possibility, there also exists in the African American population a protective factor against internalized stigma induced by racism/discrimination. Cheng and colleagues (2013) found that in the African American sample, there was a correlation between a greater ethnic identity and a lower internalized stigma associated with help seeking. In other words, African Americans who are positively anchored within their own racial identity – those who embrace it with a sense of pride, unity, belonging, or another positive affect thereof – had a stable psychological foundation that shielded them significantly from internalized stigma regarding help seeking. What was unique about this finding is that this correlation of a greater ethnic identity and lowering internalized stigma of help seeking was only found to be statistically significant for African Americans in this study (Cheng et al., 2013). Although internalized stigma of help seeking is not identical to the internalized stigma of mental illness, they are related, and this finding highlights a potential direction for future internalized stigma research. Although there is a narrative that points toward African Americans being potentially more susceptible to internalized stigma due to racism/discrimination compared to other ethnic identities, there may exist a protective silver lining for African Americans when they maintain a sense of belonging and security in their own ethnic identity.

Another protective factor appears to be supported in another study that explores how internalized stigma works as a mediator between cultural conformity differences to masculine norms and attitudes toward counseling between African American men and European American men (Vogel et al., 2011). Vogel and colleagues found that although African American men may endorse some masculine norms to a much larger degree than European American men, they nonetheless had lower levels of internalized stigma. It goes on to postulate that because African American men are often a marginalized group, and thus separated from hegemonic European American norms, it is likely that they may reject the hegemonic European American masculine culture in favor of their own unique cultural subset of masculine norms. This is relevant because the hegemonic European American masculine norms (i.e., being strong by not asking for help) may view help seeking as weakness, creating an increased internalized stigma. However, rejection of this dominant view as found in African American men could allow for a more accepting view of help seeking. As the authors state, "One explanation for this finding is that cultural roles for African American men encourage them to live up to certain aspects of the male gender . . . while allowing them more freedom in regard to other aspects . . ." (Vogel et al., 2011, p. 376).

As we recall, the silver lining from the Cheng et al. study existed when African Americans had a greater ethnic identity; they experienced significantly less internalized stigma than any other ethnicities with this same quality. Vogel et al. suggested that the reason African American men had less internalized stigma than European American men was due to an adherence and acceptance of their own culture's unique definition of masculinity – in other words, their ethnic identity. Both studies seem to agree that ethnic identity may play a particularly impactful role for African Americans. Moreover, the studies reviewed in this section may even suggest a polarizing effect of internalized stigma for African Americans in that despite ethnic identity being protective, racism and discrimination could be a risk factor. All in all, there seems to be a subtle yet uniting trend in the literature that suggests that ethnic identity may radically change the outcome of whether African Americans have greater or less internalized stigma than other ethnic groups. However likely this postulation seems to be, it cannot be taken as conclusive due to the limited body of research studying the intersectionality between being African American and having internalized stigma due to a mental illness. Nonetheless, there are convincing narratives in the literature that merit further and more direct investigation into the intersectionality of having two distinct stigmatizing identities – whether that be being African American and having internalized stigma due to mental illness, or otherwise.

Consequences of Internalized Stigma among Mental Health Providers with Mental Illness

The Prevailing Myth. Often, clients complain that their mental health providers do not understand what it is to manage a mental health challenge. Traditionally, providers typically do not disclose if they do or do not manage a history of, or current, mental health challenge (Psychopathology Committee of the Group for the Advancement of Psychiatry, 2001). However, truth be told, it is an inaccurate assumption that most mental health providers have not personally encountered mental health challenges (Boyd, Graunke et al., 2016; Boyd, Zeiss, et al., 2016; Byrne et al., 2016; Harris et al., 2016). Across studies, 60% to 80% of mental health providers have reported mental health challenges (ranging from mental illness to seeking help for significant life stressors; Bike et al., 2009; Gilroy et al., 2002; Harris et al., 2016; Nachshoni et al., 2008; Tay et al., 2018). While proportions of providers who have sought psychotherapy may be affected by training programs that require psychotherapy, studies (e.g., Gilroy et al., 2002; Nachshoni et al., 2008; Tay et al., 2018) assess experiences with mental health diagnoses.

In many states, disclosure of a mental health challenge or mental illness may interfere with licensure (Bender et al., 2015; Beran, 2014; Boyd, Zeiss et al., 2016; Cohen et al., 2016), despite the fact that such a consequence for disclosure may violate the Americans with Disabilities Act (1991). Because the American Psychological Association's Ethics Code (APA, 2017) requires disclosure if a psychologist is impaired, disclosures can be mistaken for an ethical admission of impairment. Disclosure of a mental illness can also interfere with acceptance to or completion of graduate study (Appleby & Appleby, 2006). Some mental health professionals report fears that if they disclose their mental health challenges, they risk a negative impact on their employment or promotion potential (Harris et al., 2016).

Are Providers with Lived Experience Underperforming? Stereotypes of prosumers are based on the assumption that they would be impaired or ineffective mental health providers if they had a mental illness (Harris et al., 2016). Research on mental health providers with lived experience of a mental health challenge indicates that, on average, not only is this group functioning well professionally, but they are also assets to the field. Providers with lived experience are less likely to stigmatize clients, and have more knowledge of rehabilitative, recovery-model care than those without lived experience (Harris et al., 2016). In a sample of providers with lived experience, while only 15% sought accommodations, 47% were in leadership positions, 72% were involved in training other providers, 82% had excellent or outstanding employee evaluations, 51% had published in the professional literature, and 36% had done funded research (Boyd et al., 2016). Given the difficulty of sampling providers with lived experience due to closeting, these samples may not be representative of all clinicians. However, available evidence does not support the idea that mental health providers with lived experience are uniformly impaired, or that their right to licensure should be routinely questioned.

Providers with Lived Experience as a Clinical Culture Asset. Provider stigma about mental health challenges has a profound effect on clinical decision making that results in suppressing recovery (Hugo, 2001; Peris et al., 2008; Sercu & Bracke, 2016). According to Hugo et al. (2001), professionals have more negative ideas about mental health prognoses than the general public. Peris and colleagues (2008) found that many mental health providers had biases that contributed to overdiagnosis. Sercu and Bracke (2016) found that mental health providers with more stigma made more restrictive recommendations for care and recommended providing less total care for people with more stigmatizing diagnosis. The culture of nondisclosure deprives mental health providers of one of the most critical means of reducing this stigma – the opportunity to identify with members of the stigmatized group (Bamgbade et al., 2016; Corrigan et al., 2012; Ungar et al., 2016) – and likely increases internalized stigma among the prosumers themselves. Organizational research documents that when prosumers "come out of the closet" to professional peers, the organizational and clinical practice culture changes such that stigma, and its impact on clinical decisions, is reduced (Harris et al., 2019). This is an example of the way that addressing and resolving internalized stigma allows for better functioning not only for the individual, but also for the health system and society as a whole.

Limitations of Current Research and Suggestions for Future Studies

Having summarized the current state of the field in the study of the consequences of internalized stigma, and having identified some examples of relevant intersectional identities, next we review the trends in the literature, limitations of current work, and suggestions for future research.

Trends in the Literature. In Livingston and Boyd's (2010) meta-analysis, most of the studies were cross-sectional, with an average of 100 participants per study and an average age of participants of 41.1 years. The majority of the samples were from North American countries, followed by Europe and finally Asia. In addition, the samples were mostly European Americans with at least a high school education and composed of a slight majority of men versus women. Furthermore, more than half of the participants had a diagnosis of schizophrenia. Most of these study trends seem to continue in the past decade, finding in the 2020 meta-analysis (Del Rosal et al., 2020) that most research remains cross-sectional and with an average size of 100 people, but with an average age of 52.1 years. The majority of the samples continue to be composed of European Americans, with a minority of African Americans or Latinx. In terms of gender, women are still slightly underrepresented compared to men. And in relation to diagnoses, the majority of samples continue to be composed of participants with psychotic spectrum diagnoses or other serious mental illnesses. The main difference in recent years is found in the origin of the studies, with most of the studies coming from Europe or Asia, showing an increase in studies outside of North America in the past decade.

Limitations in Meta-Analyses. Although in the past decade, the different studies reviewed in the meta-analyses have allowed for improvement in our knowledge about internalized stigma, research still presents different limitations that should be highlighted. Some of the main limitations are derived from the characteristics of the samples themselves. First, most studies over time are conducted only on European Americans. A greater representation of other ethnic groups is needed. This would contribute to the understanding of the phenomenon with an approach that takes into account the current multicultural reality of most societies where the stigma associated with mental health problems can also interact with other stigmas associated with ethnicity or culture. Second, it is important to highlight that in general the age range of participants in most studies is restricted, with the inclusion of children or adolescents and older people in the research being rare (see Chapter 16 in this Handbook for additional discussions of age). In addition, women continue to be underrepresented compared to men, and studies that take a non-binary gender perspective are virtually nonexistent. Achieving equality in terms of gender representativeness in the samples, with broadening the perspective and not conducting only cisgender studies, is also necessary. Third, the same seems to be true for diagnoses other than serious mental disorders, with far fewer studies involving people with anxiety problems or depression, despite the fact that the prevalence of these disorders is very high in many societies. It is necessary to study the stigma in heterogeneous samples in terms of diagnosis, as well as to try to broaden the knowledge of the stigma associated with specific diagnoses that so far have been little studied, such as personality disorders, developmental disorders, eating problems, and so on. Fourth, the studies found over time are mostly cross-sectional. Longitudinal studies would allow us to know in greater detail how the evolution of stigma occurs and how it relates to other relevant variables; therefore, an effort should be made in this direction. Without longitudinal studies, we can't draw conclusions about the direction of causality. Additionally, it is necessary to emphasize that studies carried out on a large scale are also necessary, which will allow for more realistic data about the prevalence and incidence of the phenomenon. The current small-scale studies use different sampling frames and methodologies, making it difficult to generalize beyond what we can do with meta-analyses. It would be very helpful to have more directly comparable data from large-scale studies on the prevalence and incidence of internalized stigma in specific populations and across cultures. Conversely, culture-specific aspects of internalized stigma have also been little studied (see also Chapter 13 in this Handbook for additional discussion) and would make an important contribution to the literature that to date tends to use standardized instruments such as the ISMI regardless of the context.

In relation to clinical variables, it is worth noting the absence of studies that take into account pharmacological medications and the type of drug prescribed. Perhaps this is due to the fact that the study of stigma tends to be carried out from a more psychological or social perspective, and it is less common for medical studies to include variables of a more psychosocial nature such as stigma.

Additionally, in relation to psychosocial variables, it could be beneficial to study the relationship between internalized stigma and the appearance of various associated emotions and feelings, as well as the inclusion of variables such as personality traits, which are also absent in most studies on the subject to date. Finally, it should be noted that most of the studies from which we can draw conclusions are carried out only with explicit self-report measures, without taking into account other automatic or implicit measures of stigma that could provide interesting information.

Intersectional Stigma and Marginalized Identities. There is consensus regarding the importance that different variables or conditions can play in the different types of stigma and, in particular, in internalized stigma. Stigma does not affect all people with mental disorders equally, but the internalization of the stigma is mediated by the different conditions of each individual (Bowleg, 2012; *intersectional stigma*). In an intersectional sense, there is a stigma caused by the mental health condition that is mediated (enhanced or diminished) by the different class conditions that affect each person (race, sex, age, social class, etc.; Stangl et al., 2019). These class conditions are reflected in a special way in some groups of people who are affected by a process of extreme social exclusion (*marginalized groups*). For example, homeless people, elderly people, LGBTQI groups, women, people with different ethnic origins, professions of special risk such as healthcare, and a long list that is difficult to summarize.

When people have two marginalized identities, is their internalized oppression higher? The intersectional discrimination hypothesis discussed above would argue that it would be higher ("double disadvantage," Oexle & Corrigan, 2018). On the other hand, if people have learned how to cope with having one marginalized identity, they may be able to apply these skills to both identities ("stigma competence," Balsam & D'Augelli, 2006). In other words, a sense of being comfortable with one's identity may generalize to various components of one's identity. Further research is needed in this area with regard to internalized stigma of mental illness, as it has clear implications for intervention strategies. As Oexle and Corrigan (2018) argue, it may be more effective to use a tailored rather than one-size-fits-all intervention to best suit people with dual marginalized identities (see also Chapter 10 in this Handbook for additional discussion).

Gender. For future lines of research in this area, we consider it necessary to carry out a greater number of studies specifically focused on gender, with large samples, including variables that may affect the relationship, and not only from a cisgender perspective. The inclusion of gender, and not only biological sex, in the study of internalized stigma may need to be accompanied by an intersectional internalized stigma approach, covering various conditions, which may also entail the need for the development or adaptation of new internalized stigma assessment tools that include the various gender-related aspects that may affect people who have mental health problems.

Race/Ethnicity. We must bear in mind that the conclusions drawn here are less direct findings in the internalized stigma literature than they are deductions that seem to merge commonalities found in literature. Thus, they serve as a suggested directional shift that may bear fruit in future internalized stigma research. We find it to be evident that internalized stigma regarding mental health help seeking does not have strictly universal consequences, or universal causes for all people or groups. Instead, as displayed in the review above, dynamics that would seemingly increase internalized stigma (i.e., masculine norms) might in fact have a reduced or protective effect when there are other variables in play (i.e., ethnic identity in African Americans). Thus, to further our understanding of mental health internalized stigma, we must seek to understand the multitude of interactive variables, or dual stigmatizing identities, that affect internalized stigma for different groups. That there is a dearth of intersectionality effect/multiple stigmatizing condition studies can be clearly seen, even by professionals in the field (Oexle & Corrigan, 2018). These deductions, pieced together by the narratives present in internalized stigma research, are substantial if they are indeed true, and thus merit further research. This research should look closely at how African Americans uniquely experience mental health internalized stigma in comparison to other ethnicities, if similarly unique experiences are found in other ethnicities, and how other intersectionalities between other stigmatizing identities may affect one's experience with mental health internalized stigma and its consequences.

Prosumers. There are initial steps being taken to facilitate tapping the power of providers with lived experience; groups of such providers are organizing, such as the VA Mental Health Lived Experience Community of Practice (Boyd, Zeiss et al., 2016), leveraging networking as a force to produce safer visibility, speakers' bureaus, consultation, research, and other resources to enhance safety for those who serve the mental health community by taking the risk of coming out. The advent of peer support as a mental health discipline is an important step in changing the culture of nondisclosure (Repper & Carter, 2011). Diversity policies requiring representation of individuals managing psychiatric disability can give employers incentives for recruiting and protecting employees who are "out of the closet" (Individuals with Disabilities Employment Program, 2020). Manuals for assisting organizations in retraining mental health staff to reduce stigma are available (Harris et al., 2019). Altering the training and licensing infrastructure built to prevent individuals with lived experience from becoming providers would be an important step; research shows that policy shapes discrimination, so changing policies is a needed step (Kendi, 2017). Expanding research on stigma reduction among healthcare providers, both toward one another and toward clients, is an essential future direction for our field. Reducing internalized stigma for prosumers is an essential step to dismantling the public stigma affecting all people managing mental health challenges.

Summary and Conclusion

In summary, we see that internalized stigma has a wide range of important and harmful consequences for people with mental illness. A robust global literature continues to show many negative effects of internalized stigma for the general population. Among the consequences that are most frequently studied, the 2010 and 2020 meta-analyses show that internalized stigma is related to reduced hope, self-esteem, empowerment, and quality of life. The relationship of internalized stigma was somewhat weaker in 2020 than in 2010 for empowerment. Although more longitudinal studies are needed to better test the causal direction of these relationships, the overall findings are consistent with the idea that internalized stigma impedes recovery and adds unnecessarily to the already-heavy burden of mental illness.

Research on internalized stigma has increased over time. Although we have much more information than a decade ago with which to address it, more comprehensive investigation is needed to reflect the changes that society has undergone in recent years, as well as to pay attention to those aspects of the problem that have been little studied. More work needs to be done to understand the effects of internalized stigma on particular groups and intersectional identities, as the literature is relatively sparse and less conclusive. Our literature reviews focusing on gender, African Americans, and prosumers show that there may be important differences in the nature and effects of internalized stigma of mental illness that would affect how we might approach assisting individuals from particular groups. Gender plays a complex role, with some studies showing higher internalized stigma in women, others in men, and none studying internalized stigma of mental illness among transgender people. We see that African Americans with mental health challenges appear to experience greater internalized stigma and greater stigma regarding help seeking unless they have a strong ethnic identity, which is protective. The prosumer identity is more likely to be concealable, so issues there tend to involve disclosure versus staying “closeted.” Prosumers who apply stigma to themselves may be more likely to be closeted, which in itself has negative effects on their mental health as well as depriving their clients of the opportunity to find connection around this. Prosumers are also not immune to stigmatizing other prosumers and their clients, and this is particularly likely among prosumers who are closeted and have high internalized stigma, although the research is as of yet scant on this.

In conclusion, the consequences of internalized stigma or self stigma are manifold, they undermine recovery, and they may vary across intersectional identities. Internalized stigma continues to affect a wide range of people who have mental health challenges, serving as an obstacle to their recovery and a fulfilling and satisfying life. Although there has been a notable increase in research on the consequences of internalized stigma in recent years, and although our review could not possibly do justice to the myriad of specific findings from this global endeavor, our brief review of a few intersectional identities underscores that we still have much to discover.

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7 Self-Stigma of Seeking Help

A Meta-Analysis

Daniel G. Lannin & Jacqueline Bible

Introduction

The stigma associated with seeking psychological help has been linked to factors related to therapy utilization such as negative attitudes toward therapy, reduced intentions to seek counseling, decreased likelihood of seeking mental health and counseling, and less willingness to return for a subsequent session (Lannin et al., 2016; Vogel et al., 2006; Wade et al., 2011). Specifically, those who perceive a need for professional psychological help may feel threatened by stigmatizing labels associated with seeking treatment such as awkward, insecure, inadequate, inferior, weak, and disturbed (King et al., 1973; Sibicky & Dovidio, 1986). As such, this type of stigma may represent a threat to a person's self-worth (Ben-Porath, 2002; Lannin et al., 2015; Tucker et al., 2013; Vogel et al., 2006). Because help-seeking self-stigma is personally threatening to self-esteem, it can evoke defensive responses that are aimed at reducing psychological help's perceived threat (Lannin et al., 2013); this may ultimately erode help-seeking attitudes, help-seeking intentions, and help-seeking behaviors (Lannin et al., 2015; Vogel et al., 2006, 2007).

Importantly, the extant stigma literature distinguishes between society's negative attitudes toward stigmatized others and peoples' negative and stigmatizing evaluations of themselves, often respectively termed *public stigma* and *self-stigma* (see Corrigan, 2004). In other words, public stigma of seeking psychological help reflects the belief that "those seeking psychological help" are socially unacceptable, whereas self-stigma of seeking psychological help corresponds to the belief that "if I were to seek psychological help I would be unacceptable" (cf. Vogel et al., 2006). We define this *self-stigma of seeking psychological help* as the anticipated stereotyping, separation, status loss, and discrimination experienced by someone who seeks help or is considering seeking professional psychological help.

Theoretical and empirical research indicates that self-stigma occurs when public stigma is internalized and applied to one's self over time, and for many populations self-stigma is a more proximal and powerful indicator of

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We would like to acknowledge Jeremy B. Kanter for his guidance on meta-analytic procedures as well as several people for their help on article screening: Krissy Okamura, Lindsay Chassay, Audrey Falzone, Emily McLaughlin, Alexa Snodgrass, and Madison Maciejewski.

help-seeking outcomes than public stigma (Corrigan, 2004; Lannin et al., 2015; Ludwikowski et al., 2009; Vogel et al., 2007, 2010, 2013). Indeed, self-stigma associated with seeking psychological help has been linked to negative attitudes toward professional psychological help, reduced intentions and willingness to seek professional psychological help, and general avoidance of psychological treatment (Vogel et al., 2006; Wade et al., 2011). Therefore, the meta-analysis presented in this chapter focuses on the relationship between self-stigma of seeking help and help-seeking variables that include attitudes toward seeking help, intentions/willingness to seek help, and actual help-seeking behaviors.

Self-Stigma's Relationships to Attitudes and Intentions

The study of attitudes has a long and prominent history in psychology; earlier conceptualizations were broad and encompassing of numerous cognitive, emotional, motivational, and behavioral aspects, and contemporary conceptualizations have tended to focus on likes and dislikes (i.e., evaluative judgments) toward particular objects (cf. Schwarz & Bohner, 2001). In the present study, we define *attitude toward seeking psychological help* as the overall evaluation (as positive or negative) one makes of the act of seeking professional psychological help (cf. Fischer & Farina, 1995; Fischer & Turner, 1970; Hammer et al., 2018).

Help-seeking attitudes have consistently been identified as one of the strongest theoretical and empirical predictors of help-seeking intentions (Li et al., 2014; Vogel et al., 2007). Moreover, there are many factors that erode positive attitudes about help seeking, including self-reliant mindsets, beliefs that problems are self-correcting, and doubts in the effectiveness of psychological help (MacKenzie et al., 2014); however, self-stigma may be an especially relevant predictor.

Empirical research supports the notion that self-stigma often finds its expression in negative help-seeking attitudes (e.g., Vogel et al., 2006), which is not surprising because self-stigma associated with seeking psychological help specifically highlights threats to self-worth that can occur during the help-seeking process (Lannin et al., 2013). Those who perceive psychotherapy as personally threatening are also likely to view therapy in a negative light, and this will be reflected by negative attitudes and beliefs about psychotherapy.

Self-stigma is also likely to reduce intentions to seek psychological help. People reporting higher self-stigma tend to estimate that they would be less likely to seek help in the future, regardless of whether help-seeking requires deliberate planning or a more spontaneous reaction to offered help (Hammer & Vogel, 2013; Lannin et al., 2013). The construct of help-seeking intentions is often studied as a proxy for help-seeking behavior because Ajzen and colleagues' behavioral theories (e.g., theory of reasoned action and theory of planned behavior; Montaño & Kasprzyk, 2015) posit that intentions are the most immediate antecedent of behaviors (Madden et al., 1992). That is, understanding the factors that influence help-seeking intentions also reveal salient predictors of help-seeking behaviors. Studies assessing intentions to seek psychological help have often conceptualized this construct as a person's self-reported estimate of how likely they would be to seek professional psychological help if they were experiencing distress (cf. Cash et al., 1975; White et al., 2018; Wilson et al., 2005). In the present study we define *intentions to seek psychological help* as a self-estimate of a person's own likelihood of engaging in future help-seeking behavior. This conceptualization may capture aspects of help-seeking intentions that are both deliberate and planful as well as spontaneous and immediate (Hammer & Spiker, 2018; Hammer & Vogel, 2013), which reflects the wording of most help-seeking intention measures (White et al., 2018).

In addition to eroding predictors of help-seeking behaviors – such as help-seeking attitudes and intentions to seek help – it is also likely that the self-stigma of seeking psychological help is a barrier to help-seeking behaviors themselves. While there are relatively few studies examining the link between help-seeking self-stigma and actual help-seeking behavior, there is some evidence that self-stigma is linked to lower probability of seeking mental health and counseling information (Lannin et al., 2016) and reduced likelihood of actually seeking professional help in the future (Vogel et al., 2006). Examining the magnitude of these effects is important work that we aimed to accomplish in the present meta-analysis.

Overview of the Present Study

The primary aim of the current study was to integrate and conduct a meta-analysis of the results from studies that examined the association between self-stigma of seeking help and help-seeking outcomes such as attitudes toward seeking help, intentions to seek help, future help-seeking behavior, and initial decisions to seek online help-seeking information. Although our primary focus was on the overall relationship between self-stigma of seeking help and help-seeking outcomes, moderating factors can influence these relationships across studies. Because meta-analytic techniques are ideally suited to examine such variability, we considered study-level characteristics as potential moderators, including type of sample, country/continent, gender, race, age, year of publication, and type of help-seeking measure used.

Study Selection and Inclusion Criteria

In January 2020, the search strategy included locating relevant articles by first examining manuscripts that had cited the original validation article of the Self-Stigma of Seeking Help (SSOSH) scale (Vogel et al., 2006) on the Google Scholar search engine. The SSOSH scale was chosen because it is the most widely utilized help-seeking self-stigma scale, and there is strong evidence of reliability and validity; at the time this meta-analysis was conducted, the initial scale validation paper (Vogel et al., 2006) had been cited 454 times as reported by Web of Science and 1,248 times on Google Scholar (retrieved February 2021). This scale is described in more detail in the measures section below. Following the utilization of the Google Scholar search engine, a search term "self-stigma of seeking help scale" was used on PsycINFO to explore the possibility of additional citations. English-language titles were obtained, with additional titles retrieved by examining the references of articles. All articles were entered into Rayyan QCRI online software for managing decisions regarding inclusion or exclusion from the meta-analysis (Ouzzani et al., 2016). We included peer-reviewed studies published in academic journals and unpublished work such as dissertations and book chapters, as the latter two outlets may help reduce publication bias (Card, 2012).

The following rubric was utilized to determine whether an article warranted further review for inclusion in the meta-analysis:

1. Article represents *primary research* published in a scholarly or professional journal or a dissertation or thesis whose results are not published in a scholarly or professional journal (i.e., not a review paper or another meta-analysis).
2. Article can be retrieved by contacting the author or through university library services.
3. Article involves a *quantitative study*, or includes a quantitative study.
4. Article includes the Self-Stigma of Seeking Psychological Help (SSOSH; Vogel et al., 2006) scale, and at least one of the following constructs:
   a. Attitudes toward seeking help,
   b. Intentions/willingness to or likelihood of seeking help,
   c. Observed or self-reported help-seeking behavior subsequent to completing the SSOSH (e.g., prospective study designs that include self-reports of attending therapy or seeking online help-seeking information).
5. Article reports on the statistical bivariate relationship between the SSOSH scale and another of help-seeking variable from criteria #3 (e.g., *r*), or this statistic could be obtained by contacting the author(s) of the study.
6. Article is written in English.

Articles were excluded if their adaptation of the SSOSH scale or other outcome variables did not reflect mental health–oriented psychological help seeking. For example, studies were excluded if they modified the SSOSH to measure stigma associated with seeking academic help, career counseling, couples counseling, group counseling, or substance abuse help. The inclusion criteria for the systematic review did not contain restrictions on publication date or methodological rigor; however, given that one of the criteria was that articles utilized the SSOSH scale, no articles were published before 2006. Figure 7.1 (cf. Moher et al., 2009) provides an overview of the search and evaluation process, which began in January 2020 and concluded in January 2021.

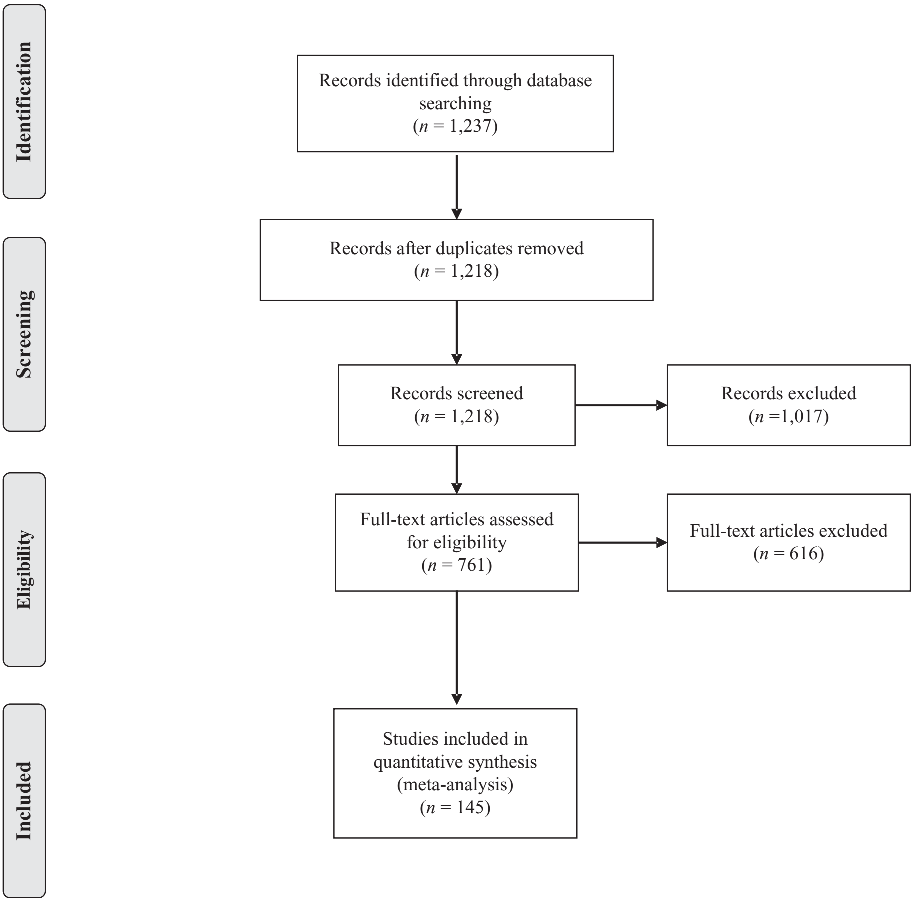

Figure 7.1 *Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) flowchart of the study selection process.*

Data Extraction

Data on the following variables were coded and entered into an MS Excel spreadsheet: author, publication date, journal, country, sample size, proportion male and female, proportion White/European American, average age, information about measures of interest, and main findings. Some studies removed items from the SSOSH scale or other measures, and so Cronbach's alpha statistics and number of items of each scale were also recorded to assess internal consistency of measures in the meta-analyses. Because some manuscripts reported multiple studies, each distinct and relevant sample was included in the appropriate meta-analysis. When manuscripts included multiple measures of each construct in the same sample (e.g., two different measures of attitudes; Hammer et al., 2018), we extracted the construct that was the focus of the manuscript or, when this was not discernible, the most recently published scale.

Some, but not many, manuscripts reported multiple waves of data (e.g., Seidman et al., 2018); when this occurred, we extracted correlations from the first wave's cross-sectional data and did not extract multiple correlations because this would bias the weight of the study's effects.

Measures in the Meta-Analyses

Self-Stigma. The present meta-analysis used the SSOSH scale to measure participants' self-stigma related to seeking psychological help (Vogel et al., 2006). Respondents rate items on a 5-point Likert-type scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*. Five items are reverse-scored so that higher scores correspond to higher self-stigma. To examine internal consistency, we conducted a meta-analysis of the SSOSH's internal consistency. The estimate of Cronbach's alpha (k = 129) for the SOSSH indicates high internal consistency, α = .84, 95% Confidence Interval (CI) = [.83, .85]. Figure 7.2 displays a forest plot of 129 Cronbach estimates. Hedge's Q test indicated that internal consistency is likely heterogeneous across samples, Q(df = 128) = 5464.16, $p < .001$, and that this heterogeneity is relatively large, I^2 = 97.22% (i.e., 97.22% of variation reflects actual differences in population parameters across studies; Huedo-Medina et al., 2006).

Attitudes. A variety of validated help-seeking attitudes measures were represented in the following meta-analysis, with the most common being the Attitudes Toward Seeking Professional Psychological Help (ATSPPH) scale (k = 96; Fischer & Turner, 1970; Fischer & Farina, 1995), the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS) (k = 8; Mackenzie et al., 2004), followed by the Mental Health Seeking Attitudes Scale (MHSAS) (k = 4; Hammer et al., 2018; Knowles & Apputhurai, 2018), variations on the Face-to-Face Counseling Attitudes Scale (FCAS) (k = 4; Rochlen et al., 2004), and the Beliefs About Psychological Services (BAPS) scale (k = 1; Aegisdottir et al., 2009), with the remaining studies utilizing attitude measures that were created or specially adapted for their respective studies (k = 7). We examined the internal consistency of these measures across 110 studies, for which information was available. The estimate of Cronbach's alpha for the attitudes measures indicated good overall internal consistency, α = .80, 95% CI = [.79, .82]. Internal consistency is likely heterogeneous across samples, Q(df = 109) = 4540.56, $p < .001$, and this heterogeneity is relatively large, I^2 = 97.02%.

Intentions. A variety of validated help-seeking intentions and willingness measures were represented in the following meta-analysis; half of all studies utilized some version of the Intentions to Seeking Counseling Inventory (ISCI) (k = 37; Cash et al., 1975), with the General Help-Seeking Questionnaire (GHSQ) (k = 11; Wilson et al., 2005) being the next most common, followed by the Mental Help Seeking Intention Scale (MHSIS) (k = 3; Hammer & Spiker, 2018) and the Willingness to Seek a Counselor (WSC) questionnaire (k = 3; Gim et al., 1990). Other studies adapted measures from previous studies

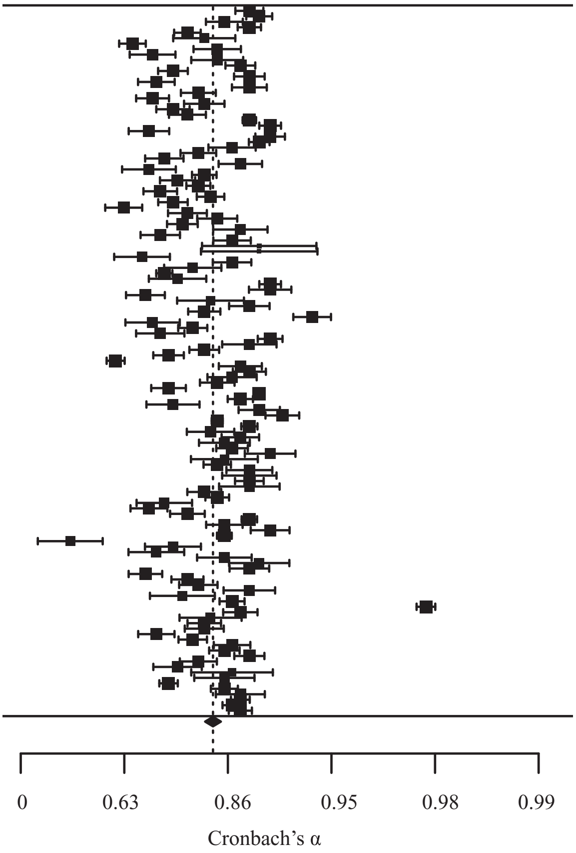

Figure 7.2 *Forest plot of weighted studies detailing Cronbach's alpha estimates of the SSOSH scale. Each horizontal line corresponds to an individual study's Cronbach's alpha estimate, with the 95% Confidence Interval displayed as a thin line. The diamond on the plot represents the point estimate and confidence intervals of all the weighted studies averaged together.*

to examine the likelihood of seeking psychological help in the future or created unique measures for their studies (k = 10) or did not specify their measure (k = 10). We examined the internal consistency of these measures across 110 studies, for which information was available. The estimate of Cronbach's alpha (k = 52) for the attitudes measures indicate excellent internal consistency, α = .90, 95% CI = [.88, .91]. Internal consistency is likely heterogeneous across samples, Q(df = 51) = 2327.87, p < .001, and the heterogeneity is relatively large, I^2 = 97.72%.

Help-Seeking Behaviors and Decisions. Only a few studies assessed actual help-seeking behaviors (k = 3), but for those that did, follow-up times after completing the SSOSH ranged from 2 to 24 months. There were also relatively few studies that assessed decisions to seek online help (k = 4).

Data Analysis

To address our first aim regarding the association between self-stigma and help-seeking variables, data analyses were conducted using the *metafor* package in R software (cf. Polanin et al., 2016; Viechtbauer, 2010). Each meta-analysis was conducted examining relationships between SSOSH and the respective help-seeking outcome (attitudes, intentions, help-seeking behaviors, information-seeking decisions) using random-effects models to estimate the weighted average effects, which assumes heterogeneity in effect sizes across studies, and may improve generalizability of results (Card, 2012). Data analyses were specified so that correlation effect sizes used Fisher's z transformation for calculations, and then back-transformed those estimates for ease of interpretation. Chi-square parameter estimates were transformed into r coefficients, but beta coefficients were excluded from analyses and not converted unless there were no other covariates in a study's regression model. The number of samples across moderation analyses vary because some manuscripts did not provide information relevant for those analyses.

Results

Characteristics of Studies

A total of 145 studies (n = 60,597) were included in meta-analyses (see Table 7.1), representing 6 continents (see Figure 7.3) and 26 countries: Australia (k = 2), Botswana (k = 1), Brazil (k = 1), Canada (k = 3), China (k = 4), Dominican Republic (k = 1), Ghana (k = 1), Hong Kong (k = 1), Iran (k = 1), Ireland (k = 1), Israel (k = 2), Lebanon (k = 1), Japan (k = 1), South Korea (k =4), Macao (k =1), Malaysia (k =1), Netherlands (k =1), Philippines (k =1), Portugal (k =1), Romania (k =1), Sweden (k =1), Taiwan (k =1), Turkey (k = 3), UAE (k = 2), UK (k =1), and United States (k =102). Some studies indicated samples from Africa (k = 1), South Asia (k = 1), North America (k =1), and Multinational (k = 1). Samples sizes ranged from 29 to 4,744, with a median sample size of 270 and an average sample size of 417.91 (SD = 553.08). Mean ages of the samples ranged from 14.22 to 67.60. Additional characteristics of each meta-analysis are reported in Table 7.2.

Self-Stigma and Help-Seeking Attitudes

As shown in the Forest plot in Figure 7.4, a random effects model estimated the weighted average effect of the association between self-stigma and attitudes, and this indicated a large effect size, $r = -.53$, 95% CI = [–.55, –.5049], $p < .001$. Approximately 28% of the variance in help-seeking attitudes is accounted for by help-seeking self-stigma. Results of Hedge's Q test was statistically significant, Q(df = 119) = 1618.74, $p < .001$, indicating that studies are not likely to share a

Table 7.1 *Study key*

S.	Authors	Year	S.	Authors	Year	S.	Authors	Year
1	Vogel et al., 2006A	2006	**51**	Cadaret & Speight, 2018	2018	**101**	Shechtman et al., 2010	2010
2	Vogel et al., 2006B	2006	**52**	Porcari et al., 2017	2017	**102**	Cheng et al., 2018	2018
3	Vogel et al., 2006C	2006	**53**	Blake, 2009	2001	**103**	Choi & Miller, 2014	2014
4	Vogel et al., 2006D	2006	**54**	Vally et al., 2018	2018	**104**	Karaffa & Koch, 2016	2016
5	Vogel et al., 2007	2007	**55**	Wang, 2013	2013	**105**	Cheng et al., 2015	2015
6	Topkaya, Vogel et al., 2017	2017	**56**	Harewood, 2009	2009	**106**	Boafo-Arthur, 2014	2014
7	Wade et al., 2015	2015	**57**	Miller, 2009	2009	**107**	Tsang et al., 2020A	2020
8	Pheko et al., 2013	2013	**58**	Spiker et al., 2019	2019	**108**	Tsang et al., 2020B	2020
9	Fox et al., 2018	2018	**59**	Topkaya, Sahin et al., 2017	2017	**109**	Bitman-Heinrichs, 2017	2017
10	Whato & Swift, 2016	2016	**60**	Seidman et al., 2019	2019	**110**	Kuok & Rashidnia, 2019A	2019
11	Lee et al., 2014	2014	**61**	Hammer & Vogel, 2017	2017	**111**	Kuok & Rashidnia, 2019B	2019
12	Blais & Renshaw, 2014	2014	**62**	Cage et al., 2020	2020	**112**	Bernstein, 2016	2016
13	Vogel et al., 2017A	2017	**63**	Dschaak & Juntunen, 2018	2018	**113**	Brenner et al., 2020	2020
14	Vogel et al., 2017B	2017	**64**	Nam & In Park, 2015	2015	**114**	Pheng et al., 2019	2019
15	Vogel et al., 2017C	2017	**65**	Ina & Morita, 2015	2015	**115**	Tuliao & Velasquez, 2017	2017
16	Vogel et al., 2017D	2017	**66**	Jean-Michel, 2014	2014	**116**	Yee et al., 2020	2020
17	Vogel et al., 2017E	2017	**67**	Sheperd, 2012	2012	**117**	Kristensen, 2015	2015
18	Vogel et al., 2017F	2017	**68**	Lannin et al., 2019	2019	**118**	Rauch, 2017	2016
19	Vogel et al., 2017G	2017	**69**	Boudreaux et al., 2014	2014	**119**	Mills, 2009	2008
20	Vogel et al., 2017H	2017	**70**	Nitzarim & Thompson, 2019	2019	**120**	Bird et al., 2019	2019
21	Vogel et al., 2017I	2017	**71**	Li et al., 2017	2017	**121**	Shea et al., 2019	2019
22	Vogel et al., 2017J	2017	**72**	Levin et al., 2018	2018	**122**	Cole & Ingram, 2020	2020
23	Lienemann & Siegel, 2016A	2016	**73**	Rogers, 2009	2009	**123**	Vasilescu, 2012	2012
24	Lienemann & Siegel, 2016B	2016	**74**	Lueck, 2018	2018	**124**	Hillard, 2019	2019
25	Bathje et al., 2014	2014	**75**	Chong, 2015A	2015	**125**	Hilliard, Redmond, & Watson, 2019	2019

Table 7.1 (*cont.*)

S.	Authors	Year	S.	Authors	Year	S.	Authors	Year
26	Heffren & Hausdorf, 2016	2016	**76**	Chong, 2015B	2015	**126**	del Castillo, 2017	2017
27	Hammer et al., 2018	2018	**77**	Vogel et al., 2011	2011	**127**	Koleoso & Odunmayowa, 2017	2017
28	Wasylkiw & Clairo, 2018	2018	**78**	Pederson & Vogel, 2007	2007	**128**	Murphy, 2018	2018
29	Kaplan et al., 2012	2012	**79**	Hamidi, 2014	2014	**129**	Choi et al., 2019	2019
30	Chen et al., 2014	2014	**80**	Altiere, 2009	2009	**130**	Hammer, Spiker et al., 2019	2019
31	Vogel et al., 2009	2009	**81**	Tucker et al., 2013A	2013	**131**	Brenner et al., 2018	2018
32	Hobson, 2008	2008	**82**	Tucker et al., 2013B	2013	**132**	Hassan, 2015	2015
33	Fripp & Carlson, 2017	2017	**83**	Reynders et al., 2014	2014	**133**	Cameron, 2019	2019
34	Garriott et al., 2017	2017	**84**	Hammer & Vogel, 2010	2010	**134**	Wahto, 2017	2017
35	Nam & Lee, 2015	2015	**85**	Blais & Renshaw, 2013	2013	**135**	Giroux & Geiss , 2019	2019
36	Allen et al., 2016	2016	**86**	Wade et al., 2011	2011	**136**	Knowles & Apputhurai, 2018	2018
37	Pasupuleti, 2013	2013	**87**	Weatherhead, 2015	2015	**137**	Noble, 2018	2018
38	Beatie et al., 2016	2016	**88**	Lannin, 2016	2016	**138**	Gochicoa, 2019	2019
39	Cantazaro, 2009	2009	**89**	Hackler et al.,2010	2010	**139**	Luc, 2018	2018
40	Andoh-Arthur et al., 2015	2015	**90**	Lannin et al., 2013	2013	**140**	Kearns et al., 2019	2019
41	Pfohl, 2010	2010	**91**	Vogel et al., 2010	2010	**141**	Lannin, Barrowclough et al., 2020	2020
42	Ballesteros & Hilliard, 2016	2016	**92**	Jennings et al., 2015	2015	**142**	Lannin, Kanter et al., 2020	2020
43	Cheang & Davis, 2014	2014	**93**	Shepherd & Rickard, 2012	2012	**143**	Heath, 2019A	2019
44	Bird et al., 2018A	2018	**94**	Held & Owens, 2013	2013	**144**	Heath, 2019B	2019
45	Bird et al., 2018B	2018	**95**	Lannin et al., 2015	2015	**145**	Hammer, Perrin et al., 2019	2019
46	Freitas-Murrell & Swift, 2015	2015	**96**	Soheilian & Inman, 2009	2009			
47	Shechtman et al., 2018	2018	**97**	Yakunina et al., 2010	2010			
48	Jennings et al., 2017	2017	**98**	Levant et al., 2013	2013			
49	Seidman et al., 2018A	2018	**99**	Stewart et al., 2015	2015			
50	Seidman et al., 2018B	2018	**100**	Lienemann et al., 2013	2013			

Note: Studies with the same citation but with a different letter (e.g., A, B) represent discrete studies from the same manuscript.
S. = Study Number

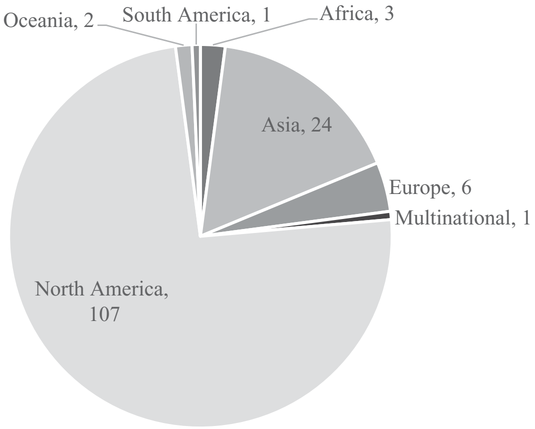

Figure 7.3 *Number of studies from different continents in the meta-analyses.*

common effect size, and it is likely that the heterogeneity of effect sizes across samples is large, I^2 = 93.69% (i.e., 93.69% of variation reflected actual differences in population parameters across studies). Neither Egger's regression test for funnel plot asymmetry (z = 1.00, p = .316) nor the Rank correlation test for funnel plot asymmetry (Kendall's tau = 0.03, p = .632) was statistically significant, suggesting that there is no evidence of publication bias. Figure 7.8 displays all funnel plots for meta-analyses in this study.

Moderation analyses were then conducted. The type of sample (college student, adult, military, adolescent) was not a statistically significant moderator of the relationship between self-stigma and attitudes, QM(df = 3) = 2.77, p = 0.429,[1] nor was country of the sample, QM(df = 28) = 35.77, p = 0.149; however, continent was a significant moderator, QM(df = 6) = 19.28, p = 0.004, with countries from North America and Europe exhibiting stronger relationships between self-stigma and help-seeking attitudes (see Table 7.3). Year of publication (k = 120) was also a significant moderator, QM(df = 1) = 6.54, b = 0.01, SE = 0.005, p = 0.011. Specifically, a publication in 2006 would be predicted to have a correlation of –0.78 between self-stigma and help-seeking attitudes, whereas in 2021 that correlation would be predicted to be –0.60, and it would be predicted to be –0.49 in 2030.

Additionally, samples with a higher proportion of Whites/European Americans exhibited a stronger relationship between self-stigma and attitudes, QM(df = 1) = 13.67, b = –0.19, SE = 0.05, $p < 0.001$. Specifically, the correlation between self-stigma and attitudes for a completely White sample would be predicted to be –0.79, but –0.50 for a completely non-White sample. Proportion of males in the sample was not a statistically significant moderator of the association between self-stigma and attitudes, QM(df = 1) = 1.98, b = –0.10, SE = 0.07, p = 0.159, nor was age, QM(df = 1) = 0.27, b = –0.001,

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[1] There were too few adolescent samples (k = 3) to include in this analysis.

Table 7.2 *Sample characteristics of studies in each meta-analysis*

Characteristic	All studies (*k* = 145)		SSOSH-attitudes (*k* = 120)		SSOSH-intentions (*k* = 74)		SSOSH-HS (*k* = 3)		SSOSH-IS (*k* = 4)	
	N	Valid %	*N*	Valid %	*N*	Valid %	*N*	Valid %	*N*	Valid %
Total	60,597	100	52,892	100	31,679	100	868	100	1,174	100
Type of Sample										
College Students *k* = 100, 82, 55, 1, 3	36,862	61%	30,152	57%	22,742	72%	655	75%	1,000	85%
Adults *k* = 27, 26, 11, 0, 0	19,157	32%	18,881	36%	5,930	19%	0	0%	0	0%
Military/Security *k* = 14, 9, 6, 2, 0	3,795	6%	3,250	6%	2,518	8%	213	25%	0	0%
Adolescents *k* = 4, 3, 2, 0, 1	783	1%	609	1%	489	1%	0	0%	174	15%
Gender *k* = 143, 118, 3, 4										
Men	28,944	51%	25,658	52%	13,901	44%	442	51%	316	27%
Women	27,970	49%	23,552	48%	17,441	56%	426	49%	858	73%
Race/Ethnicity *k* = 116, 92, 56, 3, 4										
White	27,714	54%	23,093	57%	13,305	55%	752	87%	712	61%
Non-White	20,099	46%	17,147	43%	10,904	45%	116	13%	462	39%
Age M (SD) *k* = 116, 90, 58, 3, 2	26.11 (8.90)	—	26.80 (9.47)	—	24.94 (8.05)	—	36.60 (2.33)	—	18.80 (1.97)	—

Note: HS = Help-Seeking Behavior; IS = Information-Seeking Behavior.

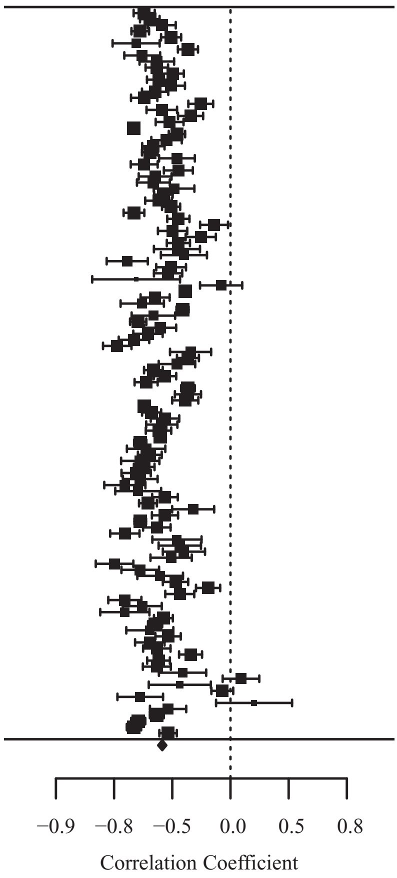

Figure 7.4 *Forest plot of weighted studies detailing effect sizes of the association between self-stigma and attitudes. Each horizontal line corresponds to an individual study's effect size, with the 95% Confidence Interval displayed as a thin line. The diamond on the plot represents the point estimate and confidence intervals of all of the studies averaged together.*

SE = 0.002, $p = 0.603$, nor type of attitude measure used, QM($df = 9$) = 11.58, $p = 0.238$.

Self-Stigma and Intentions to Seek Help

A random effects model estimated the weighted average effect of the association between self-stigma and intentions, and this indicated a moderate effect size, $r = -.28$, 95% CI = [–.32, –.25], $p < .001$. See Figure 7.5. Approximately 8% of the variance in help-seeking intentions is accounted for by help-seeking self-stigma. Results of Hedge's Q test were statistically significant, Q($df = 73$) = 1299.45, $p < .001$, which indicates that studies are likely to demonstrate heterogeneity and that the heterogeneity across samples is large, $I^2 = 91.15\%$. Neither Egger's regression test for funnel plot asymmetry ($z = -0.10$, $p = .921$)

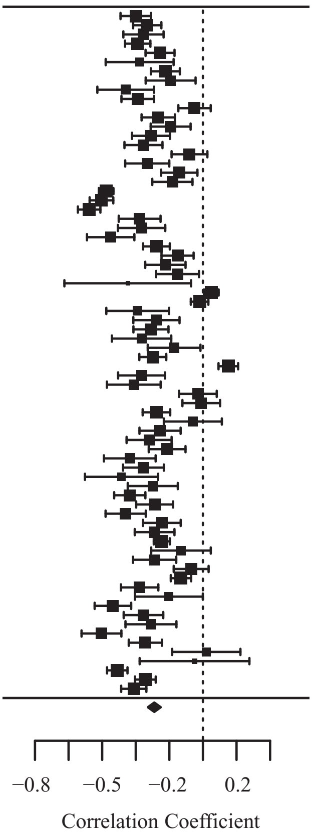

Figure 7.5 *Forest plot of weighted studies detailing effect sizes of the association between self-stigma and intentions. Each horizontal line corresponds to an individual study's effect size, with the 95% Confidence Interval displayed as a thin line. The diamond on the plot represents the point estimate and confidence intervals of all the studies averaged together.*

nor the Rank correlation test for funnel plot asymmetry (Kendall's tau = 0.01, p = 0.907) was statistically significant, suggesting that there is no evidence of publication bias.

The type of sample (college student, adult, military) was not a statistically significant moderator of the relationship between self-stigma and intentions, QM (df = 3) = 5.81, p = 0.121, nor was country of the sample, QM(df = 19) = 29.61, p = 0.057. While continent was a significant moderator, QM(df = 5) = 20.95, $p <$ 0.001, the nature of these moderation effects are unclear (see Table 7.3). Year of publication was not a significant moderator, QM(df = 1) = 0.0004, b = –0.00011, SE = 0.005, p = 0.985.

Again, samples with a higher proportion of Whites/European Americans exhibited a stronger relationship between self-stigma and intentions, QM(df = 1) = 13.81, b = –0.21, SE = 0.06, $p <$ 0.001. Specifically, the correlation between self-

Table 7.3 *Meta-regression of continent predicting relationship between self-stigma and attitudes*

Attitudes (k = 112)			Intentions (k = 73)		
Characteristic	*b (SE)*	*p*	Characteristic	*b (SE)*	*p*
Intercept	–0.26 (0.13)	.045	Intercept	–0.22 (0.10)	.045
Asia	–0.26 (0.13)	.054	Asia	0.10 (0.11)	.380
Europe	–0.43 (0.15)	.004	Europe	–0.11 (0.13)	.422
Oceania	–0.09 (0.18)	.630	Oceania	–0.04 (0.18)	.812
North America	–0.36 (0.13)	.005	North America	–0.11 (0.11)	.288
South America	–0.25 (0.22)	.255	South America	0.03 (0.18)	.863
Multinational	–0.20 (0.24)	.397	—	—	—

stigma and intentions for a completely White sample would be predicted to be –0.41, but –0.20 for a completely non-White sample. Proportion of males in a sample was not a statistically significant moderator, QM(*df* = 1) = 0.51, *b* = 0.06, *SE* = 0.08, *p* = 0.477, nor was age, QM(*df* = 1) = 0.95, *b* = –0.003, *SE* = 0.003, *p* = 0.330, nor type of intentions measure used, QM(*df* = 9) = 7.97, *p* = .538.

Self-Stigma and Help-Seeking Behaviors and Decisions

Finally, meta-analytic procedures explored the relationship between self-stigma and more behavioral help-seeking assessments such as self-reported help seeking in prospective studies where help-seeking behavior was assessed some meaningful amount of time after completing the SSOSH scale (e.g., 2 months later, 2 years later) as well as decisions to spontaneously seek help-seeking information via clicking on a web link.

A random effects model estimated the weighted average effect of the association between self-stigma and help-seeking behaviors, and this indicated a moderate effect size, *r* = –.21, 95% CI = [–.27, –.14], $p < .001$. Approximately 4% of the variance in help-seeking behavior is accounted for by help-seeking self-stigma. Because of the small number of studies examining actual help-seeking behaviors in prospective designs (k = 3), most tests of moderators were not possible. The length of time between completing the SSOSH and reporting help-seeking behaviors was not a statistically significant predictor of help-seeking behaviors, Q(*df* = 1) = 0.15, *p* = .699. For self-reported help-seeking behaviors, results of Hedge’s Q test were not statistically significant, Q(*df* = 2) = 0.43, *p* = .805, which indicates that studies (*k* = 3) are homogeneous, I^2 = 0.00%. Neither Egger’s regression test for funnel plot asymmetry (*z* = –0.40, *p* = .689) nor the Rank correlation test for funnel plot asymmetry (Kendall’s tau = –1.00, *p* = 0.333) was statistically significant, suggesting that there is no evidence of publication bias. See Figure 7.6.

For decisions to click on web links to immediately access help-seeking information, a random effects model estimated the weighted average effect

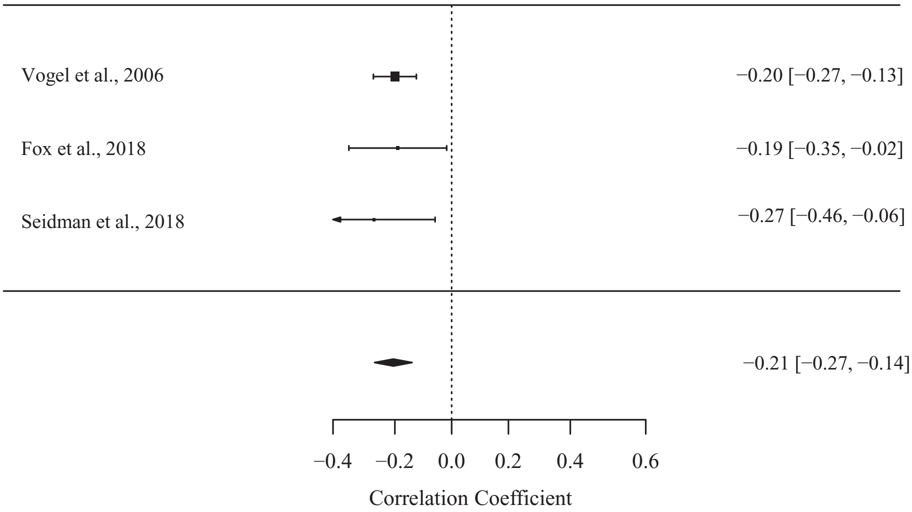

Figure 7.6 *Forest plot of weighted studies detailing effect sizes of the association between self-stigma and help-seeking behaviors. Each horizontal line corresponds to an individual study's effect size, with the 95% Confidence Interval displayed as a thin line. The diamond on the plot represents the point estimate and confidence intervals of all the studies averaged together.*

of the association between self-stigma and help-seeking behaviors, and this indicated a small effect size, $r = -.09$, 95% CI = [-.15, -.04], $p = .002$. Approximately 1% of the variance in clicking on web links for help-seeking information is accounted for by help-seeking self-stigma. Results of Hedge's Q test were not statistically significant, $Q(df = 3) = 0.51$, $p = .917$, which indicates that studies ($k = 4$) are homogeneous, $I^2 = 0.00\%$. Neither Egger's regression test for funnel plot asymmetry ($z = -0.44$, $p = .661$) nor the Rank correlation test for funnel plot asymmetry (Kendall's tau = –0.33, $p = 0.750$) was statistically significant, suggesting that there is no evidence of publication bias. See Figures 7.7 and 7.8.

Discussion

The results of the present meta-analyses add to the literature by providing an estimate of the magnitude of the relationships between self-stigma of seeking psychological help and important help-seeking variables in meta-analyses of 145 studies and 60,597 participants from 26 countries and 6 continents. Results indicated that self-stigma is linked to lower help-seeking attitudes, lower intentions to seek help, lower likelihood of actually seeking help, and lower likelihood in deciding to take initial help-seeking actions such as seeking online help-seeking information. These findings were robust across gender, age, and type of sample (e.g., college, adult, military), but the presence of

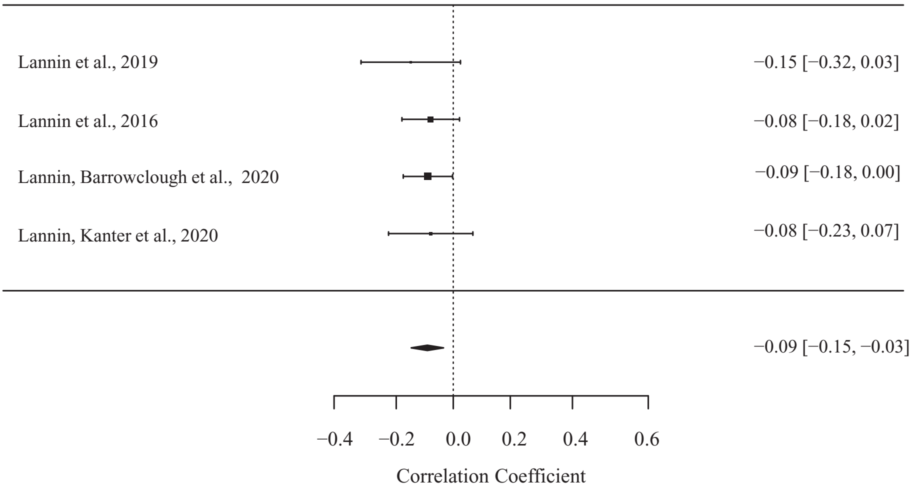

Figure 7.7 *Forest plot of weighted studies detailing effect sizes of the association between self-stigma and decisions to seek online help-seeking information. Each horizontal line corresponds to an individual study's effect size, with the 95% Confidence Interval displayed as a thin line. The diamond on the plot represents the point estimate and confidence intervals of all the studies averaged together.*

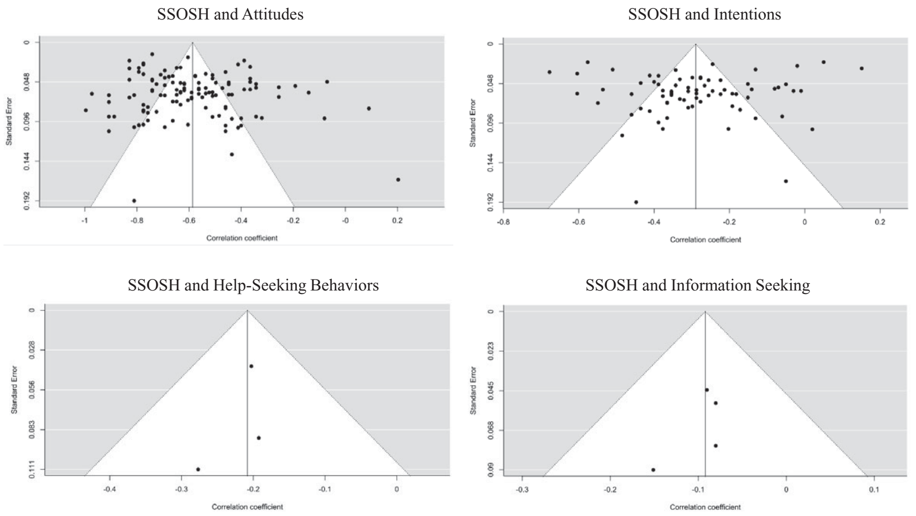

Figure 7.8 *Funnel plots of primary meta-analyses. Each study is represented by a dot, with the x-axis representing correlation coefficients and the y-axis representing standard error estimates. Asymmetry may suggest the presence of publication bias.*

moderators such as continent of sample and race suggests the need for future research to examine cultural influences on self-stigma and its role as a barrier to seeking psychological help. Importantly, there was no evidence of publication bias, which lends additional confidence to the present study's findings.

The present meta-analysis provides strong evidence that help-seeking self-stigma has a robust and large negative relationship to help-seeking attitudes. The effect size of this relationship across 120 studies and 52,892 participants was – .53. This large effect suggests that more than one quarter variability in help-seeking attitudes can be accounted for by peoples' perceptions of self-stigma. In other words, the extent to which people evaluate psychological help as positive or negative is intimately related to the extent to which they view psychological help as threatening to their self-worth (Vogel et al., 2006). Location (i.e., continent) moderated the relationship between self-stigma and attitudes, with North American and European countries exhibiting the strongest relationships. Relatedly, there was a stronger correlation between stigma and attitudes for Whites, compared to non-Whites. It is conceivable that White and Western worldviews may emphasize individualistic aspects (e.g., independence, personal agency, and perceptions that the self is a separate entity from others; Kashima et al., 1995) that heighten the consequences of self-stigma. That is, threats to personal agency may be viewed more negatively for people who prioritize their own personal agency over the well-being of others and interpersonal harmony (Lannin, Ludwikowski et al., 2020). Interestingly, more recent studies have exhibited weaker relationships between self-stigma and help-seeking attitudes. While the reason for this is not clear, it is conceivable that newer samples have expanded findings to more diverse samples or that self-stigma is decreasing over time.

The present meta-analysis also provides strong evidence that help-seeking self-stigma has a moderately negative relationship with help-seeking intentions. In other words, those who view psychological help as personally threatening anticipate that they will be less likely to seek psychological help for different mental health concerns. The effect size of this relationship across 74 studies was – .28. While this effect size indicates that a meaningful proportion of variance in intentions is accounted for by self-stigma, it also suggests that other important factors may influence this effect. Again, the link was strongest for Whites, but the nature of moderating effect of continent of sample was inconclusive. As described above, it is plausible that White and Western worldviews may reflect an orientation toward individualism (Kashima et al., 1995), which exacerbates the impact of self-stigma. Nevertheless, future studies may benefit from empirically testing this notion.

In addition to its effects on help-seeking attitudes and intentions, there is also evidence that help-seeking self-stigma has a small, negative effect on actual help-seeking outcomes. First, help-seeking self-stigma is negatively linked to future help-seeking behaviors. The effect, $r = -.21$, is moderate, and suggests that self-stigma is an important predictor of whether (or not) people actually seek professional psychological help. Second, help-seeking self-stigma is a barrier to the initial decision to seek online help-seeking information. The effect, $r = -.09$, is small though, which suggests that self-stigma may be one of a number of predictors of whether (or not) people decide to click on help-seeking information.

Implications for Research and Practice

The present meta-analysis has important implications for professional psychological help. Practitioners and researchers can consider helping different groups understand self-stigma and its effects on clients' and potential clients' perceptions of professional psychological help. To promote the use of psychological services for underserved populations it may be helpful to provide options for addressing the negative effects of help-seeking self-stigma via a multifaceted approach. First, it may be useful to consider interventions that may forestall the emergence of self-stigma or directly reduce it. Existing approaches to reducing self-stigma of seeking psychological help that may be beneficial for some clients include normalizing help-seeking behavior, discussing therapy's benefits, and challenging false beliefs about therapy (Schomerus & Angermeyer, 2008).

In addition, it may be beneficial to promote the use of coping strategies that may help reduce stigma's likelihood of eroding peoples' self-esteem. There is some evidence that self-compassion (demonstrating kindness and understanding to one's self when suffering; Heath et al., 2018), self-affirmation (reminding one's self of important and positive aspects of one's identity; Lannin et al., 2013), and coming out proud (framing one's mental illness identity as a source of pride rather than shame; Ege & Lannin, 2021) may bolster and protect self-worth from being eroded by help-seeking stigma. Additionally, the present meta-analysis indicated that continents where communal orientations are more prevalent reported lower links between self-stigma and attitudes. It may be possible that how the self is construed may influence self-stigma's impact on attitudes, and this may be an important area for practitioners to consider.

Limitations and Future Research Recommendations

Although the present meta-analysis provides robust evidence of the role of self-stigma as a salient barrier to psychological help, the present investigation is not without limitations. First, the vast majority of studies were conducted in North America, but only one study was from South America. There is a need for future research to examine the effects of self-stigma in global populations, and there appears that efforts in South America and Africa may be especially beneficial. Second, the vast majority of studies examined the relationship between self-stigma and other self-reported variables that serve as proxies for help-seeking behavior, i.e., attitudes and intentions. There is a need for additional prospective studies that examine actual help-seeking behavior over time, as there may be relevant variables (such as distress) that have differential effects on help-seeking intentions and actual help-seeking behavior (Nagai, 2015).

While the present meta-analysis focused on help-seeking outcomes, future meta-analyses may consider predictors of the self-stigma of seeking psychological help such as public stigma, masculine gender norms, therapeutic experiences, personal values, self-compassion, and self-affirmation. Given the fact that therapeutic experiences have often been associated with lower self-stigma

(Mittal et al., 2012; Wade et al., 2011), it may be beneficial for research to explore whether there is a minimum "dosage" of therapeutic activity that is effective while also being nonthreatening enough to forestall avoidance.

Conclusion

The adverse effects of self-stigma are well established, and the present study provides robust evidence that the self-stigma of seeking psychological help is a strong and salient barrier to efforts to seek professional psychological help for mental health concerns. The present meta-analysis included 145 articles and revealed a strong negative relationship between help-seeking self-stigma and help-seeking attitudes, a moderate negative relationship between self-stigma and help-seeking intentions, a moderate negative relationship between self-stigma and actual future help-seeking behaviors, and a small negative relationship between self-stigma and decisions to seek online help-seeking information. Cultural variables likely play important roles in determining how mental and social processes interact with self-stigma to influence help-seeking beliefs and behaviors. Nevertheless, the present meta-analysis confirms important theoretical links from previous literature. A person who perceives psychological help as threatening to their self-worth is likely to evaluate psychological help negatively, predict that they would avoid seeking help if they needed it, fail to seek out relevant help-seeking information, and ultimately avoid actually seeking psychological help.

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8 Stigma and Suicide

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Suicide Stigma: Origins and Definitions

In Western societies, suicide stigma has been perpetuated both religiously and legally for centuries and can be traced back to the denial of a proper burial for those who died by suicide, property confiscation, and the excommunication of family members bereaved by suicide (Frey et al., 2016; Hanschmidt et al., 2016). Ancient Greek and Roman societies were largely hostile to suicide, although philosophers such as Socrates and Plato argued that there were specific situations in which suicide could be justified (Chen et al., 2017). The view that suicide was immoral became entrenched in the early Christian church, with the writings of St. Augustine and Thomas Aquinas depicting suicide as a mortal sin or an act against God (Chen et al., 2017). Although the stigmatization of suicide has since taken on more subtle forms such as isolation and shunning in some cultures, in others, suicide stigma includes physical molestation and social ostracism by family and community (Osafo et al., 2015). The language used publicly to describe suicidal behavior reflects the entrenched stigma associated with suicide. Terms such as “commit suicide” suggest that suicide is illegal or immoral (Silverman, 2006).

Theoretical conceptualizations of stigma distinguish three dimensions of stigma that are typically referred to in the literature as personal stigma, perceived stigma, and self-stigma (Busby Grant et al., 2016; Hanschmidt et al., 2016). Personal stigma, also referred to as public stigma, is the endorsement of negative attitudes and behaviors directed at a particular group (Busby Grant et al., 2016). Perceived stigma refers to the perception that others in the community hold negative attitudes toward a group (Busby Grant et al., 2016). Self-stigma is the process through which stigmatized individuals internalize the negative attitudes of others, recognizing and applying the public stigma to themselves (Hanschmidt et al., 2016; Sheehan et al., 2017). Stigma can refer to attitudes or behavior, encompassing unconscious biases, stereotyping, negative attitudes, prejudice, and discrimination (Kopera et al., 2015; Sheehan et al., 2017). These attitudes and behaviors may have negative effects for people with suicide ideation, people who have attempted suicide, and people bereaved by suicide, in that it may elicit feelings of shame and embarrassment and reduce future disclosure and help-seeking behavior. However, measuring discriminatory behavior or prejudice is complicated by social desirability and may be confounded by level of exposure (Corrigan & Shapiro, 2010; Henderson et al., 2012). For example, if an individual has not knowingly encountered a person experiencing suicidal thoughts, it is also unlikely that they would report discriminatory behavior. Therefore, stigma is most often assessed on the basis of self-reported negative attitudes.

While suicide stigma is often conflated with mental illness stigma, a number of studies have explored the specificity of suicide stigma. Sheehan et al. (2016), for example, found those who have attempted suicide experience public stigma and self-stigma. Suicide stigma shares similarities with the way in which mental illness stigma manifests, such as attitudes related to dangerousness, incompetence, or emotional weakness. However, there are attitudes that are unique or more commonly endorsed with respect to suicide compared to mental illness, such as attitudes related to selfishness (e.g., "punishing others" and "hurtful"), recklessness, and immorality (Batterham et al., 2013b; Cryer et al., 2020). Furthermore, recovery from suicide attempt is viewed as less malleable than recovery from depression (Sheehan et al., 2017), and stereotypes (e.g., "weak," "crazy," "distressed") and prejudices (e.g., "fear," "distrust," "anger") directed toward suicidal individuals appear to be more prevalent than stigma related to depression or many physical health problems (Cryer et al., 2020; Sheehan et al., 2017). Not all people who attempt or die by suicide have diagnosable mental illnesses (Phillips, 2010), and therefore measures adapted directly from mental illness measures without attention to potential differences between the stigmas of mental illness and suicide may not capture distinct aspects of suicide stigma. As described below, there are distinct relationships between suicide stigma and specific poor outcomes (Calear et al., 2014; Frey et al., 2016; Oexle et al., 2019). There is consequently a strong case for the differentiation of suicide stigma from mental illness stigma in suicide stigma research. Despite these differences, much of the research into suicide stigma continues to be grouped with mental illness stigma, which may misrepresent the true impacts of suicide stigma.

Measuring Suicide Stigma

Assessment of suicide stigma has matured only in the past decade. A broad focus on measuring attitudes toward suicide has been problematic for a number of reasons. First, the target of the stigma has been imprecisely defined. Attitudes toward people who experience suicidal thoughts, people who attempt suicide, and people who die by suicide are likely to be distinct. Some attitudinal scales have stretched the definition of suicide to include euthanasia, physician-assisted suicide, or ritual suicide (Anderson et al., 2008; Domino et al., 1982; Jenner & Niesing, 2000; Kodaka et al., 2011; Sawyer & Sobal, 1987; Stillion et al., 1984), which again may be viewed differently to "typical" suicidal behavior, leading to further imprecision. In contrast, other scales have focused on specific subgroups such as young people or drug users (Domino et al., 1982; Goldney et al., 1987; Jenner & Niesing, 2000; Sawyer & Sobal, 1987; Stillion et al., 1984), which limits the generalizability of the construct. Second, the attitudes or behaviors measured within scales has at times gone beyond the scope of stigma. Attitudes that are neutral (not overtly negative) cannot be directly classified as stigmatizing. Acceptability or normalization of suicide, preventability, impulsivity, or attribution of suicidal behavior to mental illness or isolation may be important attitudes to measure, but form constructs that are likely to be distinct from stigma (Batterham et al., 2013a, 2013b; Kodaka et al., 2011). Some scales have conflated attitudes with public knowledge or suicide prevention literacy (Domino et al., 1982). Third, self-report scales need to have demonstrated validity, reliability, and utility. Earlier scales tended to have modest validity and reliability, with an inconsistent factor structure (Anderson et al., 2008; Domino et al., 1982; Kodaka et al., 2011; Rogers & DeShon, 1992, 1995). Many existing stigma scales, such as SUIATT (SUIcide ATTitude questionnaire, Diekstra & Kerkhof, 1988), SEDAS (SEmantic Differential scale Attitudes toward Suicidal behaviour, Jenner & Niesing, 2000), and SSAS (Suicide Stigma Assessment Scale, Corrigan et al., 2017), are lengthy, requiring at least 10 minutes to administer, which may preclude use in large epidemiological studies, evaluations, or randomized controlled trials.

Batterham et al. (2013b) developed the Stigma of Suicide Scale (SOSS) to assess stigma toward people who have died by suicide. The SOSS consists of three independent subscales that measure stigma, normalization/glorification, and attribution of suicide to depression/isolation. There is a long form (58 items) and a short form (16 items) available. Both forms of the SOSS have been extensively validated, including in cross-national samples and translated versions (Han et al., 2017; Ludwig et al., 2020; Öztürk et al., 2017; Williams et al., 2018), demonstrating a consistent factor structure. While the scale primarily focuses on stigma, its measurement of two other factors, normalization/glorification and attribution of suicide to depression/isolation, provides information on complementary attitudes that have been shown to be influenced by suicidal experience (Batterham et al., 2013a; Chen et al., 2017). The scale's brevity and sound psychometric properties have led to its use in national suicide prevention programs (e.g., Shand et al., 2020), program evaluations (e.g., Dreier et al., 2019; Kennedy et al., 2018), epidemiological studies (e.g., Oliffe et al., 2016), and clinical trials (e.g., Calear et al., 2016).

Other scales have been developed to measure the stigma of suicide attempt. Sheehan et al. (2018) developed the Self-Stigma of Suicide Attempt Scale (SSSAS) to measure self-stigma experienced by suicide attempt survivors. Corrigan et al. (2017) drew on previous qualitative research with suicide stakeholders to create the Suicide Stigma Assessment Scale (SSAS-44), a measure of public suicide stigma. Corrigan et al. (2017) refer to how broadly stigma is measured, for example, whether it is encompassing of aspects of stereotypes, prejudice, and discrimination rather than drawing only on one or two of these areas. They adopted elements of co-design in developing their scale, as involvement of end-users in scale development can be highly beneficial in ensuring measures have high construct validity (Batterham et al., 2020; Sheehan et al., 2018).

Nevertheless, a focus only on people with suicidal experience may miss diverse forms of stigmatizing attitudes seen in the wider population, as many stigmatizing attitudes may be hidden, implicit, or confined to specific subgroups of the population (Rüsch et al., 2010; Stier & Hinshaw, 2007). Scocco et al. (2012) designed the Stigma of Suicide Attempt (STOSA) scale and the Stigma of Suicide and Suicide Survivor (STOSASS) scale to measure public stigma directed toward suicide attempt survivors and those bereaved by suicide, respectively. The scales group items into two factors, one measuring supportive, respectful, and caring attitudes, the other focusing on stigmatizing attitudes and beliefs. Although only a single validation study has been reported for these two scales, the reliability of each scale was shown to be good in terms of both internal coherence and test-retest stability. Scocco et al. (2012) suggest the evaluation of stigma with these scales could serve as a predictor of outcome in therapeutic interventions in suicide attempters as well as those bereaved by suicide.

Factors Associated with Suicide Stigma

Associations between suicide stigma and sociodemographic and psychological factors have been tested in several studies, with samples recruited from the community, universities, and clinical settings. Age has a complex relationship with suicide stigma. Some studies have found that stigma is highest in young adults, reducing into early adulthood (Batterham et al., 2013a, 2013b; Mackenzie et al., 2019). However, one study reported that stigma was greater in older adults than in younger adults (Park et al., 2015), and other studies have found no age differences (Batterham et al., 2019). It may be possible that findings are culturally dependent or that there is a U-shaped relationship across the life span. Findings related to gender are more consistent, with males reporting higher levels of stigma than females (Batterham et al., 2013a, 2013b, 2019; Mackenzie et al., 2019; Park et al., 2015).

There are likely to be significant variations in stigma across different cultural groups. Chinese students had higher stigma ratings than Australian students in cross-national comparisons (Han et al., 2017), while ethnic background has also been shown to influence stigma (Money & Batterham, 2019). Further investigation of the effects of culture is warranted, as it is unclear whether these relationships might be attributable to religious beliefs about suicide, social norms, acceptability, and prevalence of suicide, or extrinsic factors such as economic influences (Money & Batterham, 2019). Stigma levels tend to be lower in samples with greater educational attainment (e.g., in university samples relative to general population samples), although evidence for a direct effect of education on stigma is mixed and may be more related to the field of study or exposure to mental health training (Batterham et al., 2013a, 2013b; Chan et al., 2014).

Personal experience of suicidal thoughts or behaviors, or exposure to mental illness or suicidality in others, may also influence levels of stigma. Batterham et al. (2019) found that a sample of patients with difficult-to-treat mood disorders reported lower levels of suicide stigma compared to a community sample. This difference was attributed to greater knowledge about suicide prevention and increased exposure to individuals experiencing suicidal thoughts or behaviors. Batterham et al. (2013a) also reported that history of suicidal ideation was associated with lower levels of personal stigma in a population-based sample. In contrast, Scocco et al. (2016) found the experience of a previous attempted suicide is related to greater self-stigma toward suicidal behavior and that psychopathological distress may significantly increase the individual's perception of stigma. These studies highlight the differences in personal or public stigma compared to self-stigma: whereas individuals who are exposed to suicide may have greater understanding and empathy toward other suicidal people, the shame and prejudice of others may lead to internalization of negative self-image.

Impacts of Suicide Stigma

There is limited research on the direct effects of stigma on suicidal thoughts and behavior, although there is considerable speculation about how stigma might influence suicidality. Much of the research in this area is qualitative or examines mental illness stigma rather than suicide stigma. For example, in a cross-sectional ecological study, Schomerus and colleagues (2015) found mental illness stigma is associated with higher national prevalence of suicide. They reviewed levels of social acceptance of mental illness with suicide rates and socioeconomic indicators from 25 European countries and found the social acceptance of those with a significant mental health problem was negatively correlated with age-standardized national suicide rates in the same year. While this finding does not necessarily indicate that individual levels of stigma directly influence suicidal behavior, the authors hypothesized that the link may result from the social isolation that can be a consequence of stigma, and that stigma may act as a stressor within communities. Based on a qualitative study of clinicians and people who had attempted suicide, Rimkeviciene and colleagues (2015) suggested that mental illness stigma may exacerbate suicidal thoughts in individuals already at high risk of suicide. They reported that personal stigma and self-stigma may manifest as feelings of perceived burdensomeness and thwarted belongingness, two interpersonal-psychological factors that are associated with the development of suicidal ideation (Ma et al., 2016). Similarly, in their qualitative study of 13 survivors of suicide attempt, Oexle et al. (2019) reported that both mental illness stigma and suicide stigma can lead to substantial emotional strain, including loneliness and hopelessness and therefore increased risk for suicide. Frey et al. (2016) also found that individuals with previous suicidal behavior reported high rates of perceived stigma and that prevalence of perceived stigma was a predictor of depression symptom severity.

There is considerably more research on the impacts of stigma on help-seeking outcomes. Calear et al. (2014) found that suicide stigma had a strong association with more negative attitudes toward help seeking, and lower intentions to seek help from a mental health professional. They also reported that specific stigmatizing attitudes, such as the view that people who die by suicide are immoral or stupid, were associated with reduced intentions to seek help from primary care services. There is also evidence that stigma interacts with suicide literacy. Theories of behavior change, such as the theory of planned behavior (Ajzen, 2011) and theory of reasoned action (Montaño & Kasprzyk, 2015), suggest that knowledge about a health behavior, such as seeking mental health treatment, influences normative beliefs and attitudes about the behavior. These attitudes and beliefs, in conjunction with an individual's perceived control related to seeking help, can influence intentions to seek help and help-seeking behaviors.

However, evidence for the direct relationship of stigma on help-seeking behaviors is mixed. Calear and Batterham (2019) found stigma had very limited effects on disclosure of suicidal ideation to formal and informal sources, whereas Calear et al. (2014) found more consistent effects of suicide literacy than stigma on help-seeking behaviors. Calear et al. (2014) showed that while anti-stigma messages are likely to increase help seeking in general, claims that people who die by suicide are not "irresponsible" or "vengeful" may reduce intentions of seeking help from family, friends, and general practitioners. A cross-national study comparing intentions to seek help from a mental health professional among students in China and Australia found no effects of stigma (Han et al., 2018). Similarly, an Australian study of medical students found that glorification of suicide was associated with lower help-seeking intentions, but stigma had no significant effect (Chan et al., 2014). It is possible that stigma influences help-seeking attitudes directly for some people, but that the effect attenuates with more distal outcomes such as intentions and behaviors. Alternatively, personal or public stigma may have a lesser effect than self-stigma on the decision to engage in clinical services, although few studies have assessed effects of self-stigma. These mixed findings suggest that the effects of stigma on help seeking may not be consistent and may not directly affect behavioral outcomes.

Reviews by Han and colleagues (2015) and (2018) have highlighted the complex role of stigma in help seeking and corroborate the mixed findings summarized above. Han and colleagues (2018) found that increased stigma toward people who die by suicide was significantly associated with lower help-seeking intentions in some populations, but not in others. Hom and colleagues (2015) note that while globally only 7% of individuals with suicidal ideation report stigma as a barrier to help seeking, it is possible stigma of help seeking may be more relevant in specific populations and that reported barriers to care, such as lack of perceived need, may capture more subtle aspects of stigma. Few studies, however, have used validated measures of suicide stigma to examine the relationship, and more studies have focused broadly on mental illness stigma. In addition to stigma and health literacy, other factors that may be salient in help-seeking intentions or behaviors include preference for self-management or self-reliance, structural barriers such as cost or service accessibility, lack of perceived need, fear or mistrust of service providers, and more permissive attitudes toward suicide (Carlton & Deane, 2000; Han et al., 2018b; Hom et al., 2015; Stillion et al., 1986). Furthermore, there is some evidence of a help negation effect: that increasing severity of suicidal ideation may be associated with lower intentions to seek help. It has been suggested that maladaptive coping behaviors are associated with increased severity of ideation, which is associated with rejection of professional treatment, particularly in adolescents (Deane et al., 2001).

Suicide stigma may also have social or interpersonal consequences. People who have experienced suicidal ideation or attempt may be at increased risk of social isolation because of avoidance related to talking about suicide attempts with others (Fulginiti & Frey, 2018). In addition, although disclosure of suicidal behaviors to family is typically associated with positive reactions, there is a risk of negative outcomes in families with high levels of stigma, such as withdrawal of support after disclosure of a suicide attempt (Frey & Fulginiti, 2017). Poor social support may also perpetuate the help-negation effect, with studies finding higher levels of suicidal thoughts and lower intentions to seek support among those with poor social support (Yakunina et al., 2010).

In addition to effects on individuals who are experiencing suicidal thoughts or behaviors, there is emerging evidence that stigma may play a negative role in the well-being of people bereaved by suicide. Hanschmidt and colleagues (2016) and Bartik and colleagues (2015) found that people bereaved by suicide showed higher levels of stigma than the general population or those bereaved by other causes of death. Family members may perceive that they contributed to their loved one's death through abuse, neglect, denial, or failure to provide adequate help (Sheehan et al., 2018) and experience higher levels of shame, responsibility, and guilt, compared with those bereaved by either sudden natural or unnatural death (Pitman et al., 2016). Higher levels of shame and self-stigma carried by people bereaved by suicide are linked to concealment of the death, social withdrawal, withdrawal of support systems, reduced psychological and somatic functioning, and grief difficulties (Hanschmidt et al., 2016; Sheehan et al., 2018). Similarly, Scocco and colleagues (2016) found that psychological distress in suicide survivors was positively related to levels of perceived stigma. Furthermore, people bereaved by suicide report greater bereavement stigma than people bereaved by sudden natural or unnatural death (Pitman et al., 2016). Worryingly, Pitman and colleagues (2017) found that high levels of suicide bereavement stigma are associated with increased risk of suicidal thoughts and suicide attempt.

Future Research Directions

Despite the relatively high prevalence and pernicious influence of suicide stigma, the study of suicide stigma is less developed than research on the stigma of depression or psychosis. There consequently remain many research questions to be addressed or better established. Understanding the processes by which stigmatizing attitudes emerge, taking a developmental and cultural approach, and combining qualitative and quantitative data may provide insight into how suicide stigma may be combatted. There are clearly considerable cultural influences on attitudes toward suicide (Chen et al., 2017; Money & Batterham, 2019). Normalization of suicide is prevalent in countries with high suicide rates (Chen et al., 2017), but reducing this normalization should be seen as distinct from perpetuating stigmatizing attitudes. Learning from diverse cultures about the ways in which societal cultural norms influence diverse attitudes toward suicidal behavior, including the influences of permissive, pathologizing, normalizing, or stigmatizing attitudes, may result in more effective health promotion campaigns. Another approach to addressing stigma is to better understand and modify developmental changes that influence the way that suicide is perceived. Suicidal ideation often develops in adolescence, which may coincide with rapid changes in social identity (Tanti et al., 2011). There may be distinct opportunities in adolescence and early adulthood to shape healthier attitudes toward mental illness and suicidal behavior, enhancing perspectives toward professional and informal supports, and building self-efficacy to respond appropriately to the emergence of mental illness. Social norming interventions that have shown some success in modifying health behaviors may be one approach to stigma reduction in young people that has yet to be tested (Blanton et al., 2008).

In addition, better establishing the roles of both personal stigma and self-stigma on mental health outcomes, including risk of suicidal behaviors, should be a key priority, as there is currently insufficient evidence of the degree to which stigma might perpetuate suicidal thinking. Although there has been considerable recent research on the effects of stigma on help seeking, it remains unclear the extent to which stigma influences the decision to initiate and maintain the use of professional mental health services. Identifying subgroups of the population for whom stigma is a pertinent barrier to help seeking and further investigation of how stigma interacts with other barriers to service use (e.g., structural, knowledge, attitudinal) are research questions that have yet to be addressed thoroughly. Self-stigma may be both particularly pernicious and challenging to identify in the general community. Supporting at-risk individuals and social groups to increase appropriate help seeking may therefore require the development of highly accessible destigmatization interventions, such as digital interventions, and universal health promotion programs to enhance community readiness for supporting people at risk of suicide.

However, there has been limited intervention research testing approaches to stigma reduction in the general community to date. Some research has identified key messages for use in public health campaigns that may be beneficial for reducing stigma and encouraging help seeking (Calear et al., 2014). Psychoeducation programs have shown promise in increasing knowledge related to suicide prevention, but meaningful changes to stigmatizing attitudes may require a more comprehensive approach (Dueweke & Bridges, 2017; Taylor-Rodgers & Batterham, 2014). Studies testing the effects of mental health disclosure programs, which help participants make informed decisions about whether and how to disclose their mental health status, have shown promise in regard to mental illness stigma reduction (Conley et al., 2019; Mulfinger et al., 2018), but limited research has been conducted to directly examine whether the effects of these programs might extend to suicide prevention (Sheehan et al., 2019). Disclosure programs may influence both personal and self-stigma, so testing the effects of supported suicide disclosure programs should be prioritized.

There is also evidence that cognitive behavioral strategies or cognitive behavioral therapy (CBT) may have subsidiary effects on stigma (Griffiths et al., 2014), although no research has been conducted to assess whether suicide stigma specifically is reduced through engagement with CBT. Similarly, contact interventions have shown encouraging results in reducing mental health stigma (Corrigan & Shapiro, 2010), although may have modest and time-limited effects (Mehta et al., 2015). The use of internet-based interventions and social media interventions to deliver stigma reduction programs may allow effective programs to be scaled up rapidly in the community, with the potential to maximize the public health benefit of evidence-based programs (Kennedy et al., 2018; Reavley & Jorm, 2013).

The people best equipped to identify effective elements of interventions and support systems are those with lived experience of suicidal behaviors or those bereaved by suicide (Watling et al., 2020). Respectful and meaningful partnerships between people with lived experience, researchers, and clinicians may lead to more impactful and effective programs (Suomi et al., 2017). However, people with lived experience of suicidal behaviors often report negative, stigmatizing, or discriminatory encounters with mental health professionals (Sheehan et al., 2016), which may perpetuate self-stigma and hinder effective collaboration. Building effective alliances requires addressing potential power imbalances and ensuring that people with lived experience have agency over decision making and their level of engagement in such partnerships (Suomi et al., 2017).

Conclusions

Until recently, suicide stigma had not been widely assessed or evaluated in the population, due in part to a lack of valid and reliable measures. There is a range of sociodemographic and psychological factors that have been found to influence levels of suicide stigma within community, university, and clinical settings. These factors include gender, ethnic and cultural background, educational attainment, and exposure to suicide through personal experiences and the experiences of others. Preliminary research has demonstrated that suicide stigma may be associated with an increased risk of suicide, although more research is needed to better understand this relationship and how stigma develops and is maintained over time. Similar to mental illness stigma, suicide stigma has been found to have a negative association with help-seeking attitudes and behavior and is commonly cited as a barrier to accessing mental health services and support. Given the positive effects that disclosure, contact, psychoeducation, and CBT-based interventions have had on mental illness stigma, there is hope that similar interventions may be effective in reducing suicide stigma. However, there is a paucity of evidence examining programs to reduce personal stigma and self-stigma related to suicide. Creative and rigorous research is needed to develop effective and sustainable strategies to reduce the negative impacts of suicide stigma. Reducing the stigma of suicide may require whole-of-community approaches that take into account cultural, developmental, and disclosure processes. There is also a need to consider how stigma reduction interventions can be implemented in diverse yet targeted settings to enable delivery at scale and maximize public health impact. Learning from the lived experience of people who have engaged in suicidal behavior or been bereaved by suicide is an important step toward developing better systems of support to reduce stigma and prevent suicide.

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9 Intellectual Disability Stigma

The State of the Evidence

Shirli Werner & Katrina Scior

According to the UN Convention on the Rights of Persons with Disabilities (2007), all individuals with disabilities, inclusive of those with intellectual disabilities, have the right to full and active participation in society. Nevertheless, it is well known that individuals with intellectual disabilities face great disadvantages in most domains of life. As Sir Michael Marmot put it, they experience “some of the worst of what society has to offer,” including low incomes, unemployment, poor housing, social isolation and loneliness, bullying, and abuse (Rickard & Donkin, 2018, p. 3). It is our contention that a deep-seated disregard for their rights and needs, born out of a belief that their lives are not of equal value, is at the root of the discrimination persons with intellectual disabilities face across many areas of life and the limited life opportunities available to them.

Intellectual disability, according to the American Psychiatric Association (2013), refers to significant limitations in cognitive functioning, indicated by an IQ score below 70, alongside significant limitations in adaptive (social) functioning that affect how a person copes with everyday tasks. The limitations in both areas of functioning must be present before the age of 18.

In 2016, Scior and Werner published an edited book dedicated to the topic of intellectual disability stigma (*Intellectual Disability and Stigma: Stepping Out from the Margins*). The book takes an in-depth view at the consequences of intellectual disability stigma in various areas of life, as well as initiatives used to tackle such stigma. Research presented in the book and in other publications has shown mixed reactions toward individuals with intellectual disabilities. Whereas on the positive side, many individuals may respond with compassion, sympathy, and a desire to help, reactions on the negative side involve pity, anxiety, avoidance, hostility, or even disgust (Scior, 2016).

In the intellectual disability field, stigma is conceptualized as a process beginning with negative stereotypes (cognitions), moving through prejudice (emotions), and leading to discrimination (behavioral reactions) in the context of differential access to social power (Werner, 2015). The main stereotypes attributed to people with intellectual disabilities include that they are childlike (Gilmore et al., 2003), lack potential to change (Jahoda & Markova, 2004), and are overly friendly, in need of help, unintelligent, dependent, naive, aggressive, and disinhibited (Pelleboer-Gunnink et al., 2017). These stereotypes frequently lead to emotional reactions including pity, discomfort, and fear (Scior et al., 2013; Werner, 2015). In turn, both may lead to discriminatory behavior, including avoidance or rejection in different contexts such as social situations and employment, withholding or being excluded from opportunities in education, leisure, and other community activities, or making decisions on their behalf (Werner, 2015) .

Similar to the stigma attributed to other conditions, the literature about intellectual disability stigma relates to three main types of stigma: public stigma, self-stigma, and stigma by association (courtesy stigma). Stigma theoreticians propose that public stigma is at the heart of all other types of stigma (Pryor & Reeder, 2011). Public stigma refers to the attitudes held by individuals in the general population or among key stakeholder groups (e.g., health and social care providers, teachers, and the police) toward stigmatized individuals (Link et al., 1997). While these stakeholders have a key role in helping individuals with disabilities realize their rights to full social and civil inclusion (Werner & Araten-Bergman, 2017), negative stigmatic attitudes held by them may act as a barrier to accessing quality services (Ali et al., 2013), reaching full inclusion, and realizing their human rights (Pelleboer-Gunnink et al., 2017).

Self-stigma, or the process of endorsing negative social stereotypes and the associated self-blame (Recio et al., 2020), occurs when individuals direct stigmatizing attitudes toward themselves and internalize them (Ali et al., 2016). Theoreticians in the mental illness field have suggested that a preliminary step in self-stigma formation is being aware of the existence of stigma (Corrigan et al., 2006), which may occur via perceived and/or experienced stigma. Perceived stigma relates to how people view the stigmatization and discrimination that exists toward one’s group (Paterson et al., 2012; Recio et al., 2020), while experienced stigma relates to receiving social treatment based on one’s stigmatized status (Monteleone & Forrester-Jones, 2017). A recent review concluded that most individuals with intellectual disabilities are aware of their ascribed label or that others perceive them as “different” and that the intellectual disability label is usually viewed negatively by others (Logeswaran et al., 2019).

Finally, stigma by association or courtesy stigma refers to situations in which stigma toward individuals with disabilities tends to spill over to those associated with the stigmatized individual, most specifically their families; thus, stigma by association is also known as family stigma (Recio et al., 2020). Family members may be teased, blamed, shunned, or considered responsible for the individuals’ disability (Larson & Corrigan, 2008). A related construct is affiliate stigma, which refers to the internalization of stigma by family members and its corresponding psychological responses (Mak & Cheung, 2008).

In the current chapter, we examine the state of the evidence in the field, by looking at research published since the publication of *Intellectual Disability and Stigma: Stepping Out from the Margins* in 2016, focusing on possible changes in research during these years. Using the search terms “intellectual disability” and “stigma” and restricting the year of publication from 2016 onward, we sought to collect the research published during this time. We provide a summary of the published studies in Table 9.1.

Table 9.1 *Summary of published studies*

Authors, year, country	Main issue of focus	Theoretical basis of the stigma construct	Methodology	Sample size	Study instrument to measure stigma	Main results
PUBLIC STIGMA						
Pelleboer-Gunnink et al., 2021; Netherlands	Elicit main stereotypes. Examine the relationship between (1) familiarity and stereotypes; (2) stereotypes and discriminatory behavior	Social-psychological perspective of stigma: from negative cognitions to negative affect and discriminatory behavior	Mixed-method population survey	892 individuals from lay public	Trait-rating scale; Open question: "What comes first to your mind when you think about people with ID?" Social distance scale (Link et al., 1999) Discrimination: withholding help	Familiarity associated with "in need of help" stereotype and lower support of "Nuisance." "Friendly," "Nuisance," and "Unintelligent" stereotype factors associated with social distance and helping.
Blundell et al., 2016; UK	Relationship between contact, ID recognition, social distance, and causal beliefs	(1) Intergroup contact theory (Allport) – contact leads to improved attitudes. (2) Attribution theory (Weiner) – people make causal inferences to explain disability	Quantitative	1,264 lay public	Contact – Frequency, closeness, nature of relationship Intellectual Disability Literacy Scale (Scior & Furnham, 2011) 4 Social distance items; Causal Beliefs (Scior & Furnham, 2011)	(1) No contact – more social distance. (2) Recognition of ID – lower social distance. (3) Contact explained little variance in social distance. Closeness of contact relationship more important than frequency and nature of contact. (4) Attributions of adversity and biomedical beliefs – reduced social distance.

Rasdale et al., 2018; USA	Effects of labels on stigma: Social distance and perceptions of dangerousness of ID, schizophrenia, and comorbid condition	No theory specified	Quantitative Vignette design	160 university students	Modified Social Distance Scale (Link et al., 1987) Perceived Dangerousness of Mental Patients Scale (Link et al., 1987) Familiarity – Level of Contact Report (Holmes et al., 1999)	(1) Unlabeled vignettes more desire for social distance; (2) Comorbidity elicited less social distance than schizophrenia. (3) Perceived dangerousness in ID was relatively low.
Scior & Furnham, 2016; UK	Relationship between lay knowledge, causal beliefs, and social distance	Attribution theory (Weiner)	Quantitative	1,752lay public	Intellectual Disability Literacy Scale; 4 Social distance items; Causal Beliefs	(1) More supported environmental causes, then adversity and biomedical causes. (2) Biomedical causes negatively correlated with social distance. Environmental causes positively related to social distance. (3) Causal beliefs mediated the association between disability awareness and social distance.
Albert et al., 2016; USA	Examine student bystander behavior in relation to the use of the R-word	Bystander roles	Quantitative	3,330 students	Student pro-socialness scale (Caprara et al., 2005);	(1) 82% heard the r-word in school, most toward students without ID.

Table 9.1 (*cont.*)

Authors, year, country	Main issue of focus	Theoretical basis of the stigma construct	Methodology	Sample size	Study instrument to measure stigma	Main results
					School social inclusion scale (Brand et al., 2003); R-word questionnaire (Siperstein et al., 2010)	(2) 65% reported taking action. (3) Prosocial students more likely to take action. (4) Perception of social inclusion not related to responses to the r-word.
STIGMA AMONG PROFESSIONALS						
James, 2019; USA	Compare attitudes and beliefs of ID among employees of a care facility for individuals with ID and university students	Three components framework: stereotypes, prejudice, and discrimination	Quantitative	97 employees and 92 university students	Community Living Attitudes Scale (Henry et al., 1996); ID Literacy Scale (Scior & Furnham, 2011)	(1) Employees vs students: more support of sheltering; less support of biomedical causes. (2) Students who knew someone with ID - less support of adversity, biomedical, fate or environmental causes. Less support of need for lifestyle changes and expert interventions.

Werner & Araten-Bergman, 2017; Israel	Professional stigma toward individuals with ID, schizophrenia, or dual diagnosis	Social process composed of stereotypes, prejudice, and discrimination	Quantitative Vignette design	158 social workers	Attribution Questionnaire (Corrigan et al., 2003)	(1) For ID, low perceptions of dangerousness and responsibility. (2) Pity was strongest emotional response. (3) Strongest behavior was helping, then avoidance and coercion.
EXPERIENCED STIGMA AND SELF STIGMA						
Buljevac et al., 2020; Croatia	Experiences of discrimination among people with ID	None specified	Qualitative	25 people with mild ID	Interviews	Experienced disability harassment from teachers and professionals, economic disadvantages, denied right to intimate relations, peer rejection.
Monteleone & Forrester-Jones, 2017; UK	Meaning and experiences of disability by persons with ID	None specified	Qualitative	15 adults with ID	Interview	(1) Expressed need to behave in socially acceptable manner. (2) Experiences of disability were accompanied by feelings of self-degradation and injustice. (3) Had limited knowledge of disability terminology.

Table 9.1 (*cont.*)

Authors, year, country	Main issue of focus	Theoretical basis of the stigma construct	Methodology	Sample size	Study instrument to measure stigma	Main results
Voermans et al., 2021; Netherlands	Experiences of people with ID in competitive employment	None specified	Qualitative	6 adults with ID	Interview	Experienced stigmatizing attitudes in personal and work environments
Spassiani et al., 2017; Canada	Stigma experiences of adults with ID who interact with emergency services (their and caregivers' perspective)	None specified	Qualitative	12 individuals with ID; 4 family members; 5 staff members	Interview	Experiences of stigma within the emergency department
Potvin et al., 2019; Canada	Experiences of women with ID of attitudes of support staff toward their pregnancies	None specified	Qualitative	3 women with ID	Interview	Overall experienced positive attitudes, more positive from informal vs. formal support figures
O'Byrne & Muldoon, 2017; Ireland	Relationship between experiences of stigma, social comparison, and self-perceptions (global self-worth) among adolescents with ID	Social comparison theory (Festinger)	Quantitative	54 adolescents with ID from segregated schools	Experience of stigma checklist (Cooney et al., 2006); Self-perceived stigma (Ali et al., 2008); Harter's Self Perception Profile for Learning	Males and adolescents with moderate ID report more positive social comparisons. Differences were found in stigma according to gender, but not according to level of ID.

					Disabled Students (Renick & Harter, 1988); Social Comparison Scale (Paterson et al., 2012)	
Ali et al., 2016; UK	Self-reported stigma and self-stigma	Social cognitive model of stigma (stereotypes, prejudice, discrimination)	Quantitative	229 adults with ID	Perceived Discrimination: Reaction to Discrimination (Ali et al., 2008)	Moderate ID and older age - related to greater perceived discrimination. Age related to reaction to discrimination.
Marriott et al., 2020; UK	Shame among individuals with ID	None specified	Case study	2 individuals with ID	—	Shame is a prevalent issue experienced by persons with ID
FAMILY STIGMA AND AFFILIATE STIGMA						
Song et al., 2018; USA	Experiences of stigma among parents of individuals with developmental disabilities (inclusive of ID) or mental illness	None specified	Quantitative	Parents – 76 of individuals with DD, 52 of individuals with MI; 2,256 comparison	Embarrassment/ shame (one item); Daily discrimination (Williams et al., 1997)	Parents of individuals with disabilities experienced greater shame and discrimination than comparison group.
Duran & Ergün, 2018; Turkey	Experiences of stigma among parents of individuals with ID	None specified	Qualitative	19 parents	Interview	Parents experienced both positive and negative attitudes from family members toward their child's diagnosis.

Table 9.1 (*cont.*)

Authors, year, country	Main issue of focus	Theoretical basis of the stigma construct	Methodology	Sample size	Study instrument to measure stigma	Main results
Recio et al., 2020; Spain	Affiliate stigma and social support as mediators between perceived discrimination and self-esteem among parents of individuals with autism or ID	None specified	Quantitative	Parents – 109 of individuals with autism + 83 of individuals with ID	Multidimensional Perceived Discrimination Scale (Molero et al., 2013); Affiliate Stigma Scale (Mak & Cheung, 2008)	Affiliate stigma and social support mediated the relationship between perceived discrimination and self-esteem.
Mitter et al., 2018; UK	Examines relationship between perceived stigma and its internalization among family members of persons with ID	Three components: affect, cognition, and behavior	Quantitative	407 family carers of individuals with ID and autism	Scale measuring perceived family stigma; affective, cognitive, and behavioral aspects of affiliate stigma	Affiliate stigma was associated with burden and subjective wellbeing.
Aldersey et al., 2018; Congo	Stigma experiences of family members of people with ID and coping strategies	None specified	Qualitative	20 family members of individuals with ID	Interviews	Stigma was addressed toward both the family member with ID and their family members.

Tilahun et al., 2016; Ethiopia	Experiences of stigma among family members	None specified	Quantitative	102 family carers of children with autism and/or ID	Stigma in the community measured with the Family Interview Schedule (FIS; Sartorius et al., 1996)	Caregivers (1) endorsed many stigma experiences, (2) cited supernatural causes for disability, (3) First sought help from traditional sources.
Werner et al., 2019; Israel	Family stigma and help-seeking stigma as predictors of help seeking by parents	None specified	Quantitative	187 parents of adolescents with ID or dual diagnosis	Family stigma – Devaluation of Consumer Families Scale (Struening et al., 2001); Help-seeking stigma – Parental Attitudes Toward Psychological Services Inventory (Turner, 2012)	Help-seeking stigma, but not family stigma, predicted help-seeking.
Wolowicz-Ruszkowska & McConnell, 2017; Poland	Experience of growing up with a mother who has ID	None specified	Qualitative	23 adult children of mothers with ID	Interview	The greatest challenge was facing stigma rather than the mother's actual functional limitations
STIGMA-CHANGE INITIATIVES						
Anderson & Bigby, 2017; Australia and UK	Experiences of persons with ID in self-advocacy groups and its impact on self-identity	None specified	Qualitative	25 individuals with ID from self-advocacy groups	Interviews	Self-advocacy enabled individuals with ID to assume positive identities that changes their sense of self and had the potential to counter stigma experiences

Table 9.1 (*cont.*)

Authors, year, country	Main issue of focus	Theoretical basis of the stigma construct	Methodology	Sample size	Study instrument to measure stigma	Main results
Harrison et al., 2019; USA	Explicit and implicit attitudes toward ID of peer mentors in a university program versus controls	Explicit versus implicit attitudes	Quantitative	17 peer mentors + 14 uninvolved students	Attitudes toward Disability Questionnaire (Morin et al., 2013); Implicit Association Test	Volunteer involvement in program had positive impact on attitudes toward people with ID among typical college students.
Maguire et al., 2019; UK	Development of anti-bullying intervention for adolescents “talking about difference”	None specified	Mixed methods Based on literature/ best practice, interviews, and focus groups with people with ID, and feasibility study	31 individuals with ID interviewed + 390 typically developing students surveyed across 5 schools	Interviews, focus groups, feasibility study	Developed lessons aimed to be interesting, informative and emotionally engaging
Lindau et al., 2018; UK	Compared the effects of brief interventions consisting of education and indirect and imagined contact	Allport’s contact hypothesis – intergroup contact reduces prejudice and hostility	Quantitative	401 adults	General Evaluation Scale (Wright et al., 1997) measured attitudes; Intergroup Anxiety Scale (Stephan & Stephan, 1985); Social	Brief film-based education combined with indirect contact delivered via the Internet was more effective in improving

	components on laypeople's attitudes				Distance Subscale of Intellectual Literacy Scale (Scior & Furnham, 2011)	attitudes than textual education alone.
Sullivan & Mendonca, 2017; USA	Examined effect of fieldwork experience on students' attitudes toward individuals with ID	Three components (cognitive, emotion, and behavior)	Quantitative	62 occupational therapy students	Attitudes toward Disability Questionnaire (Morin et al., 2013)	Fieldwork improved attitudes
Siperstein et al., 2018; USA	Impact of school-based intervention on bystander behavior in response to the R-word	None specified	Quantitative	1,233 students	Student pro-socialness scale; R-word questionnaire.	The following were associated with active bystander behavior: Pro-socialness, hearing the word as an insult, participating in R-word Campaign, participating in Unified Club.

DD, developmental disability; ID, intellectual disability; MI, mental illness; R-word, “retarded”

This chapter is not intended to perform an exhaustive and structured systematic review of the literature, but rather to provide a descriptive summary and critical examination of the available literature.

Overview of Studies

Overall, we found 29 studies dealing with the topic of intellectual disability stigma. These are summarized in Table 9.1. As can be observed, nine originated from the UK; seven from the United States; two each from Canada, Israel, and the Netherlands; and one each from Australia, Congo, Croatia, Ethiopia, Ireland, Poland, Spain, and Turkey (one study was conducted in two countries).

Conceptualization of Intellectual Disability Stigma and Methodology

While 6 of the 29 studies were based on a conceptualization of intellectual disability stigma as composed of cognitive, affective, and behavioral dimensions, none examined the stigma process as a whole, that is, the path leading from the cognitive dimension, through the affective, and to the behavioral dimension. Additional studies employed part of attribution theory to focus on causal inferences of disability (Weiner, 1985), intergroup contact theory (Allport, 1954), and social-comparison theory (Festinger, 1954). However, it should be noted that more than half of the studies published in the past years (*n* = 17) did not mention any specific theoretical background.

Regarding the research methodology used, 17 of the 29 studies were quantitative, 9 qualitative (based mostly on the use of in-depth interviews), 2 used mixed methods, and 1 was a case study. Furthermore, 26 studies were cross-sectional, 2 employed a pre-post design, and 1 described program development. Quantitative methodology was used mainly to examine public stigma, while qualitative methods were mostly used to explore experienced stigma. Of note, only one study (Aldersey et al., 2018) reported employing participatory action research methods; this study included parents of individuals with intellectual disabilities within the research team rather than co-researchers with intellectual disabilities themselves.

Types of Intellectual Disability Stigma

The studies published since 2016 dealt with public stigma (*n* = 5), professional stigma (*n* = 2), experienced stigma (*n* = 3), both experienced and self-stigma (*n* = 4), self-stigma (*n* = 1), and family or affiliate stigma (*n* = 8), with some studies addressing more than one type. Given that only one study focused solely on self-stigma, experienced stigma and self-stigma will be introduced together in the sections below. Of six studies that reported stigma-change initiatives, one focused on self-stigma and five on public stigma. These will be discussed below in a separate section.

Public Stig**ma**. Studies that examined public stigma tended to investigate attitudes and much less often actual behavior. These studies have been mostly quantitative in nature and employed fairly large samples (range 158 to 3,330), composed mainly of the general public or typically emerging adults (i.e., college students).

Four studies used social distance – the tendency of people to avoid interactions with individuals with certain conditions (Whatley, 1959) – to measure public stigma. In a Dutch study involving 892 laypeople (50.8% female, 43.8% in the age range of 40 to 65), researchers found that the most common stereotypes attributed to people with intellectual disabilities were “friendly,” “in need of help,” “unintelligent,” and “incompetent” (Pelleboer-Gunnink et al., 2021). However, their findings showed that these cognitive attributions were not associated with high levels of explicit discrimination, but with more subtle discrimination, such as providing individuals with intellectual disabilities with limited opportunities for choice and self-determination.

In a second study, conducted with 1,264 individuals residing in the UK (66.1% female, mean age 26.2 years), the researchers attempted to tease apart different aspects of prior contact with persons with intellectual disabilities (Blundell et al., 2016). The relationship between social distance and the nature of contact (voluntary or not), its frequency, closeness, and type of the contact relationship were assessed. This is an important aim since increased contact has been defined as one of the main strategies to reducing stigmatic beliefs (Pettigrew & Tropp, 2006). Surprisingly, only closeness of the contact relationship was negatively associated with social distance toward individuals with intellectual disabilities (Blundell et al., 2016). It is possible that greater closeness allows opportunities to challenge stigma in the context of personal relationships. This study highlights the importance of examining contact as a complex construct rather than a binary one.

A third study examined the impact of the use of labels on social distance. University students (n = 160, 87% female; mean age 21.2 years) in the United States responded to one of six vignettes describing an individual with intellectual disability, schizophrenia, or comorbid intellectual disability and schizophrenia. Three vignettes included a diagnostic label and three did not (Rasdale et al., 2018). Contrary to expectations, participants expressed higher levels of social distance when presented with the unlabeled rather than the labeled targets. While the authors offer an explanation to this finding in relation to the schizophrenia vignette, no clear explanation was offered in relation to the intellectual disability vignette. Among the labeled vignettes, the one describing a person with schizophrenia elicited more desired social distance than the one referring to comorbid intellectual disability and schizophrenia or intellectual disability alone. These interesting findings may suggest that labeling may result in positive outcomes in terms of stigma.

A fourth study, conducted among 1,752 UK residents (55.6% female; mean age 25.4 years), examined the association between perceptions of the causes of intellectual disability and social distance. Similar to findings of studies on mental health challenges (Angermeyer et al., 2010), the researchers found that endorsement of biomedical causes was associated with reduced social distance, while endorsement of environmental or supernatural causes was associated with increased social distance (Scior & Furnham, 2016). These findings are of importance to stigma change interventions that aim to educate the public by promoting biomedical causal beliefs and challenging supernatural beliefs.

While social distance continues being the most commonly examined discriminatory behavior (or behavioral intention) toward people with intellectual disabilities, other behavioral reactions have also been examined in the last five years. For example, Albert and colleagues (2016) examined bystander behavior (i.e., taking actions toward inappropriate acts of others) among 2,297 U.S. high school students (48% female, mean age 16.2 years) when witnessing the use of the word "retarded" (the R-word) by others. Results showed that as much as 82% of students who participated in the study had heard the R-word being used in their schools (Albert et al., 2016). Its most frequent use was toward individuals without intellectual disabilities (94%); while less frequent, a hugely concerning 41% had heard this highly stigmatizing term directed at individuals with intellectual disabilities. Regarding the behavioral reaction elicited by the R-word, results of this study showed that when used toward someone with an intellectual disability, students were more likely to be active bystanders (i.e., likely to challenge the user of the term), compared to when the word was used toward students without intellectual disabilities. Overall, this study demonstrates that stigma toward people with intellectual disabilities remains strong, and that the R-word perpetuates devaluation of individuals with intellectual disabilities even in their physical absence (Siperstein et al., 2018).

In sum, these studies indicate that discriminatory behavior, defined in most studies as social distance toward persons with intellectual disabilities, is still prevalent among the general public. A key limitation of the above studies is their focus, mainly, on social distance and reliance on self-report rather than observed behaviors toward individuals with intellectual disabilities.

Stigma among Professionals. In relation to stigma held by key stakeholders, we located only two studies published in the past few years. Findings from the first study, conducted with 97 staff members working at a care facility for people with intellectual disabilities, showed fairly positive attitudes. However, when comparing staff members' attitudes to those of university students, care staff were more likely to endorse a need for sheltering people with intellectual disabilities than students. The importance of this study is that while upon first look it may seem to present a fairly positive picture, its results can also be seen as quite worrying. Albeit care staff's support for sheltering may be well intended and informed by both a recognition of the support needs of people with intellectual disabilities and the risk of negative encounters in the community, in actuality it is likely to reinforce their exclusion from opportunities others take for granted rather than challenging the status quo.

A second study, conducted in Israel with 158 social workers, showed that participants' perceptions of an individual with intellectual disability presented in a vignette as dangerous was associated with higher levels of coercion, segregation, and avoidance. Similarly, higher levels of pity were positively associated with higher levels of coercion and helping, but with lower levels of avoidance (Werner & Araten-Bergman, 2017). This study is one of the few assessing stigma toward people with intellectual disabilities as a multidimensional and progressive process. That is, by using attribution theory (Weiner, 1985) the authors showed how stereotypes were related to behaviors. Although these studies are important, they are limited in number, cross-sectional, and limited in the stakeholder groups involved.

Perceived, Experienced, and Self-Stigma. Most of the research published since 2016 on perceived, experienced, or self-stigma (n = 5 of the eight studies in Table 9.1) was based on relatively small-scale qualitative studies (between 3 and 25 participants) and used mainly in-depth interviews; one study was a case study and two utilized quantitative measures. Overall, the qualitative studies conducted have shown that adults with intellectual disabilities experience "otherness" (Monteleone & Forrester-Jones, 2017), as one participant said, "and then you do know that obviously they've got something strange about them, but gradually you know why" (p. 307). They also experience discrimination in many life domains (e.g., education, employment, intimacy, use of services) from people in their immediate social environment, including teachers, employers, family member, professionals, and peers without intellectual disabilities (Buljevac, 2020; Spassiani et al., 2017; Voermans et al., 2021) – for example, "I'm actually hiding my disability more, but I do that on purpose, because I want to be treated normally, like anyone else … that happens an awful lot" (Voermans et al., 2021, p. 244).

On the positive side, a qualitative study conducted with three expectant mothers with intellectual disabilities (Potvin et al., 2019) found that they experienced mainly positive attitudes toward their pregnancies, with more positive attitudes held by informal support persons than formal supporters, such as medical professionals and social workers. This reiterates the importance of contact in bringing about positive experiences.

The two quantitative studies assessed the correlates of experienced stigma among people with intellectual disabilities. The first was conducted in the UK with 229 adults with mild to moderate intellectual disabilities (47.6% female, mean age 40.9 years). The second was conducted in Ireland with 54 adolescents (38.9% female, mean age 13.1 years) with intellectual disabilities who attended segregated special education schools. While gender was found as a significant correlate of experienced stigma in both studies, the direction of the relationship was not identical. In the first study, men, those with moderate intellectual disabilities, and older participants were more likely to report stigmatizing experiences (Ali et al., 2016). In Ireland, males reported fewer experiences of stigma with no differences in stigma according to severity of intellectual disability (O’Byrne & Muldoon, 2017). These inconsistencies might stem from differences in the samples used, especially in terms of age, or from the use of different measures.

Studies on self-stigma have generated inconsistent results regarding the emotional and behavioral consequences of experienced stigma for individuals with intellectual disabilities. Monteleone and Forrester-Jones (2017) reported in their qualitative study that experienced stigma leads to self-degradation and feelings of injustice. In contrast, O’Byrne and Muldoon (2017) did not find experienced stigma to be associated with global self-worth. In terms of behavioral attributions, it has been reported that individuals with intellectual disabilities who internalized stigma try to struggle against it either by distancing themselves from others with intellectual disabilities (Voermans et al., 2021) or by adhering to behaviors and social norms that suggested non-otherness, such as trying to be perceived as nice, clean, and quiet. These individuals also place salience on other parts of their identities (e.g., employment or leisure; Monteleone & Forrester-Jones, 2017). Future research could be done to examine the consequences of these different ways of coping with experienced stigma and what factors and processes may place individuals at greater risk of, or conversely protect them from, self-stigma.

Family or Affiliate Stigma. Studies that examined family and affiliate stigma within the intellectual disability field have mainly focused on the experiences of stigma among parental caregivers of individuals with intellectual disabilities (four out of eight studies focused solely on parents, three others mainly on parents, and one on adult children). Methodologically, studies on this type of stigma were mainly quantitative ($n = 5$), were cross-sectional ($n = 8$), were conducted in many different locations (e.g., Congo, Ethiopia, Israel, Poland, Spain, Turkey, UK, United States), and ranged in their sample size (19–407 participants).

Findings from across these studies shed light on understanding family members’ experiences. First, they show that similarly to studies examining public stigma, parental caregivers hold their own set of beliefs regarding the causes of their child’s condition. These studies, originating mainly from African countries, found that parental caregivers attributed their child’s condition to spirit possession, a sinful act, or a punishment from God or sorcery (Aldersey et al., 2018; Tilahun et al., 2016; see also Chapter 17, this volume, for more on stigma and religion). This is important, as some causal attributions carry more stigmatization than others and, consequently, influence the source of help sought by these parents (Tilahun et al., 2016).

Second, studies examining family members of persons with intellectual disabilities as the target of stigmatic beliefs showed that they are frequently attributed with negative attitudes by the general public, especially parents. These negative reactions include dispiritedness, maltreatment, and pity (Aldersey et al., 2018; Duran, 2018; Song et al., 2018; Tilahun et al., 2016). They can lead to family members experiencing serious consequences, such as distress (Aldersey et al., 2018) and poorer health outcomes (Song et al., 2018). To the best of our knowledge, only one study, conducted with 19 parents of individuals with intellectual disabilities in Turkey, found family members reporting positive responses from some extended family members, including "mercy" and offers of support (Duran & Ergün, 2018).

Third, in terms of their emotional attributions, several studies showed parental caregivers feeling ashamed and embarrassed of their child's condition (Song et al., 2018; Tilahun et al., 2016). Finally, studies showed that parents of people with intellectual disabilities deal with negative feelings with a variety of behavioral reactions. For example, some restricted their social interactions in the community (Duran & Ergün, 2018) and some kept their child's condition a secret (Tilahun et al., 2016). It should be noted that, although as stated the majority of the studies on this type of stigma were conducted with parents, similar experiences were reported by 23 adults who grew up with a mother with intellectual disabilities (Wołowicz-Ruszkowska & McConnell, 2017). These adults recalled that as young children they consistently received messages from others that their mother was "different," warranting shame and humiliation. These emotions resulted in attempts to hide their mother, avoiding those who knew of their mother, and showing indifference toward negative social responses.

The literature on mental health stigma shows that one of the most serious consequences of stigmatic beliefs is avoiding to seek help (Kirschner et al., 2020). A recent study has shown that this also applies to stigma of intellectual disabilities. Werner and colleagues (2019) examined the association between family stigma and help seeking among 187 Israeli parents of adolescents with intellectual disabilities or a dual diagnosis of intellectual disability and mental health problems. They found that although family stigma existed, it was not associated with parents' intentions to access services for their child. Rather, stigma associated with the services themselves was negatively associated with seeking out support. This is an interesting finding, as it shows that some but not all stigma influences parents' decision to seek out important services and support for their children.

Despite the value of the many studies conducted in this area, it should be noted that only two looked at the entire family stigma process, i.e., the path from family stigma to its potential internalization to affiliate stigma (Mitter et al., 2018; Recio et al., 2020). These studies showed that family caregivers first become aware of others' negative evaluations, next, some, but not all, experience negative thoughts and emotions, such as reduced self-esteem, and consequently some actively avoid social interactions or being seen in public with the family member with intellectual disabilities (Mitter et al., 2018; Recio et al., 2020). In addition, in these studies social support acted as a protective factor and buffered the association between discrimination and affiliate stigma and between discrimination and negative self-esteem. Examining the full process of stigma formation has important repercussions for the development of interventions aimed at reducing the stress and burden associated with providing care or support for persons with intellectual disabilities. Special attention should be paid to increasing and optimizing social support, as it might be an appropriate strategy for reducing stigmatic beliefs.

Stigma-Reduction Initiatives

The previous sections show that people with intellectual disabilities and their families continue to face stigma in their everyday lives. Following our statement in Werner and Scior (2016), we argue that interventions to reduce intellectual disability stigma should be implemented at four levels. Interventions at the intrapersonal level are those that focus on the individual with intellectual disabilities themselves, with the aim of helping them cope with the negative consequences of stigma (i.e., self-stigma) or take a more active stance in challenging stigma. These interventions may include engagement in self-advocacy, education, and skills training, informed by an empowerment paradigm (Jansen-van Vuuren & Aldersey, 2020). Family-level interventions attempt to reduce negative attitudes and behaviors that some family members may hold toward their relative with intellectual disabilities, as well as to improve family members' ability to resist stigma they and their relative face. Interpersonal-level interventions seek to reduce stigmatizing attitudes and behaviors among the public and key stakeholders. Finally, structural-level interventions focus on social forces and institutions via legislative action, mass media, governmental, or organizational policies and service structures (Werner & Scior, 2016). An examination of the published literature on interventions targeting intellectual disability stigma shows that interpersonal-level interventions continue to be the most commonly cited (n = 5), followed by intrapersonal-level interventions (n = 1).

The only study examining intrapersonal-level interventions was a qualitative study conducted in Australia and the UK (Anderson & Bigby, 2017). It concluded that self-advocacy groups help individuals with intellectual disabilities develop enhanced positive identities and provide a sense of ownership and control. Such groups also contribute to confidence and engagement with life. As such, self-advocacy was viewed as an important means to further social inclusion of individuals with intellectual disabilities.

Of the five studies that employed interpersonal-level interventions, two were conducted with university students (Harrison et al., 2019; Sullivan & Mendonca, 2017) and one with members of the general public (Lindau et al., 2018). The interventions included training and support (Harrison et al., 2019), field work experience (Sullivan & Mendonca, 2017), and the use of an educational film (Lindau et al., 2018). All three studies showed that education and contact were useful strategies to improve attitudes toward people with intellectual disabilities. Furthermore, and in accordance with the mental health literature (Cook et al., 2014), contact was found to be a more useful strategy than education (Sullivan & Mendonca, 2017).

Two additional interpersonal-level interventions, which combined education and increased contact, were conducted in high schools, with the main aim of counteracting bullying and encouraging greater acceptance and active bystander behavior (Maguire et al., 2019; Siperstein et al., 2018). These important studies provide us with early evidence that similar to interventions to reduce mental health stigma, the use of multicomponent strategies might provide the best avenue to attain their goal.

No studies were found that examined familial and institutional-level interventions. This is unfortunate given the extensive impact of stigma at these levels. Interventions at the family level should take into account cultural values and should include the family member with intellectual disabilities (Jansen-van Vuuren & Aldersey, 2020). For example, in cultural communities that attribute intellectual disabilities to supernatural forces, information should be provided to counter stigmatizing attributions by collaborating with community and religious/spiritual leaders (Aldersey et al., 2018). Importantly missing is evidence on the effects of interventions that focus at the structural level and that seek to change social forces and institutions.

Summary and a Look into the Future

This chapter has shown that although the topic of intellectual disability stigma continues to attract research attention, people with intellectual disabilities and their families continue to face stigma. Indeed, a look at studies published between 2016 and late 2020 indicates that despite the contribution of published research, the area is still limited conceptually, methodologically, and practically.

Conceptually, many studies cited in this chapter are a-theoretical or lack a clear conceptualization of the stigma construct (Werner, 2015). The lack of such a definition limits our ability to draw conclusions and develop theory-driven interventions. Further, the majority of those studies that do use a conceptual framework, most commonly the tripartite definition of stereotypes, prejudice, and discrimination, do not assess the three dimensions jointly; very few examined the stigma formation process. This limits our ability to elucidate at what step of the process and how efforts to reduce stigma should be invested. Also missing are studies on stigma held by various stakeholder groups, such as law enforcement professionals and policy makers. These are important populations, as they are involved in many important decisions that influence opportunities open to persons with intellectual disabilities and their quality of life and well-being. Thus, stigmatic beliefs toward people with intellectual disabilities may be an important element in their decisions and actions.

An additional conceptual limitation is that while public stigma, experienced stigma, and family and affiliate stigma have been the focus of research in recent years, structural stigma is almost totally ignored. Structural stigma refers to societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and well-being of stigmatized individuals (Corrigan et al., 2005). In terms of persons with intellectual disabilities, many of the societal-level conditions in which these individuals live a priori undermine their life opportunities, such as living in large group homes and, in some countries, even remaining institutionalized, which remove the ability of individuals to make decisions regarding their own everyday life.

Finally, examination of the role of culture in intellectual disability stigma is largely missing. Only studies on family stigma were conducted in a variety of countries and even these did not make cross-cultural comparisons. Specifically, while these studies were conducted in different countries, each was limited to the country of study and did not compare between different population groups. This is of importance given that different interventions may be more appropriate in different cultural contexts.

Methodological limitations are abundant in the existing research. First, most studies have been cross-sectional, limiting the understanding of causality or of changes in stigma across time. Longitudinal studies should be employed to study stigma change across time and at multiple levels. Second, only one study explicitly employed a participatory action research design. This is of importance as co-researchers with intellectual disabilities should navigate the research conducted, starting from the research question and throughout the entire research process. Third, research has focused separately on various types of stigma, thus lacking in understanding of how various types of stigma influence each other.

Practically, this chapter highlights some important limitations. In addition to the scarcity of studies examining the entire stigma process, none examined which interventions are appropriate for which part of the stigma process. Further, most interventions have been geared to changing public stigma, and there is a real lack of interventions focusing on family, especially family members beyond parents, or structural stigma. There is a need to better evaluate and track stigma change programs aimed at professionals. In addition, national or international stigma change initiatives are scarce.

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PART III

Stigma and Mental Health in Specific Contexts

10 The Intersection of Mental Health Stigma and Marginalized Identities

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Individuals with mental illness commonly experience stigma and discrimination beyond the discrimination faced by individuals with other health problems (Hallett, 2015; Holley et al., 2016a; Mantovani et al., 2017; Zerger et al., 2014). Mental illness stigma can cause adverse consequences, such as negative physical health symptoms, and further exacerbates mental health outcomes by contributing to the production and maintenance of mental illness (Holley et al., 2016a; Mantovani et al., 2017; Zerger et al., 2014). It can also interfere with seeking education, treatment, employment, housing, and intimate personal relationships (Flanigan, 2019; Holley et al., 2016a). Mental illness stigma undermines self-esteem and lowers confidence in the individuals affected by it (Flanigan, 2019). These adverse effects are exacerbated when an individual has a serious mental illness (SMI): a major mental illness with severe impairment in functioning, for whom stigma can be more deleterious than the mental illness itself (Corrigan et al., 2013; Hallett, 2015; Lawson, 2016).

Many individuals who experience mental illness are also members of multiple stigmatized groups, and there is a gap in the literature in this area (Oexle et al., 2018). Early research in psychology focused on samples that are male, middle class, heterosexual, able bodied, and White (Ghavami & Peplau, 2013). There is a need to better capture the experiences of people who face multiple stigmas, which could also help develop more effective mental health interventions (Oexle et al., 2018). Furthermore, much of the current research that does account for the effects of multiple domains of discrimination has assumed that the consequences of discrimination compound and result in even worse health outcomes (Zerger et al., 2014). Thus, the research assumes an additive effect. However, an individual's particular social context may also contain elements of privilege, disadvantage, and resilience (Hallett, 2015; Mizock & Russinova, 2015). Furthermore, perceived differences may be based on salient social characteristics or less visible ones (Oexle et al., 2018). Discrimination may also fluctuate depending on the number and types of intersecting social group memberships an individual belongs to. These intersecting identities produce a unique social position that is different from what is conceptualized when using an additive viewpoint (Hallett, 2015).

As a result, a comprehensive understanding of the specific elements of an individual's experience with mental illness stigma benefits from the lens of intersectionality. In this chapter, we will apply the intersectionality model to examine mental illness stigma. We will synthesize the literature in this area on mental illness stigma among various intersecting stigmatized groups and present implications for future treatment and research.

Intersectionality

Although the term varies somewhat depending on the research context (Shields, 2008), *intersectionality* generally refers to the interdependent relationship between social identities and the systems of oppression surrounding these social identities (Logie et al., 2011). The term was derived from the work of feminist scholars of color, specifically Kimberlé Crenshaw's (1989) critical race theory. The theory posits that social group identities and structural inequalities intersect and mutually construct qualitatively different social identities for each person depending on their location within the matrix of identities (Collins, 2000; Warner, 2008). An individual's specific social identity has also been referred to as one's social location (Williams et al., 2016). Social location is an individual's place and location within society at a point in time, and is composed of their intersecting demographics, such as race, immigration status, gender and sex, level of education, sexual orientation.

Many individuals who are members of multiple stigmatized groups also experience mental illness and can face mental health stigma (Oexle et al., 2018). *Mental health stigma* refers to negative attitudes, prejudice, and discrimination directed toward individuals with mental illness and other marginalized groups (Mizock & Russinova, 2015). This process of devaluing, labeling, and stereotyping that occurs within the context of power results in the loss of status, unfair treatment, social disadvantage, and social isolation for marginalized individuals or groups (Logie et al., 2011). Three interacting and mutually reinforcing levels of stigma exist, including social or public stigma, structural stigma, and self-stigma (Mantovani et al., 2017). *Social or public stigma* is created by the individual and collective beliefs of the "dominant" members of society, which form the socially acceptable ways of interacting with individuals living with mental illness or other marginalized identities (Mantovani et al., 2017). *Structural stigma* occurs when an organization's activities, such as hospital healthcare, deliberately or inadvertently create and maintain social inequalities (Mantovani et al., 2017). Finally, *self-stigma* refers to internalized stigma or stigma directed at oneself (Mizock & Russinova, 2015). This type of stigma occurs when individuals with mental illness are socialized into believing that they are devalued members of society, which results in negative self-perceptions, feelings of shame, and, at times, engaging in maladaptive behaviors (Mantovani et al., 2017).

The disadvantage experienced by individuals with mental illness might differ depending on their membership in other stigmatized social groups (Oexle et al., 2018). For instance, an individual who is a member of multiple stigmatized groups may face additional public stigma than would an individual who is a member of only one or two stigmatized groups. For example, a landlord's decision to rent to an individual may be influenced by the number of stigmatized groups that person belongs to. This may happen because those individuals may be perceived as increasingly different from the majority. A second example might involve a healthcare worker's decision to hospitalize someone involuntarily depending on that person's group membership(s). In other scenarios, one social identity may be perceived as more salient than the others, and that individual may face discrimination based on that specific social identity. For example, as the literature below will highlight, a person of color may be judged by the color of their skin in a White community, but within their own racial community, they may be judged by the status of their mental illness. Therefore, taking an intersectional view of stigma is essential in understanding each individual's unique experience with mental health stigma.

One study examining a willingness to seek help among individuals with mental illness found that service use was differentially affected by multiple, interacting features of an individual's social advantages and disadvantages (Cairney et al., 2014). The study found that there was a complex relationship between age and service use that was mediated by interactions between gender and other social determinants. For instance, formerly married men (ages 23–46) were more likely to seek out services than never married or married men. On the other hand, women's service use was not influenced by marital status; instead, women who were in low socioeconomic brackets (ages 23–46) were more likely to use services than women who were in higher socioeconomic brackets. Thus, different social identities result in unique outcomes depending on an individual's location within the matrix of identities and the intersection between these identities.

Building on the construct of intersectionality, the framework of intersectional stigma links an individual's exposure to oppression with their experiences of stigma (Taylor et al., 2019). *Intersectional stigma* is a concept that helps to explain how individuals uniquely experience marginalization and discrimination resulting from the convergence of multiple stigmatized social identities (Quinn et al., 2019). This perspective enables a better understanding of the consequences of living with multiple stigmatized identities. Intersectional stigma can occur at multiple levels of influence including interpersonal, community, and structural levels.

While other terms have been used to describe this construct, such as "double" or "layered" stigma, these terms are limited by the implication that the effects of living with multiple stigmatized identities are merely additive (Turan et al., 2019). Intersectional stigma, however, implies a multiplicative or complex intersection of identities that creates unique stigma experiences for individuals. The term was popularized by a study done by Logie and colleagues (2011) that examined how HIV-positive women experienced stigma resulting from multiple levels of overlapping forms of stigma, including stigma related to sex work, HIV-positive status, racism, sexism and gender discrimination, and homophobia and transphobia.

Intersectionality theory challenges researchers and clinicians to consider social determinants not in terms of single factors, but in terms of multiple, interacting factors (Cairney et al., 2014). This has important implications for how individuals experience mental health stigma. It is essential to understand how the presence of multiple marginalized identities impacts the mental health stigma individuals experience. Research examining the intersection of mental health stigma and marginalized identities provides essential information on how contextual factors influence stigma, which in turn impacts how public policy makers and clinicians intervene with mental health stigma (Oexle et al., 2018).

Research on Intersectional Stigma

Even though research has established that there is a relationship between social adversity and negative mental health outcomes, few studies have assessed how individuals with multiple marginalized identities are differentially affected (Williamson et al., 2017). As readers will see throughout this chapter, there are very few studies examining each social location subset. Rather than recruiting a set group defined by a specific social location of individuals, it appears that studies have recruited based on a particular topic, such as women who are homeless and living with a serious mental illness or individuals who identify as LGBTQ+, HIV positive, and as having a mental illness. This has resulted in research samples that have individuals with multiple unique social locations. This also creates difficulties in grouping the studies below into subsections, because studies may have individuals from multiple social locations, but the findings may only be presented in terms of some of these individuals' social identities. Furthermore, it is difficult to draw broad conclusions from the studies about specific social locations given the unique contextual experiences of the individuals with these social locations.

The diverse samples have also created a challenge for researchers attempting to examine intersectionality using a multiplicative lens rather than an additive lens. Consequently, many of the studies below take an additive perspective, meaning that they do not examine the unique results of each particular social location. Instead, the researchers provide broad results, such as having more than one marginalized identity results in increased difficulties with mental health or discrimination. A second challenge that emerged pertains to the examination of invisible social identities (i.e., individuals living with learning disabilities, mental illness, medical disabilities that are not obviously evident, or sexual orientation) and visible social identities (i.e., the color of one's skin or one's gender). In the studies below, individuals with both invisible and visible social identities have been included; however, the context of discrimination experiences is not always clearly identified. This has resulted in mixed findings, with some studies finding that individuals have unique experiences with discrimination based on a specific social identity, and others finding that discrimination experiences do not vary based on social identity.

Furthermore, discrimination of visible social identities and invisible social identities may vary across in-group and out-group membership. More nuanced research strategies are required with respect to intersectionality, which will be discussed in the "Future Research Recommendations" section. First, the existing research on intersecting identities and mental health stigma are discussed (please see Table 10A.1 in Appendix 10 for a list of existing studies and the main findings).

Gender and Mental Illness

Negative stereotypes, assumptions, and beliefs about mental illness impact women differently than men (Hallett, 2015). Power imbalances associated with sex and gender exist in the historically patriarchal healthcare environment (Van Den Tillaart et al., 2009). Furthermore, the more marginalized identities that the women possess, the more complex these experiences are. Several articles have examined the intersection of being a woman with a mental illness.

In one case study focusing on a woman with a SMI, Hallett (2015) reports on the client, Ms. D., recognizing aspects of privilege in relation to her race and education, but also her experiences of marginalization with respect to her socioeconomic status, her gender, and her physical and mental health. Given her positioning within the web of social identities, Ms. D. often spoke about her "lack of fit" to the specific prototype of each identity and her feeling misunderstood or invisible to others. In fact, Ms. D. reported experiencing mental health professionals as speaking "about" her, rather than "to" her, and using simplistic language and speaking in a loud voice, as if she could not comprehend what they were saying to her. These experiences reinforced her feelings of self-stigma, which has interfered with her ability to seek and receive mental and health services and with her ability to establish healthy relationships.

A second study by Mizock and Russinova (2015) examined intersectional stigma and its impact on women's mental illness acceptance using qualitative methods. The 30 participants interviewed were between19 and 72 years old and had received mental health services for a minimum of 5 years. The authors found that women experiencing mental illness face intersecting levels of oppression based on sexism and mental illness stigma. For example, the women in the study who experienced compounded levels of intersectional stigma tended to have a more difficult time accepting their mental illnesses. The women in the study also faced increased risk for poverty, sexual and physical violence, homelessness, unemployment, and mistreatment by mental health services compared to their men counterparts. However, the women's awareness of intersectional stigma also increased empowerment and acceptance of their mental illnesses and, ultimately, their resilience. Specifically, prior physical or psychiatric conditions facilitated resilience and the acceptance process of a later mental illness diagnosis.

Another study also examined how gender influences mental health stigma. Wirth and Bodenhausen (2009) had 172 culturally diverse participants (54%

women) view case studies of men and women with either gender-typical (i.e., women with depression or men with alcoholism) or gender-atypical psychiatric conditions (i.e., men with depression or women with alcoholism). The authors found that when the cases were gender-typical, participants expressed less sympathy and a decreased willingness to provide support to these individuals than when the cases were perceived as gender-atypical. The authors also found that gender-atypical illnesses were thought to be less controllable. Consequently, participants believed that individuals who had gender-atypical illnesses were less personally responsible for their illnesses than those who experienced gender-typical illnesses. Thus, individuals with gender-typical illnesses likely face higher levels of stigma, like victim blaming, than individuals with gender-atypical illnesses.

One final study has examined the experiences of women living with a mental health diagnosis. Using a feminist qualitative approach, Van Den Tillaart et al. (2009) examined how women with a mental health diagnosis experience healthcare structures and professionals. The authors recruited participants from a peer outreach group in British Columbia. The women were 19 years of age or older, living independently, deemed "competent," and had not had a hospital admission for 6 months or more. Seven women participated in focus groups and responded to questions about their experiences with diagnostic label(s), healthcare professionals, and the healthcare system. Conceptual categories emerged from the data including issues of poverty, changes to family relationships, work, and evidence of power imbalances associated with sex within healthcare services. This contributed to the women's feelings of powerlessness and feeling like they had little say in their treatment (i.e., being silenced by the healthcare system, healthcare professionals, and family or friends), placing their health at greater risk.

All of the studies in this section underscore how social identities can create both unique and intersecting experiences with stigma. Additionally, the studies in this section draw attention to various social identities that include components of hidden stigma, such as socioeconomic status, types of mental illness, level of education, and sexual orientation. A noteworthy factor across the studies is that when these social identities became visible, the women in the studies encountered marginalization, feelings of powerless, and silencing. On the other hand, two of the studies highlighted that when participants were able to recognize the stigma they experienced, they became more resilient. This is essential to consider when working with clients who may face intersecting stigma. Helping to facilitate awareness could increase resiliency through self-advocacy and self-acceptance.

There are also several limitations to the studies above. First, the studies are limited by small sample sizes. Additionally, while detailed case examples provide evidence of multiplicative or unique effects, there is a need to ask specific questions about intersecting social identities and contextual factors (e.g., how different contexts cause certain social identities to have more or less influence on one's experience). Further, recruiting participants with many different social locations may also provide opportunities to cross-compare experiences.

Race/Ethnicity and Mental Illness

Race or ethnicity intersects with mental illness (Mantovani et al., 2017). For example, studies have found that marginalized identities can increase mental illness severity (Wadsworth et al., 2020). A few studies have explored the intersecting relationship between race or ethnicity and mental illness stigma in detail. One study examined factors associated with mental illness stigma for Asian men living in Canada (Livingston et al., 2018). In this study, the authors collected data over a 4-year period from 428 Asian men. The participants completed self-assessments on social stigma and self-stigma. The bivariate results revealed that there was a greater level of social and self-stigma among Asian men who were older, had immigrated to Canada, were unemployed, or whose first language was not English. More social stigma was also reported by participants whose first language was not English, were not students, and were in a relationship. The authors hypothesized that these differences may be related to cultural and generational attitudes about mental illness. They also note that gender-normative expectations for Asian men regarding help seeking may have impacted the findings.

Another study examined the experiences with depression of U.S.-born Mexican Americans (USBMAs) using an intersectional analysis approach (Martinez, 2017). Martinez interviewed eight individuals and ten family members about depression. Martinez highlights that the structural and systemic barriers for USBMAs with mental illnesses, such as clinician bias, stereotyping, cultural insensitivity, lack of access to care, and language barriers, create mistrust and deter USBMAs from seeking mental health services. The participants discussed cultural perceptions of depression, like depression is a personal weakness and a burden to one’s family, and they only used mental health services if approved by the family. The study also found that there were generational and gender differences in perceptions of depression, with older generations and men denying that depression exists. In turn, women and younger participants viewed counseling and biomedical help as viable options.

Another qualitative study ($N = 26$) sought to explore the factors involved in the social production and practice of stigma within faith-based African-descended communities in South London, England (Mantovani et al., 2017). Several factors contributed to mental illness stigma and help-seeking behavior. These included the following: cultural beliefs about the causes of mental illness; practices within the faith communities that resulted in the “silencing” of mental illness; the anticipation of negative consequences from one’s community and family; the preference for nondisclosure; and finally, community-level stigma that produced and encouraged the maintenance of mental illness stigma. The authors found that participants had mixed opinions about the definitions of mental illness, with some defining it based on socio-Christian beliefs about demon possession, and others viewing it in non-normative ways, such as “a curse,” or “insanity.” These beliefs have imbedded assumptions about the meaning of an individual’s psychological distress, including that it is indicative of a moral failing. Thus, community messages impacted individuals' conceptualizations of mental illness, leading to self-stigma. Finally, participants spoke about the negative consequences that would result from a mental illness diagnosis within their families. Mental illness not only impacted the individual, but it was also seen as contaminating the extended family, and possibly even the community. These beliefs were often internalized by individuals affected by mental illness. Affected individuals are likely to experience triple jeopardy in terms of stigma, including rejection by their families and their communities, and self-stigma. Thus, these individuals may struggle with mental illness recovery and are at higher risk of relapse, which reinforces the stigma.

A final study (N = 715) in this area examined the intersection of race and ethnicity with mental illness stigma (Wadsworth et al., 2020). Wadsworth and colleagues investigated how multiple jeopardy affected symptom severity and treatment response for individuals in a hospital-based program for obsessive-compulsive disorder (OCD). The authors found that there is less access to intensive treatment services for individuals with OCD who have one or more marginalized identities. Individuals in the study who held one or more marginalized identities in addition to their SMI, experienced higher rates of symptoms than individuals who did not have other marginalized identities. The higher levels of symptoms persisted throughout treatment and remained higher at discharge. As well, negative stereotypes affected individuals' obsessions and compulsions, for example, African Americans in the study had higher levels of contamination symptoms than their White counterparts. The authors note that it is possible that this is because of their experiences with interpersonal and systemic oppression, such as identity-based violence and discrimination.

The studies within this subsection highlight some unique considerations. It is essential to note that individuals of a particular race/ethnicity are heterogeneous. For instance, two articles, Livingston et al. (2018) and Martinez et al. (2017), discussed the unique positionality of immigrant status and acculturation with respect to identity. Individuals possessing this social identity cannot be assumed to fit neatly into acculturation binaries. Moreover, these two studies also differ based on where the research was conducted, Canada and the United States, respectively. The country an individual immigrates to will also affect an individual's social location, identity, and acculturation process. Another study within this section examined a unique population of African-descended faith communities (Mantovani et al., 2017). While the participants in this study identified as Christian, and this social identity impacted their experiences, it did not lead to stigmatization from out-group members. Interestingly, the study found that Christian religious affiliations contributed to in-group stigmatization, or stigma from members of one's religious community. This community-based stigma impacted healthcare-seeking practices and contributed to internalized stigma of the participants. An important takeaway from this subsection is that each of these distinctive study populations has unique experiences with intersectionality. Consequently, like the studies examining gender and mental illness, the findings in this section are not necessarily representative of all individuals, and researchers and clinicians need to examine the unique ways that social identities intersect and create unique experiences of stigma and marginalization.

However, even though each of these populations is unique, there are some common themes across the findings. The studies in this area of intersectionality have found the one's race or ethnicity can affect the level of community stigma individuals may experience as well as contribute to self-stigma. Race or ethnic social identities may also affect whether individuals seek out care and the type of care that they seek. Finally, mental illness stigma does not just affect the individual in isolation; it may also impact their families. The research highlights that family can impact decision making, especially around how and when to seek treatments. Additionally, individuals of color may try to protect their family from the stigma that surrounds mental health treatment, or they may also face stigma from their family or community members.

The research in this subsection was not always presented using a multiplicative lens; for example, Wadsworth and colleagues (2020) found that individuals who held one or more marginalized identities in addition to their SMI experienced higher rates of symptoms than individuals who did not have other marginalized identities; also see Livingston et al.'s (2018) findings. It is worth noting, however, that the reader learned more from Livingston et al.'s multivariate findings than the bivariate findings, because the multivariate findings helped to inform readers about which of the identities in particular contributed to the findings. The two purely qualitative studies were able to add more depth to the intersectionality findings, offering a more multiplicative view that helped to highlight the idiosyncratic ways that the social identities impacted stigma. A mixed methods approach combing qualitative data with quantitative findings might help to enrich quantitative findings.

Gender, Race/Ethnicity, and Mental Illness

Experiences with stigma and discrimination can result in increased negative consequences for individuals with multiple marginalized identities and affect their help-seeking behavior. For example, Whaley and Dubose (2018) also examined the intersection of ethnicity, gender, and mental health help-seeking behavior. The study found that African American men (n = 95) indicated high levels of psychological distress, but less treatment-seeking behavior than European Americans (n = 209). Substance use (alcohol and marijuana) as an alternative method of managing depressive symptoms was endorsed by African American men and European American men and women. African American women were more likely to seek out medication to treat depression than African American men and European American men and women.

A case study by Muenzenmaier and colleagues (2015) used an intersectional perspective to examine the experiences of women of color who also have posttraumatic stress disorder. The authors aimed to help clinicians gain a more integrated understanding of women and their lived experiences. One case example, highlighted here, is a middle-aged woman of African American descent. The authors highlight that mental health stigma was experienced by the client even from mental health providers, including referring to trauma survivors as “drug-seeking,” “attention-seeking,” “manipulative,” or “borderline.” Treatment plans also ignored the context of her lived experience, including her individual, family, and community backgrounds. The authors advocated the need for considering social location, trauma-informed treatment approaches, and gender-responsive care.

The self-stigma experiences of multiple social locations can also be seen in a study by Haarmans and colleagues (2016), who examined the experiences of 44 Canadian women who were diagnosed with schizophrenia. The women all reported hallucinatory behavior and hearing voices within the past 6 months. More than half of the women self-identified as having an ethnic minority status, 66% had low educational attainment, and 14% belonged to a sexual minority. The study found that almost all of the women experienced voices that used gendered conditions of worth to denigrate them, and over half of the women who identified as an ethnic minority experienced voices that used racialized conditions of worth. For example, women reported hearing voices that denigrated their appearance and sexual purity. In addition, sanity was another common theme within the voices that the women heard, such as the voices stating, “You’re schizoid!” (Haarmans et al., 2016, p. 208). This theme tended to be more common among White women within the sample than among their ethnic minority counterparts. The voices’ use of intersecting social locations, like race, gender, and diagnosis, highlights how structural inequalities may impact the voices that women hear. Thus, contextualized forms of analysis are essential when examining individuals’ experiences with mental health stigma.

Researchers have also started to examine the intersections of gender, race/ethnicity, and mental illness stigma among different age groups. DuPont-Reyes and colleagues (2020) conducted a longitudinal study with a racially and socioeconomically diverse sample of adolescents. Vignettes including a women living with bipolar disorder (“Julia”) and a man who had social anxiety (“David”) were presented to participants. The study found that men reported greater desire for social distance and higher avoidance of individuals with mental illness than did women. Youths who identified as Black and Latinx also reported desiring a significantly greater social distance from peers with mental illness than did White youth. Additionally, the men in the sample were more likely than the women to view Julia as a “bad person.” As well, Black and Latinx participants were less likely to believe that Julia would get better than were White youths. Finally, the study found that Black men reported less knowledge about mental illness than did White men and Black women.

The studies in this section did a good job at highlighting a multiplicative view of intersectionality. In particular, the details provided in the qualitative research by Haarmans and colleagues (2016) and Muenzenmaier and colleagues (2015) helped to illuminate the unique intersection of participants’ multiple stigmatized identities. In addition, DuPont-Reyes and colleagues' findings are consistent with the studies focusing on adults (e.g., Wirth & Bodenhausen, 2009) and suggest that mental illness stigma may form early in life. Overall, the studies note some impacts of gender and race/ethnicity on mental illness stigma. More specifically, structural inequalities in relation to gender and race/ethnicity may influence the symptoms individuals have, help-seeking behavior, the type of help sought, and, finally, how mental health care providers conceptualize individuals' mental health difficulties. Future work is needed to further understand the intersection of other social locations (e.g., religious beliefs, ethnic/cultural beliefs) and mental illness stigmatization.

Homelessness, Immigrant Status, and Mental Illness

Other researchers have examined the added intersection of homelessness and immigrant status. Approximately 24%–30% of individuals who are homeless meet the criteria for SMI (Folsom et al., 2005). Homeless individuals already have complex healthcare needs, including limited access to integrated care that can meet all of their needs, facing stigma when trying to seek care, and a lack knowledge about available care (Canavan et al., 2012). Possessing additional marginalized social identities is likely create unique challenges. Benbow and colleagues (2011), for example, sought to explore the experiences of stigma among homeless mothers living with a mental illness, as well as how these women have resisted against the oppression that they have experienced. Using a feminist lens, the authors analyzed preexisting data from critical ethnography focus groups ($N = 7$). Five focus groups interviewed mothers ($n = 54$) and two focus groups were composed of service providers ($n = 13$).

Three themes emerged from the data. First, the women expressed that they experienced discrimination based on their intersecting social identities, including homelessness, poverty, mental illness, single motherhood, race, nationality, immigrant status, and language barriers. The women noted that discrimination mainly occurred from two sources: landlords and employers. The participants also spoke about being stuck in the cycle of oppression, which was described as becoming homeless, obtaining housing but within a dangerous environment, and then returning to homelessness. Being homeless with a mental illness and having children also created barriers; for example, getting a routine check-up with a physician requires a home address. Further compounding these barriers were other forms of marginalization, such as being a newcomer to Canada and having difficulty navigating the public resources, language barriers, lack of interpreter services, and racism. The final theme that emerged from the data reflected the women's resistance to oppression through their perseverance. The women were actively trying to break away from the cycle of oppression that they were trapped within. As the authors note, by "refusing to accept the worst," the mothers were acknowledging that they are deserving of safe housing; however, at times, it was safer for them to be homeless than the other options available.

Another study explored the experiences of stigma for individuals who are ethno-racially diverse, homeless, and living with a mental illness. This study sought to fill the gap in research on how non-Western cultures experience mental illness stigma (Zerger et al., 2014). The Canadian study used a mixed-methods approach. The authors used data that was collected as part of a 4-year randomized study examining a field trial of the housing first model. A sample of 231 individuals who identified as racial minorities was used. The individuals were homeless or precariously housed and living with an SMI. The qualitative data were drawn from the same study, and 36 participants were selected from the quantitative sample to participate. The authors found that perceived discrimination was very high, with 61.5% of the individuals surveyed reporting discrimination due to homelessness or poverty, 50.6% reporting stigma due to race or ethnicity, and 43.7% reporting stigma due to mental illnesses or substance use (Zerger et al., 2014). Additionally, the study found that more than half of the individuals who had experienced each form of discrimination identified as Black. Individuals who reported discrimination due to mental health, poverty, or homelessness had a significantly lower income than those who did not report discrimination. Individuals who were born outside of Canada experienced significantly more discrimination across all three forms of discrimination than their Canadian counterparts. The length of time also predicted the likelihood of discrimination, with those individuals who had been homeless for three or more years experiencing more discrimination than those who had been homeless for a shorter time. Finally, based on the qualitative findings, most of the discrimination that participants encountered occurred when seeking employment or housing or when interacting with law enforcement or service providers. From the qualitative data, participants described isolating or distancing themselves from friends and family because of the stigma associated with homelessness or mental illness. The individuals spoke about the shame of being homeless or having a mental illness. They discussed feelings of failure to meet social norms. Finally, women participants in particular framed social distancing as a survival technique, which was similar to the findings of Benbow et al. (2011).

A second theme that emerged was related to participants' experiences with different forms of stigma. Participants expressed more trouble coping with the discrimination related to their "new label" of having a mental health condition than they did coping with their "old labels" related to race/ethnicity (Zerger et al., 2014, p. 6). They reported that this new label required internal negotiation to determine how it fit within their identity. The participants discussed that becoming homeless was often related to being diagnosed with a mental illness, but that they found it easier to hide or avoid mental illness stigma than homelessness stigma.

The two studies in this section highlight that stigma is impacted by the complex nature of an individual's web of social locations. The authors in this section clearly highlighted the multiplicative view of the intersection of homelessness, ethno-racial diversity, immigrant status, gender, mental illness social identities. Additionally, the studies both had a larger number of participants than usual (i.e., $n = 67$ and $n = 36$) for qualitative research. The studies had some common findings. Both discussed how discrimination was often faced when seeking employment, housing, and healthcare. As well, all of the individuals who identified as homeless reported some form of mental health difficulty that created additional challenges when trying to access social services or obtain employment or housing. Furthermore, if participants also identified as an immigrant, they faced added challenges in navigating social services, as well as challenges related to geographical isolation that were not self-imposed to protect families from stigma by association. Overall, these studies highlight that the mutually interacting social locations of these individuals place them in a unique position within society.

LGBTQ+ and Mental Illness

Several studies have examined the intersection of LGBTQ+ identities with mental health stigma and provided support for Meyer's (2003) seminal work examining minority stress theory and its understanding of intersectionality of identity, stigma, and psychological distress (Bockting et al., 2013). For example, a study ($N = 577$) conducted by Bostwick et al. (2014) found increased discrimination experiences for individuals who identify as LGBTQ+ and who also experience mental health concerns. Additionally, qualitative research findings highlighting the lived experience of individuals demonstrate the nuanced complexity of the stigma experienced within the intersecting social identities of mental illness and LGBTQ+ status. Ghabrial (2017) conducted a study with 11 participants who identified as LGBTQ+ and as persons of color. Intersectionality was a recurring theme throughout all interviews, as participants identified the compounding stigmatization of identities that impacted aspects of daily life and health. For example, one participant identified sexual identity as something she had to conceal, as she was a South Asian cis woman and was already identified as an "other." Similar findings were reported in a study with 104 HIV+ women participants. Logie and colleagues (2011) examined the relationship between stigma and overlapping identities (i.e., ethnic minority, lesbian/bisexual identity, or identifying as transgender). The researchers found that not only does a single minority identity affect mental health stigma, but every additional minority identity compounds the stigma and discrimination experienced. Consequently, those with complex intersecting identities felt a need to hide parts of themselves, which may impact mental health services received.

As the previous studies have highlighted, there are unique impacts when individuals possess multiple stigmatized identities. Additionally, studies have shown that people of color who identify as LGBTQ+ and who also live with mental health conditions are more likely to struggle with decreased psychological well-being and have increased mental health symptoms relative to their White, cis, heterosexual counterparts (Holley et al., 2016a). Holley and colleagues (2016a, 2016b, 2019) used a mixed methods approach to further understand these experiences. The study included 13 adults who self-identified as living with mental illness and who also identified as a person of color and/or lesbian, gay, or bisexual (LGB). Family members ($n = 7$) were also included in the study because they experienced stigma by association. The authors found that each of these forms of discrimination contained negative judgments and similar behaviors and had similar effects. However, the results also revealed that the visibility, invisibility, and disclosure of invisible identities affected participants' experiences with discrimination. For instance, they study found that people of color and individuals with mental illness are often stereotyped based on their appearance, which resulted in people fearing both social identities. In another study, Holley and colleagues (2016b) explored whether people of color with a mental health diagnosis and who also identify as LGB experienced discrimination within mental health treatment programs. All but one participant reported experiencing discrimination while seeking mental health treatment, though the authors were not able to disentangle the mental health discrimination experiences from other discrimination based on race, ethnicity, or LGB status.

Finally, a third study by Holley and colleagues (2019) examined participants' experiences with mental illness discrimination within their communities of color. Several themes about discrimination emerged from the data. Participants shared that there was an overall lack of information within communities of color on mental health, with some communities believing that mental health conditions do not exist. If the mental health conditions were acknowledged, common stereotypes about them were accepted, such as people with mental illness are "crazy." Additionally, this negative view was demonstrated during interactions and behaviors with individuals with mental illness, such as shunning, laughing, and name-calling. Finally, participants noted that identity intersections affect discrimination and whether someone was a perpetrator or was targeted by mental illness stigma. Participants noted that certain groups were more likely to perpetrate discrimination, including men, newer Mexican immigrants, younger Mexican Americans, older African Americans, and individuals who had less formal education. Individuals who were unemployed and gay were more likely to be the targets of mental illness discrimination. Themes also emerged regarding supports within communities of color and LGB communities. Some participants experienced support from specific family members or others who also had mental health conditions. For example, two participants who identified as LGB and Indigenous noted that their Indigenous communities accepted their sexuality, which was helpful in their mental illness recovery. This is in keeping with the theory of intersectionality that posits that when one marginalized identity is supported, there are ameliorative effects for their overall well-being.

Overall, the studies in this section do an excellent job of considering the multiplicative effects of intersecting identities and its impact on mental health stigmatization. A major limitation of these findings is that they are largely derived from smaller samples. To further illuminate the unique effects of the participants' intersecting identities, there is a need to continue asking participants for contextual information about these experiences, which may help to understand how their intersecting identities may have contributed to their mental illness discrimination experiences. Similarly, a key finding is the importance of invisible and visible stigma. Future research into the effects of what happens when an invisible form of marginalization becomes visible is needed.

Physical Illness, Race/Ethnicity, and Mental Illness

Historically marginalized social identities are more likely to experience social adversity, which can adversely impact both mental and physical health (Williamson et al., 2017). Individuals living with a stigmatized chronic illness and a marginalized ethno-racial identity face additional mental health challenges and stigma. Two studies have sought to explore this experience in greater detail. One study examined how stigma uniquely affects depressive symptoms for individuals with different social identities, including individuals who are living with or without a stigmatized illness (HIV), White individuals, or African American individuals (Williamson et al., 2017). The authors used a diathesis-stress model that posits that a preexisting vulnerability for mental illness is activated by stress; for instance, a stigmatized social identity can result in a higher risk of depression. The authors recruited 64 African Americans and 29 White Americans who were HIV positive, and 33 African Americans and 23 White Americans who were HIV negative. The study found that the relationship between social adversity and depressive symptoms differs based on HIV status and racial or ethnic identity. There was a positive correlation between adversity and depressive symptoms for HIV-positive African Americans but not for HIV-negative African Americans. This relationship was significantly greater for HIV-positive African Americans than it was for HIV-negative African Americans, but this same finding did not hold for White individuals. Finally, only financial restrictions to care impacted depressive symptoms for African Americans who were HIV positive. These findings suggest that African Americans who are HIV positive who experience high adversity are at a higher risk for increased depressive symptoms. These findings are concerning given the barriers to treatment and the increased risk for stigmatization that marginalized ethno-racial identities often face, as highlighted throughout this chapter. The findings also emphasize the importance of studying intersectional identities in the context of mental health.

A second study, which used a qualitative research framework, examined Aboriginal individuals' experiences with HIV (Cain et al., 2013). The participants ($n = 72$) self-identified as being depressed, Aboriginal, and living with HIV. The authors asked about participants' experiences with HIV and depression and the intersection between the two during semistructured interviews. The participants reported that they often experienced stigma from community members as a result of their HIV status. Stigma led some participants to conceal their HIV status or to isolate themselves from friends and family. Aboriginal communities are often marginalized by Canadian society. As a result, when the participants in the study felt alienated from their home communities, family, and friends, it exacerbated their sense of isolation, compounding their feelings of betrayal, anger, and depression. This also resulted in increased substance use for some. Finally, individuals who identified as having depression before their HIV diagnosis reported that their diagnosis exacerbated their symptoms of depression. However, while participants noted isolation was a concern, reconnecting to their communities was also described as a source of strength. Several participants spoke about rediscovering or discovering their cultural traditions. Participants often reconnected to their communities as a result of attempts to positively cope with depression or substance use, leading to a stronger sense of identity and belonging. Consequently, the authors found that how individuals made sense of their diagnosis impacted their depression and their relationships with their families and communities.

The two studies within this section have highlighted how mental health is influenced by an individual's intersecting identities, including race/ethnicity and HIV status. The stigma associated with their chronic illness exacerbated depressive symptoms or in some cases resulted in experiences with depression. It is also noteworthy that Cain et al. (2013) found that individuals' responses to stigma related to a chronic illness resulted in similar behaviors to stigma related to mental illness found in other studies (e.g., Logie et al., 2011; Mantovani et al., 2017), such as isolating from their families. However, some limitations are present. For example, the quantitative findings by Williamson et al. (2017) are presented in an additive way, whereby the reader is unable to determine nuanced information that could be essential to interpreting findings. As such, there is need for future researchers to ensure that they are asking questions in such a way that allows participants to discuss the unique ways that each of their social locations may affect their experiences with stigma. Additional studies that include participants across the range of social identities would be beneficial in increasing the robustness of the findings.

Weight Stigma and Mental Illness

Much like the adverse effects of the other marginalized social identities previously discussed, research has also found that individuals who experience weight discrimination face social adversity. Studies have found a higher risk of mental illness, substance use disorders, further weight gain, and mortality for individuals who experience weight stigma than for those who do not experience weight stigma (Pearl et al., 2018). Furthermore, research has found that a higher percentage of overweight individuals also have an SMI than those who do not have higher weights (Mizock, 2012). One reason for this may be that weight gain is a metabolic side effect of antipsychotic medication (Hensley, 2008). However, stigma may also influence one's mental health symptoms.

One article (Mizock, 2012), a literature review, was retrieved that specifically discussed the intersection of mental illness stigma and weight stigma. Mizock highlighted that, while limited research has examined the effects of identifying as someone who faces weight and mental illness discrimination, the studies that have explored these social identities find that there is an additive effect. For example, in a personal narrative, Hensley (2008) notes that the weight gain from antipsychotic medication contributed to her low self-esteem, which compounded her experiences of depression. Double stigma has also been documented in systematic reviews. For example, Corrigan and Watson (2002) found that individuals who experienced both types of stigma were more likely to internalize it (i.e., self-stigmatize). Additionally, Link et al. (2004) found differences between the two types of stigma, with "obesity" being more visible and perceived as being "more controllable" than mental illness. These negative perceptions lead to further stigmatization and contribute to endorsing less empathy and a decreased willingness to help individuals with both obesity and mental illness (Corrigan & Watson, 2002). As such, more research is needed on this topic, especially studies that specifically examine the intersection of weight bias and mental illness stigma.

Future Research Recommendations

As the discussions above have highlighted, there is a need for more research on the intersection of marginalized identities and mental health stigma (Holley et al., 2016a). Studies using research methods that center on marginalized voices and de-center the experiences of privileged groups are necessary (Rice et al., 2019). Community interests need to be centered within the research, and diverse voices from marginalized communities also need to be considered. It is impossible to focus on every possible social position or intersection. However, the research should address historical or contemporary sociocultural forces using a political lens. To strengthen the studies of stigma across these social identities, there is a need for a more explicit and intentional integration of intersectionality frameworks into research studies (Jackson-Best & Edwards, 2018). It is not sufficient to include intersectionality as an afterthought in the discussion or conclusion sections. The studies above highlight that the research is strongest when it takes a multiplicative viewpoint rather than an additive viewpoint. The multiplicative viewpoint provides readers with important nuances that are not visible when using an additive intersectional framework. A number of research recommendations have been identified in the research presented in this chapter.

First, for White researchers in particular, engaging in critical self-reflexivity is also important (Rice et al., 2019). Reflexivity helps to disrupt power imbalances that are embedded in traditional ways of conducting research. One way to accomplish this is to examine one's biases using Socratic questioning. For example, an author might ask themselves the following: (1) "What is my social location?" (2) "How do my social identities relate to this research project?" (3) "How does my social location impact this project?" (4) "What do I recognize because of my social location that others might not?" (5) "What do I *not* recognize because of my social location?" (6) "What are some challenges people with lived experience in this topic area might face?" (7) "Does this study or the findings contribute in any way to the discrimination or oppression of the individuals being studied?" Other scholars have made suggestions for community-based participatory research teams, which include individuals with lived experience who can help identify gaps and necessary adaptations (Oexle et al., 2018).

The associations between different social factors are complex, and existing research needs to deviate from relying on standard statistical approaches (Cairney et al., 2014). For instance, Cairney and colleagues note that the classification and regression tree (CART) is one alternative method to linear regression analysis. The CART approach requires recursively identifying rules that discriminate between various variables. One advantage of this method over linear models is that this method does not make assumptions about variable distributions or relationships between variables. Additionally, and most importantly for intersectionality, this method is able to identify complex interactions.

Broadening research questions to examine heterogeneity within a specific social category may be necessary to determine inequalities within that category. Subsequently, using between-group comparisons for that heterogeneous group would also help to deepen understanding about the subtle ways that social categories are systematically interlocked and also linked to power structures. Once these more subtle nuances within a social category are understood, using between-group comparisons across all of the social categories can then be conducted. Additionally, social categories, like gender, race, or ethnicity, could be framed as person variables or stimulus variables to reflect their fluidity and to ensure a more contextual lens. As well, some researchers have proposed deriving or using instruments that assess perceived differences or how others differ compared with oneself, rather than instruments that assess stigma associated with a single social location (Oexle et al., 2018). For example, in a study examining public stigma, measure how different someone perceives another individual to be compared to themselves rather than measuring how one perceives stigma toward mental illness. Changes like these are necessary to make research more inclusive and help to increase the meaningfulness of the findings.

Large-scale laboratory research and survey research can present challenges to tapping into the subjective experiences of individuals (Shields, 2008). Another solution to this complex problem is to use more qualitative research methods (Rice et al., 2019; Shields, 2008). Qualitative research methods are compatible with the theoretical language of intersectionality. Constructivism, otherwise known as social constructivism or interpretivism, is one common framework of qualitative research (Creswell & Creswell, 2018). Within this theory, researchers endeavor to make sense of the meaning that others have placed on their surroundings. Social constructivists believe that meanings are subjective and are negotiated culturally and historically. Importance is placed on context and values, as well as the process of interaction among individuals. Furthermore, the generation of meaning is social and arises out of interactions with the human community, including interactions between the researcher and the participant.

As noted throughout this chapter, the inclusion of intersectional methods is essential to being able to understand how various groups of individuals experience mental illness stigma. There has been a gap in research, with previous studies focusing on Western, educated, White, male, and higher socioeconomical cultural groups (Shields, 2008). These culturally biased research samples make it difficult to accurately apply findings to other populations. Furthermore, studies that do not consider the complexity of individuals' social locations miss out on important insights. Experiences with stigma are nuanced and complex and cannot be adequately understood without delving into the complexity of individuals' social locations. Consequently, it is essential for researchers to consider these unique factors when conducting studies.

Conclusions

This chapter presented a review of the current literature examining the intersection of social identities and mental illness stigma. Given that the intersection of various social identities with mental illness results in unique findings, these findings were presented according to the identities that were examined within the studies. While this chapter strived to examine how individuals experience stigma in unique ways based on their web of social locations, there were some common themes across many of the studies. Stigma impacted individuals' willingness to seek care (Cain et al., 2013; Martinez, 2017), as well as the symptoms experienced (Haarmans et al., 2016; Wadsworth et al., 2020). Many of the studies also found that stigma did not just impact the individuals diagnosed, but it also impacted their families, especially within racially marginalized communities (Cain et al., 2013; Mantovani et al., 2017; Martinez, 2017). Many participants also reported that their experiences with discrimination were similar across all of their different social identities (Holley et al., 2016a, 2016b; Jackson-Best & Edwards, 2018; Williamson et al., 2017). Finally, a few studies found that when individuals are able to recognize when they experience stigma, they become more resilient (Mizock & Russinova, 2015; Van Den Tillaart et al., 2009). These more general points have important implications for both mental illness prevention and treatment, anti-stigma campaigns, and future research. Ultimately, it is important to continue to study the concept of intersectional mental health stigma to ameliorate its effects on the mental wellness of marginalized people. Readers are encouraged to implement the recommended research strategies above, including using critical self-reflexivity, CART data analysis, both within-group and between-group analysis, and qualitative methods that focus on multiplicative effects of stigma.

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Appendix 10

Table 10A.1 *Research on intersectional mental health stigma*

Reference	Research method	Participant demographics	Main findings
Mental Illness and Gender			
Hallett (2015)	Case study	$N = 1$ A 43-year-old Caucasian American, bisexual woman. Currently receiving Social Security Disability Income, Medicaid/Medicare, and food stamps. Has attended higher education. Has multiple mental health diagnoses, including dissociative identity disorder.	- Biased beliefs and attitudes of medical and mental health professionals create additional barriers to treatment and recovery. - Experiences with "intersectionality invisibility" in which one does not match the prototype of various identity groups can complicate stigma experiences and led to internalized stigma. - Need for trauma-informed models of care, like Recovery to Practice curriculum. - Need for medical professionals to understand intersectionality and underserved populations.
Mizock and Russinova (2015)	Qualitative research, narrative	$N = 30$ Participants were between 19 and 72 years old and received mental health services for a minimum of 5 years. - Twenty European American, 3 African American, 3 Asian, 2 biracial, 1 was Latino, and 1 Native American. - Three participants also identified as immigrants to the United States. - Four identified as lesbian, gay, or bisexual.	- Women with serious mental illness (SMI) face intersecting levels of oppression based on sexism and mental illness stigma. - Additional marginalized identities add to stress/struggles. - Resilience is increased through women's awareness of discrimination. - Awareness can lead to acceptance of mental illness diagnosis, empowerment, and promote recovery.

Van Den Tillaart et al. (2009)	Qualitative research, feminist approach	*N* = 7 The authors recruited participants from a peer outreach group in British Columbia, Canada, for focus groups. The women were 19 years of age or older, living independently, deemed "competent," and had not had a hospital admission for 6 months or more.	- Women with SMI face intersecting levels of oppression based on sexism and mental illness stigma. - Biased beliefs and attitudes of medical and mental health professionals create additional barriers to treatment and recovery. - Resilience is increased through women's awareness of discrimination. - Once women are aware, they are in a better position to advocate for themselves or seek other providers.
Race/Ethnicity and Mental Illness			
Mantovani et al. (2017)	Qualitative	*N* = 26 Participants were selected from faith-based organizations in South London, England. The participants included 6 faith leaders, 13 engaged in outreach projects, and 7 regular attendees. Fifty percent were women. Fourteen participants identified as African Caribbean, 5 as British, and 8 immigrated to Britain from Africa.	- Help seeking was impacted by cultural beliefs about the causes of mental illness, faith-based practices, anticipated negative consequences from the community and family, community-level stigma, and a preference for nondisclosure. - Greater mental illness stigma was found among English-speaking Caribbean communities. Similar patterns were identified among those from East or West Africa. - Mental illness was seen as "contaminating" extended family.

Table 10A.1 (*cont.*)

Reference	Research method	Participant demographics	Main findings
Livingston et al. (2018)	Quantitative	*N* = 428 Asian men living in Canada.	- Increased stigma among those who were older, immigrated, unemployed, or had no direct experience with mental illness. - Increased stigma among those whose first language was not English, who were in a relationship, and those who were not students. - Social stigma was not significantly associated with the length of time they'd lived in Canada, educational attainment, or type of Asian ethnicity.
Martinez (2017)	Qualitative	*N* = 18 Interviewees were U.S.-born Mexican Americans (USBMAs). Eight interviewees had direct experience with depression and 10 interviewees had indirect experience with depression.	- Treatment avoidance was seen as a result of structural and systemic barriers including clinician bias, stereotypes, cultural insensitivity, and language barriers. - Participants viewed depression as a personal weakness and a burden to the family. - The study found generational differences in depression perceptions. - Intrapersonally coping was interviewees' first strategy in an effort to "save face." - When intrapersonal coping failed, interviewees turned to interpersonal coping.

			- Acceptance of help was contingent on approval of family/kin. - Lack of health insurance was a barrier to treatment. - Lack of trust of the medical system and difficulty discussing personal and cultural matters due to “personalismo” prevented interviewees from accessing treatment. - The study highlighted the complexities of navigating the “hierarchical coping path.”
Wadsworth et al. (2020)	Quantitative	$N = 715$ Participants were receiving intensive residential treatment for obsessive-compulsive disorder (OCD). The sample was significantly more non-Latino White than the general population. Similarly, the sample was less representative in terms of socioeconomic status (SES), education, and religion.	- Access to treatment was more difficult for those with marginalized identities. - Symptomology increased relative to the participants’ number of marginalized identities. - Similarly, symptoms were more likely to persist and remain high at discharge compared to those with less marginalized identities. - Negative stereotypes affected participants’ obsessions and compulsions.
Gender, Race/Ethnicity, and Mental Illness			
Haarmans et al. (2016)	Qualitative	$N = 46$ Participants had a diagnosis of schizophrenia and were recruited from a major metropolitan Canadian city. More than half the participants self-identified as an ethnic minority.	- Voice hearing was affected by social inequality, immigrant status, ethnic minority status, and diagnosis status. - Results suggest that women internalize misogynistic messages that their

Table 10A.1 (*cont.*)

Reference	Research method	Participant demographics	Main findings
			cultural value is based on gender norms. - Gender norms interact with religious and cultural social location such as religious beliefs. - White women reported “sanity” as a theme within the voices.
Fuchs et al. (2016)	Qualitative – phenomenological approach Participants purposively selected from an RCT	*N* = 7 Participants were diagnosed with generalized anxiety disorder and self-identified as marginalized.	- Acceptance-based behavioral therapy resulted in a clinically significant reduction in anxiety.
Whaley and Dubose (2018)	Quantitative – normative approach using multidimensional scaling analyses	*N* = 304 Participants were gathered from a predominantly White college institution. The participants were undergraduates who identified predominantly as White (*n* = 209) and African American (*n* = 95).	- The study found high treatment needs among African American men but low treatment-seeking behavior. - Substance abuse was viewed as an alternative method for managing depressive symptoms. - African American women were most likely to seek medication to treat depression.
Muenzenmaier et al., 2015	Case study	*N* = 2 Participants were women of color who were diagnosed with severe post-traumatic stress disorder (PTSD).	- The authors noted mental health stigma associated with severe childhood trauma. - Treatment providers often referred to trauma survivors as drug-seekers, attention-seekers, manipulative, or borderline.

DuPont-Reyes et al. (2020)	Longitudinal study	*N* = 667 Participants were sixth-graders who largely identified as Latinx followed by White and African Americans. Half of participants reported household incomes of less than $50,000.	- Gender and ethnicity significantly affected mental illness stigma. - Boys desire larger social distance and higher rates of avoidance of individuals with mental illness. - Similarly, Black and Latinx youth desired greater social distance from peers with a mental illness. - Boys were most likely to view a woman with bipolar disorder as "a bad person" and unlikely to recover. - Black men demonstrated less mental illness knowledge than girls.
Wirth and Bodenhausen (2009)	Quantitative	*N* = 186 Gender: 54% women, 46% men Age range: 18–89 Race/Ethnicity: Caucasians 73%, African Americans 13%, Hispanics 9% Modal income: $40,000 Education: less than high school 15%, high school 24%, some college 33%, one or more college degrees 29%	- The study found that when participants were given vignettes of gender-typical individuals, they expressed less sympathy and were less willing to provide support. - Findings also indicated that mental illness stigma forms early and lasts into adulthood.
Homelessness, Gender, Race/Ethnicity, and Mental Illness			
Benbow et al. (2011)	Qualitative – feminist theory	*N* = 67 Participants were divided into seven focus groups, five were of mothers over the age of 16, and two groups were of service providers. Participants self-disclosed they were diagnosed with a mental health illness. Participants were recruited from	- Discrimination mainly occurred from two sources, landlords and employers. - The intersection of motherhood, mental illness, and poverty was a significant barrier to obtaining housing and employment.

Table 10A.1 (*cont.*)

Reference	Research method	Participant demographics	Main findings
		homeless shelters and shelters for abused women in London and Ontario, Canada.	- Participants felt stuck in a cycle of oppression. - To get out of homelessness many women returned to abusive or dangerous situations. - Women's situations were complicated by their immigration status.
Zerger et al. (2014)	Mixed methods	Quantitative $N = 231$ Qualitative $N = 36$ Participants were ethno-racially diverse, homeless, and living with mental illness.	- The authors found high rates of perceived discrimination due to homelessness, poverty, race/ethnicity, mental illness, and substance use. - Significant differences in discrimination were found among people with different ethno-racial identities. - More than half of participants experiencing discrimination identified as Black. - Those reporting discrimination due to mental health, poverty, or homelessness had significantly lower income than those reporting other types of discrimination. - Immigrants reported higher rates of prejudice across all forms of discrimination. - Those who had been homeless more than 3 years reported more discrimination than those who had been homeless for a shorter time period.

			- Participants reported isolating from friends and family due to stigma associated with homelessness or mental illness. - Participants reported difficulty coping with discrimination related to “new” labels of mental illness compared to their “old” labels related to race. - The perception of mental illness in the participants’ birth country were more affected by discrimination, especially when they still had relatives living in the homeland.
LGBTQ+ and Mental Illness			
Kelleher (2009)		*N* = 301 Participants were Irish youth who identified as LGBTQ.	- Psychological distress increased with each marginalized identity.
Bostwick et al. (2014)	Quantitative	*N* = 577 Participants identified as LGBTQ and reported a mental health diagnosis.	- Increased discrimination was experienced by those with a mental health diagnosis and who also identified as LGBTQ. - Participants also experienced discrimination within the mental health community. - Social stigma was positively associated with psychological distress.
Bockting et al. (2013)	Quantitative	*N* = 1,093 Participants were transgender persons both male-to-female and female-to-male.	- Finding support for the minority stress theory. - The authors found high rates of depression, anxiety, and somatization among participants. - Social stigma was positively associated with psychological distress.

Table 10A.1 (*cont.*)

Reference	Research method	Participant demographics	Main findings
Ghabrial (2017)	Qualitative	*N* = 11 Participants identified as both LGBTQ and as a person of color.	- Compounding stigma impacts all aspects of daily life and health. - More than half of participants chose to conceal their sexual identity in order to reduce overall stigma experience.
Logie et al. (2011)	Community-based qualitative investigation using focus groups	*N* = 104 Participants were women. Mean age = 38 69% ethnic minority (African Caribbean, Asian and South Asian, Latina, Aboriginal) 23% identified as lesbian or bisexual 22% identified as transgender	- Stigma was impacted by sexism, homophobia, and transphobia. - The number of marginalized identities compounded experiences of stigma and discrimination. - Participants hid parts of themselves from others.
Sexual Orientation, Race/Ethnicity, and Mental Illness			
Holley et al. (2016a)	Mixed methods	*N* = 20 Participants self-identified as living with mental illness and as a person of color and/or lesbian, gay, or bisexual (LGB). Family members were included in the study because of their experience of stigma by association.	- Mixed results. - Some participants noted overt mental illness discrimination in the workplace but not overt racism. - Participants felt that mental illness was often feared while LGB was not, with one exception. Participants felt that some heterosexual men were afraid LGB individuals would sexually assault their children. - Participants noted more progress reducing heterosexism than mental illness stigma.

Holley et al. (2016b)	Mixed methods	*N* = 20 Participants were people of color with a mental health diagnosis who also identified as LGB. Family members were included in the study because of their experience of stigma by association.	- Most participants reported experiencing discrimination while seeking treatment. - However, participants did not report difference in mental health discrimination based on their racial, ethnic, or sexual orientation.
Holley et al. (2019)	Mixed methods	*N* = 20 Participants were people of color with a mental health diagnosis who also identified as LGB. Family members were included in the study because of their experience of stigma by association.	- Participants reported that some communities of color do not believe mental health conditions exist. - When mental health conditions were acknowledged, stereotypes emerged. - Those who were unemployed or gay were more likely to face discrimination. - Most participants reported that they did not receive community support. - The groups most likely to perpetuate discrimination were men, newer Mexican immigrants, younger Mexican Americans, older African Americans, and individuals with less formal education. - Participants reported negative stereotypes about mental illness within the LGB community. - Those who received support for their sexual identity reported that their mental health recovery was positively impacted.

Table 10A.1 (*cont.*)

Reference	Research method	Participant demographics	Main findings
Physical Illness, Race/Ethnicity, and Mental Illness			
Williamson et al. (2017)	Quantitative diathesis-stress model	*N* = 149 Participants were White or African American and identified as either HIV positive or HIV negative.	- The study found a positive correlation between adversity and depressive symptoms for HIV-positive African Americans but not HIV-negative African Americans. This was not found among White participants. - Perceived racial discrimination, current and past neighborhood SES, and current personal SES did not explain the study's findings.
Cain et al. (2013)	Qualitative	*N* = 72 Participants self-identified as depressed, Aboriginal, and living with HIV. More than half of participants were men. Several participants (*n* = 26) identified as gay, lesbian, Two-Spirit, or bisexual.	- Many participants reported rejection and stigma by community members as a result of their HIV status, leading individuals to conceal their HIV status or to isolate from friends and family. - Participants also reported isolating to protect their family from community gossip. - Because Aboriginal communities are marginalized by Canadian society, participants who felt alienated by their community, family, and friends exacerbated their sense of isolation, compounding feelings of betrayal, anger, and depression. Likewise, risk of substance use also increased.

			- Those who reconnected with their community in an attempt to positively cope with depression or substance use found their community as a source of strength. - The authors concluded that how individuals made sense of their diagnosis impacted their symptoms and relationships.
Weight Stigma and Mental Illness			
Mizock (2015)	Literature review	n/a	- The study found that both overweight individuals and those living with serious mental illness experience stigma. - Research has also found that those with serious mental illness are more likely to be overweight.

11 Stigma and Mental Health in Ethnic Minority Populations

Lonnie R. Snowden, Genevieve Graaf,
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Stigma can be defined according to three widely recognized dimensions (National Academies of Sciences, Engineering, and Medicine, 2016). The first is self-stigma, or internalization of stigma, which occurs as mentally ill persons apply stigmatized, stereotyped, and other negative qualities associated with mental illness to themselves. The second is public stigma, an accepted community or cultural disapproval and social distancing from a stigmatized group. The third is structural stigma, or institutionalization of discriminatory policies or practices that marginalize a stigmatized group in a racially stratified society.

For ethnic minority persons needing treatment for mental health problems, there is reason to believe that stigma – self, public, and structural – is a significant barrier to receiving care and successfully recovering from mental illness. Minority persons can experience greater self-stigma as they internalize culturally resonant stigmatizing messages. They can experience amplified public stigma from community and cultural traditions leading to more disapproval and distancing than might otherwise occur. They can encounter public stigma in wider society from intermingled ethnic and mental illness biases and stereotypes that heighten negative judgments and adverse reactions. Through structural stigma expressing malign influences of a racist society, encounters with institutions and agents of authority – legal, employment, educational, general and mental health – can disfavor them more than others.

In what follows, we review the theoretical and research literature on stigma and its impact on mental health for the largest ethnic minority persons and communities. We focus on the largest ethnic minority groups: African American, Latinx, Asian American, and Native American group designations recognized for federal legislation and reporting purposes, as they have received the most scholarly attention. We recognize that these groups are quite heterogeneous and acknowledge distinctions based on national origins and regional differences insofar as limited attention given to these distinctions permits. Recognizing many limitations of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) from the American Psychiatric Association system, we define mental illness wherever possible as categories defined in the *DSM*. The *DSM* system drives current policy, economic, and clinical practice and is crucial to attend to on pragmatic grounds and for pointing the way to improvement nationwide.

We focus on intersections of stigma and race or ethnicity as observed in experiences of mental illness and personal efforts at help seeking, responses of the mental health treatment systems to the minority treatment seeker, as well as community responses to minority persons with mental illness and barriers to successful community functioning. We critically review existing peer-reviewed research literature on stigma and ethnic minority populations within each topic. We identify key limitations and make recommendations for new and needed research. We address translation of research findings into evidence-based interventions, and we propose strategies for dissemination to minority populations. Throughout, we focus on stigma's ethnic and cultural dimensions as we identify leverage points for research and strategic action to reduce stigma's deleterious effects.

Ethnic Minority Populations: Large, Diverse, and Growing

Comprising about 12.7% of the U.S. population, African Americans have higher poverty rates and lower educational attainment levels than Whites (Office of Minority Health, 2019a). By far, the largest group of African Americans trace their heritage to enslavement in the rural South and southern residence continues today: 58% of African Americans, versus 27% of Whites, continue to live in the South (Office of Minority Health, 2019a). At the same time, immigration is significant: About 9% of the Black population are immigrants, most from Caribbean countries, but Black immigration from Africa and Central and South America has also been significant (Anderson, 2015). More than one-third live in cities, but a slightly greater proportion live in the suburbs, yet poor African Americans disproportionately cluster in cities and rural areas (Kneebone & Reeves, 2016).

Latinx persons account for about 18.1% of the U.S. population. Persons of Mexican heritage are the largest group, but many others have roots in Puerto Rico or South or Central American nations. States with the largest Latinx populations are California, Texas, Florida, New York, Illinois, Arizona, New Jersey, Colorado, New Mexico, and Georgia (Office of Minority Health, 2019b). About 18% of Latinx live in poverty (Fontenot et al., 2018), and about 31.5% of Latinx are under the age of 18 compared to 18.8% of non-Hispanic Whites. About 72% speak a language other than English at home (Office of Minority Health, 2019b).

Asian Americans/Pacific Islanders (AAPI) represent about 5.6% of the U.S. population and trace their origins to the Far East, Southeast Asia, or the Indian subcontinent (Office of Minority Health, 2019c). These groups are diverse. Fewer AAPIs than Whites have a high school diploma, but more have a bachelor's degree or higher. Some subgroups within AAPI populations have higher incomes than Whites, but others are more likely found below the poverty line. For example, the Filipino American poverty rate stands at 6%, whereas

16.2% of Southeast Asian Hmong live in poverty in the United States (Office of Minority Health, 2019c).

American Indian/Alaska Native (AI/AN) individuals represent about 1.7% of the U.S. population. Their origins lie with North, South, and Central America's original peoples, and many maintain tribal affiliation or community attachment (Office of Minority Health, 2021). Currently, there are 573 federally recognized (AI/AN) tribes and more than 100 state-recognized tribes. About 22% of American Indians and Alaska Natives live on reservations or other trust lands (Office of Minority Health, 2021). They are less likely than Whites to have graduated from high school and college and more likely to live in poverty. About 26.9% of AI/AN speak a language other than English at home (Office of Minority Health, 2021). Under treaties and laws, the federal government has a unique responsibility to provide healthcare services to AI/AN people (Office of Minority Health, 2021).

As the White population ages faster than minority populations due to immigration and higher birth rates, African Americans, Latinx, and Asian Americans are becoming an increasingly large share of the U.S. population. By 2045, Census Bureau estimates indicate that the U.S. population will be 24.5% Latinx, 13.1% African American, and 7.9% Asian American, and that Whites will become a plurality rather than a majority, representing 49.7% of the population (Frey, 2018). In this context, understanding culturally specific stigma about mental illness and utilization of mental health services is even more critical to future mental health policy, services, practice, and research.

A general categorization of minority people continues well-established conventions followed by key agencies, including the U.S. Office of Minority Health, Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC). Still, it conceals considerable intragroup variation among individuals and component nationalities in income, education, immigration status, language proficiency and preference, and in other sources of diversity. Many theorists and researchers called upon acculturation (Chun et al., 2003) to explain intra-ethnic group variation in stigma. Thus, according to Abdullah and Brown (2011): "To investigate within-group variation, cultural variables should be used such as acculturation, the degree to which an individual identifies with the values and norms associated with his or her own culture and the values and norms associated with the predominant culture of their area" (p. 946). Acculturation is grounded in a history of scholarship (Berry et al., 1997) and, when fully deployed, it is complex. More recent conceptions engage with subtleties, for example, by focusing on negotiating "old" and "predominant" cultural perspectives (Doucerain et al., 2017; Schwartz et al., 2010). However, acculturation theory is broad and ambitious in conception, and critics have faulted it for concealing as much as it reveals (Abraído-Lanza et al., 2006). Later in this chapter, we propose truly "cultural variables" – individualism versus collectivism and honor orientation – for measuring ethnic minority intragroup cultural variation.

Why Stigma Matters to Ethnic Minority Populations: Mentally Ill Minority Persons Receive Insufficient and Inadequate Mental Health Treatment

Abundant evidence indicates that ethnic minority populations do not receive mental health treatment when they need it, and stigma is among the significant barriers to their receiving care. Results from national psychiatric epidemiological surveys assessing *DSM*-defined mental illness indicate that African Americans, Latinx, and Asian Americans have treatment rates lower than those for Whites (Abe-Kim et al., 2007; Cook et al., 2016; Doucerain et al., 2017; Samnaliev et al., 2009; Wang et al., 2005; Williams et al., 2007), even after adjusting for minority–White differences in levels of mental illness. Treatment disparities are smaller for high need groups such as Cambodian refugees who have post-traumatic stress disorder (PTSD) (Marshall et al., 2006) and for selected forms of treatment (Chen & Rizzo, 2010; Elwy et al., 2008; Olfson et al., 2009), but for African Americans, Latinx, and Asian Americans populations overall, it is well established that they are treated less than Whites. Comprehensive national estimates from the National Survey of Drug Use and Health (NSDUH) indicate that, compared with Whites' treatment rate of 16.3%, African Americans' treatment rate was 8.1%, Asian Americans' rate was 5.2%, the Latinx rate was 7.5%, and the Native Hawaiian/Pacific Islander rate was 7.3% (Substance Abuse and Mental Health Service Administration, 2015).

Disparities in treatment access and quality of care reveal that even as self, public, and structural stigma are problematic society-wide, they may be especially challenging for minority persons. Minority persons' greater exposure to public stigma can deter help seeking and interfere with treatment by transmitting and reinforcing negative stereotypes about people with mental illness. Greater exposure to public stigma also can occasion more social disapproval when people with mental illness are encountered or discussed by community members. In turn, minority persons may have internalized negative stereotypes depicting persons with mental illness as undesirable, and this can lead to avoidance of recognition and labeling of personal problems as mental illness and to adopting culturally preferred coping strategies. Such responses may prevent professional help seeking and interfere with active engagement in treatment.

Structural stigma, more often experienced by minority persons, can also expose them to racism-reflecting bias in governmental or organizational policies and practices or to lack of awareness or responsiveness to the special needs of minority persons with mental illness. For example, along with stigma-related reluctance to engage in treatment, practitioners' cultural insensitivity and lesser willingness to initiate or refer for effective treatment courses – a form of structural stigma – can lead minorities to receive less and lower quality of care. Studies of quality show that ethnic minority persons, especially African Americans and Latinx, are less likely to be assigned to psychologically oriented mental health treatments (Bender et al., 2007; Stockdale et al., 2008), to receive needed psychotropic medications (Han & Liu, 2005; Herbeck et al., 2004; Miranda & Cooper, 2004), and to receive evidence-based treatments (Alegría et al., 2008; Gonzalez et al., 2010). Kuno and Rothbard (2005) reported that community mental health centers in areas where Whites predominate provided a higher quality of care than centers located in areas where African Americans predominate.

Researchers have documented but not yet conducted studies examining sources of disparities in quality of care. In formulating explanatory accounts, researchers should address practitioners' understanding of clients' cultural backgrounds and accommodations of cultural differences in delivery of care (Benish et al., 2011; Bernal & Domenech-Rodrígeuz, 2012), the role of provider bias, as well as training and practice preparation to effectively treat ethnic minority persons with mental health disorders, along with attending to organizational cultures and structural policies tht fail to support delivery of high-quality behavioral health treatment of minority clients (Metzl & Hansen, 2014). This inattention has an adverse impact on minority persons with mental illness and may also constitute a kind of structural stigma, thereby expressing broader currents of racism coursing through U.S. society (Smedley, 2012).

Stigma as a Barrier to Minority Help Seeking: A Review of Research

Recently, a systematic review of 29 empirical studies from around the world compared majority-minority differences in stigma for common mental health disorders. The studies encompassed stigma's many aspects: discrimination, prejudice, stereotyping by stigmatizing actors, and perceived, anticipated, or internalized stigma by targets of stigma. Meta-regression of findings revealed a small but consistent effect ($g = 0.20$; 95% CI: 0.12–0.27), indicating that racial and ethnic minorities demonstrated more stigma for mental health disorders than racial majorities (Eylem et al., 2020).

Using metanalytic methods, Clement and colleagues (2015) reviewed quantitative and qualitative research comparing ethnic groups' levels of stigma in professional help seeking for a mental health problem, including attitudes and intentions to seek help and help-seeking behavior. From 144 studies meeting their criteria and available between 1980 and January 2012, they found 12 assessed disparities for the ethnic groups: 4 for African Americans, 6 for Asian Americans, and 2 for Latinx populations. Stigma was negatively associated with help seeking, "strongly" for Asian Americans and "modestly" for African Americans. No association was found for Latinx populations. Qualitative findings suggest that minority participants stated a desire to protect family secrets to avoid family embarrassment. Among African American, Latinx, and White parents of mentally ill children, Latinx parents report stigma as a more significant factor in preventing or postponing treatment seeking than African American parents (Young & Rabiner, 2015). Further, DeLuca and colleagues (2021) compared self-stigma among African American, Asian, biracial/multiracial, and White adults and children with psychosis spectrum symptoms. Self-stigma was more significant for those at greater risk of positive psychosis symptoms, but no racial or ethnic differences materialized.

Several additional studies have appeared in the referenced literature considering minority–White disparities in stigma. Among African American college students, stigma and self-concealment predict attitudes that are less favorable toward mental health help seeking (Masuda et al., 2012). Among Latinx college students, stigma has been associated with unfavorable attitudes toward recognizing personal need for psychological services, and – along with experience of professional help and greater tendency toward self-concealment – stigma predicts unfavorable attitudes toward seeking help (Mendoza et al., 2015).

Several studies have examined stigma in samples of Asian American college students. Experience with treatment seeking, for example, is associated with recognizing need and with confidence in the value of professional psychological help in Japanese and Japanese American samples (Masuda et al., 2005). In a sample of Asian American college women, Masuda and colleagues (2017) reported that for women in psychological distress, lower tolerance for stigma from seeking psychological services was explained by dysfunctional beliefs about eating and psychological inflexibility. Specifically, greater inflexibility and dysfunctional eating beliefs were associated with lowered ability to handle stigma.

Masuda and Boone (2011) reported higher levels of stigmatizing attitudes among Asian Americans and that greater stigma was associated with attitudes less favorable toward professional help seeking for a personal problem. Another study investigated differences between Japanese college students in the United States and U.S. college students on stigma toward people with psychological disorders, stigma tolerance in help seeking, and self-concealment. Japanese international students expressed greater stigma toward individuals with psychological disorders than did their U.S. counterparts. However, no interrelationships between these variables were found in the Japanese international student group (Masuda et al., 2009). In another college student sample, psychologically distressed Asian Americans perceived self- and social stigma as barriers to help seeking more than Whites. However, this stigma disparity did not explain disparities in reported intentions to seek mental health treatment (Kim & Zane, 2016).

When studying barriers to minorities' seeking mental health and psychological assistance, investigators should situate stigma within models tailored to understanding the help-seeking behavior of particular ethnic minority populations (Cauce et al., 2002; Eiraldi et al., 2006; Rogler & Cortes, 2008). The common practice of investigating disparities in personal "stigma tolerance" (Fischer & Turner, 1970) can overlook unique characteristics and pathways of influence of particular importance for understanding minority outlooks and experiences. Thus, an ethnic minority person's experience of stigma can be influenced by culturally sanctioned avoidance of thinking about mental illness categories and a preference to attribute one's suffering to culturally approved categories of distress. Minorities' experience of stigma can be influenced by a preference for culturally sanctioned coping practices and consultation with trusted community figures. Their experience of stigma can be influenced when stigmatizing messages are directed to minority persons from a disapproving wider society or from collectivist or honor-oriented communities with which they identify. Evaluating hypotheses such as these would help clarify stigma's role in minority persons' experience of seeking psychological distress assistance.

More studies should also be conducted with samples representative of minority populations in the United States and representative of settings where stigma is enacted and where anti-stigma programming and messaging might be deployed. Representative samples should be stratified by cultural and community orientation and ethnic identity, immigration status, English proficiency, and demographic and regional characteristics. Stratified, representative sampling can sharpen research questions and enrich interpretation of findings, as it better establishes boundaries of knowledge from research.

Culture, Stigma, and Minority Populations

Understanding how a minority group's stigma experiences differ from those of Whites requires theorists and researchers to identify particular cultural features producing differing experiences of stigma based on race and ethnicity. In this vein, researchers have sought to specify distinctive belief systems, values, and practices that account for minority–White differences in stigma. Reviewing research on stigma in Native American/Alaska Native populations, Grandbois (2005) reported wide variation in disparities. The evidence suggested that more acculturated groups embraced stigma more than groups more attuned to traditional cultural orientations where realms of mental and physical well-being remained undifferentiated. Grandbois (2005) concluded that because research examined many tribes – with great heterogeneity across tribes – generalizing findings to Native American/Alaska Native populations as a whole would be impossible.

Abdullah and Brown (2011) conducted a comprehensive review of research on relationships between mental illness stigma for ethnic minority groups. They uncovered a profusion of cultural elements (e.g., familism, community orientation) reported in the literature and called for greater effort to explain minority–White differences in stigma on a more systematic basis. They ultimately call for grounded theory–based discovery of key cultural values, beliefs, and customs in individual ethnocultural groups.

Cultural beliefs, values, or norms may be characterized by two underlying dimensions supported by extensive cross-cultural research worldwide: collectivism versus individualism (Triandis, 2018) and honor orientation (Nisbett & Cohen, 1996). Collectivist cultures emphasize (1) strong identifications with family, kin, and community; (2) consensus and in-group harmony and cooperation; (3)

meeting commitments to others and promoting a sense of satisfaction from fulfilling obligations; and (4) looking to in-group members for advice and sensitivity to in-group standards of appropriate conduct. In contrast, individualist cultures promote individual identity and individual obligations as greater in importance than group or family, and emphasize personal autonomy, personal agency, and negotiated social participation. Honor orientation points to a sense of ethnic pride, and it conveys an emphasis on upholding personal, family, and community virtue. Cultures high in honor orientation commit members to avoid bringing shame or disgrace on family, kin, or community.

Thus, Abdullah and Brown's (2011) characterization of Asian, Latinx, and African American cultures marked by strong family and community orientations and a shame-avoidance need for within-family privacy are closely akin to collectivism and honor orientation. Collectivist and honor concerns could lead a minority person with mental illness to reject outright or conceal mental illness and psychological conception of personal problems and to eschew mental health or psychological assistance if such conceptions were devalued by an ethnic community serving as a reference group. Explicit use of these dimensions in cultural research on stigma can help to consolidate pursuit of culture to explain increased stigma around mental illness.

The Impacts of Stigma for Ethnic Minority Populations: Minority Persons with Mental Illness Struggle to Succeed in Economic and Health-Related Well-Being

Members of society express public stigma through prejudicial attitudes and discriminatory treatment and avoid persons with mental illness, which makes it more difficult to engage in the social interactions necessary to uphold family and community responsibilities. Societal institutions express structural stigma through policies and practices that marginalize and deny opportunities to persons with mental illness. For minority persons, mistreatment such as this can go beyond ongoing racial and ethnic discrimination expressing racism in society, compounding already adverse effects from racial and ethnic bias, which members of ethnic minority groups also encounter when suffering from mental illness.

Minority communities can perpetuate stigma through cultural beliefs that embrace stereotypes about persons with mental illness. Two studies addressing minority–White differences in public stigma surveyed Californians statewide. Collins and colleagues (2017) asked respondents to indicate their willingness to move next door to, socialize with, or work closely with someone with schizophrenia, depression, or PTSD. Asian American respondents were least willing, followed by African Americans and Latinx and then by Whites. Following an educational program that was delivered as part of the statewide initiative to reduce mental illness stigma and discrimination, Asian and Latinx American participants made greater gains than Whites (Wong et al., 2018). The findings suggest that ethnic minority community members may subscribe to more stigmatizing beliefs, but these beliefs respond to stigma reduction interventions.

General public and structural mental illness stigma can further disadvantage minority persons as they seek to function successfully in the community, impacting economic success, health, and freedom from criminal justice involvement. “Double jeopardy” describes how minority status and mental illnesses might jointly affect ethnic minority persons “who already confront prejudice and discrimination because of their group affiliation and suffer double stigma when faced with the burdens of mental illness” (Gary, 2005, p. 979). One element of double jeopardy – the social and economic disadvantage stemming from minority status – is well documented in the literature on social determinants of health (Meyer & Zane, 2013). Another element of double jeopardy – society’s lack of receptivity to persons with mental illness and their diminished prospects in life – has also been documented. Abundant research demonstrates that persons with mental illness are more likely than others to be unemployed and poor (Martins et al., 2012), to suffer health problems and to live shorter lives (Eaton et al., 2008), and to have more involvement with the criminal justice system (Steadman et al., 2009). It is reasonable to believe that stigma contributes to such adverse outcomes given widespread stigma in society and reasonable to believe that mental illness stigma and minority status combine to result in twice the level of adversity.

However, the additive effects defining double jeopardy need not occur. Social psychologists find that bias can be context sensitive (Barden et al., 2004; Dasgupta & Greenwald, 2001; Lowery et al., 2001). Circumstances of elicitation can complicate expressions of racial and ethnic bias, and mental illness can preempt the anti-minority prejudice and discrimination that ordinarily would be triggered (Barden et al., 2004; Dasgupta et al., 2001; Hodgkins & Mereish, 2012; Lowery et al., 2001; Wittenbrink et al., 2001). Thus, for mental illness risk, being both African American and poor does not confer double jeopardy because their impacts are not additive: poor and non-poor African Americans are equally at risk of mental illness (Hudson et al., 2012). According to a thoroughly investigated “immigrant health paradox” tested among Latinx populations especially (Acevedo-Garcia & Bates, 2008), mental health risks associated with recent immigration do not compound the risks accompanying Latinx ethnicity: recent immigrants have fewer mental health problems than other Latinx. Evaluating immigration status and socioeconomic indicators among Asian Americans, John and colleagues (2012) report no double jeopardy but instead complex interactions like the “immigrant health paradox” that defy straightforward explanation.

Only by studying double jeopardy for minority persons with mental illness can we determine whether minority–White disparities in health, social, and economic functioning exceed levels of adversity conferred by mental illness alone. Two studies have directly addressed minority–mental illness double jeopardy. Das-Munshi and colleagues (2017) concluded that African Americans and Latinx with serious mental illness (SMI) were at greatest risk for obesity, weight gain, and diabetes when jointly experiencing SMI and racial discrimination. Studying persons with mild and moderate mental illness (MMMI) and severe mental illness (SMI), Snowden and colleagues (2021 [under review]) investigated disparities nationwide in unemployment, poverty, poor health, and arrests. African Americans showed consistent evidence of double jeopardy, whereas Native Americans and Latinx showed selective evidence and Asian Americans showed little evidence. Double jeopardy's occurrence depended on which minority group was considered at what mental illness severity and for which kind of adversity.

More research is needed that examines the economic and social well-being of minorities with mental illness and determines stigma's role in explaining resulting disparities. Smedley (2012) reviewed direct, confirming evidence of racial and ethnicity-based unfair treatment of Latinx, African Americans, and Asian Americans in mortgage lending, housing, and employment. Not yet available but needed is direct evidence of even greater discrimination against minority persons with mental illness.

Further afield lie important questions awaiting future study. As the in-progress COVID-19 pandemic reminds us, economic, climate, and health-related shocks strike society regularly and forcefully. African Americans, Latinx, and Native Americans, more than Whites, are falling ill and dying from COVID (Tai et al., 2021), and more are suffering from the accompanying recession. As minority population's social, economic, and health-related stressors rise disproportionately (Tai et al., 2021) and mental health treatment need grows (Ettman et al., 2020), self-, public, and structural stigma might decline amid disruption and uncertainty, or they might rise from a growing sense of personal threat. Stigma's impact on urgently needed minority mental health treatment might rise or fall in times of upheaval and should be investigated.

As illustrated by the Affordable Care Act (ACA) implementation, mental health policy changes regularly and alters the treatment environment. The ACA opened more treatment possibilities than existed previously by reducing financial barriers to mental health care and expanding provider networks. However, for Black Americans and Latinx populations, mental health treatment utilization remained unchanged (Creedon & Cook, 2016). Although gains in health insurance coverage from the ACA for non-White populations were notable, as were some general healthcare improvements, this underutilization of mental health treatment suggests a unique insensitivity to the needs of minority persons with mental illness – a kind of structural stigma that should be examined in future research.

Reducing Stigma's Role as a Barrier to Ethnic Minorities Engaging in Treatment and Improving Community Functioning

Improvement in the well-being of ethnic minority persons with mental illness requires that theoretical insight about stigma ultimately be translated into anti-stigma interventions, yielding widespread stigma reduction in ethnic minority communities. Health marketing anti-stigma campaigns should be developed following evidence-based public health messaging principles (Institute of Medicine, 2015). Stigma reduction efforts targeting the general public should include messages sensitizing everyone to avoid stereotypes about minority persons with mental illness.

Whether adapting standard interventions or devising culturally specific alternatives, intervention design research should be guided by empirically established principles for addressing the social and cultural circumstances of minority individuals and communities. In one of the few efforts reported to date, Alvidrez and colleagues (2008) elicited stigma management strategies from Black mental health service clients treated at a community clinic. Helpful strategies included vowing to put personal health ahead of others' opinions and seeking support from accepting family and friends. From this information, they devised and evaluated a coping strategies program to meet personal, family, and community challenges arising as the clients received care (Alvidrez et al., 2008).

The research literature includes numerous culturally and socially adapted intervention programs for de-stigmatizing conditions other than mental illness such as HIV (Beatty et al., 2004; Darbes et al., 2008; Herbst et al., 2007; McMahon & Ward, 2012; Organista et al., 2004; Wilson & Miller, 2003; Yep, 1992). These programs and their evaluations can be consulted as potential sources of culture-specific strategies, themes, and messages.

Evidence-based stigma reduction interventions and anti-stigma public health messages must be disseminated through trusted figures in ethnic minority communities who can reach persons with mental illness and their families, as well as with community opinion leaders and trusted community institutions. Community health workers (community health aids, promotores de salud, etc.) are widely employed by many health plans and community clinics to perform many mental health functions. Serving as members of comprehensive delivery teams, they act as system navigators, educators, and outreach and referral agents (Barnett et al., 2018). They are well-positioned to deliver anti-stigma interventions and stigma reduction messages to ethnic minority persons with mental illness and others in ethnic minority communities.

Not-for-profit community-based organizations (CBOs) – non-governmental, civil society, or other grassroots organizations with a community service mission (Wilson et al., 2010) – have been shown to play meaningful roles in reducing barriers to mental health treatment: by reaching out to minority communities, reducing mental health treatment disparities (Snowden et al., 2017), and otherwise addressing mental health problems in ethnic minority communities through service provision and outreach provided in linguistically and culturally competent ways (Bloom et al., 2009; Rusch et al., 2015). These CBOs' strategic plans are developed in consultation with community stakeholders, and they can come to incorporate mental health stigma reduction as a goal.

Other leverage points include health plans, clinics, and agencies that can adopt mental health stigma reduction in minority communities as a high-priority concern. Ethnic minority people are overrepresented in Federally Qualified Health Centers (Bruckner et al., 2020), which deliver a large and growing volume of mental health care (Bruckner et al., 2019) and, thus, are well positioned to undertake widescale stigma reduction efforts. Thousands of non-profit hospitals have also become community hubs in return for state, federal, and local tax relief (Rosenbaum, 2016). All not-for-profit health plans and hospitals should assess personal and public stigma levels in ethnic minority communities in their mandated community health needs assessments (Pennel et al., 2015).

Beyond the realm of anti-stigma programming, federal, state, and local anti-discrimination policies should be formulated and implemented mindful of persons with mental illness and stigma. Fair employment and fair housing policies must recognize discrimination against minority people with mental illness and account for the possibility that such people might be discriminated against twofold (see also Chapter 10 in this Handbook for additional discussion of intersecting identities). Policies requiring language assistance for persons with Limited English Proficiency in mental health settings – particularly the Americans with Disabilities Act – may be a major leverage point for preventing discrimination against people with mental illness.

Conclusion

The largest ethnic minority groups will comprise a majority of the U.S. population in the foreseeable future, and the mental health treatment system has thus far been unable to meet their treatment needs. Overcoming stigma will play a key role in fashioning a newly responsive system that meets these growing minority populations' needs. Building on theoretical insight from informative research literature and future studies testing cultural hypotheses on minority help seeking in comprehensive models, interventions to reduce self-stigma can be fashioned, tested, and disseminated. Public stigma in ethnic minority communities and beyond can extend community education programs from research-informed community response models. Systems providing mental and general healthcare, employment, and justice can identify and address structural stigma in policies and practices yielding harsh treatment of minority persons with mental illness. When benefits are documented, research-based community-wide efforts can reduce the burden of stigma for ethnic minority persons, thereby removing a key barrier to realizing a better quality of life.

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12 Mental Health Stigma among LGBTQ+ Populations

Carlos A. Vidales & Ashley J. Macbeth

Mental health stigma has been shown to be detrimental to those impacted by mental health concerns by exacerbating mental illness, decreasing physical health, and reducing treatment seeking and compliance (Holley et al., 2016; Lannin et al., 2016). Although repeated experiences of stigmatization and discrimination of minority groups are associated with greater mental health risks (Hatzenbuehler, 2009; Meyer, 2003), researchers have only started to consider the implications of holding multiple minoritized identities and the implications this has on psychosocial functioning and behavioral health (Oexle & Corrigan, 2018). As such, the mechanisms by which multiple minority identities interact to produce stigma is unclear and has been a topic of debate. Furthermore, lesbian, gay, bisexual, transgender, and queer (LGBTQ+) populations are unique in that they historically have been stigmatized both by the psychology profession (e.g., having one's identity being pathologized by the American Psychiatric Association), as well as the larger society. As such, in this chapter, we will examine the intersectionality of mental health stigma and the stigma experienced by LGBTQ+ individuals. The purpose of this chapter is to introduce the reader to relevant information about LGBTQ+ individuals, including history and current areas of focus. Additionally, this chapter will summarize the integration of LGBTQ+ related concerns with mental health stigma. This chapter will conclude with implications for future work in practice and policy.

Historical Influences

In order to understand mental health stigma among LGBTQ+ populations it is important to understand the historical influences. Until 1973, the term "Homosexuality" existed as a mental disorder as defined by the American Psychiatric Association (APA) within the *Diagnostic and Statistical Manual for Mental Disorders* (*DSM-II*). Additionally, the World Health Organization did not remove homosexuality as a mental disorder from the International Classification of Diseases (ICD) until 1992. As homosexuality was pathologized, various treatments were invented with the goal of removing homosexuality. Such practices typically utilized classical conditioning to create aversive responses to arousing stimuli, known as aversion therapy (Mandel, 1970).

Though the APA has since removed this disorder, these practices remain under the guise of "conversion therapy," provided by non-APA-affiliated psychologists and religious centers. The ethics of conversion therapy have long been debated, despite consistent evidence suggesting unfavorable outcomes (Haldeman, 1994). Though conversion therapy and the pathologizing of LGB identity is no longer part of the greater practicing psychologists' methods, the implications of these previously endorsed methods have left lingering effects of stigma both toward and within the LGB community.

Similarly, Trans identity also has a unique history with the APA. Until the release of the *DSM-5* in 2013, Gender Identity Disorder (GID) was used as a diagnosis to describe "cross-gender identification" and discomfort with one's "sex or sense of inappropriateness in the gender role of that sex" (APA, 2000). With the 2013 *DSM-5* update, Gender Dysphoria was then used as psychologists acknowledged the inappropriateness and stigmatic consequences of GID as a diagnostic label (APA, 2013). However, the relabeling of GID to Gender Dysphoria is only an extension of a history of transphobic research and clinical implications. Psychologists and psychiatrists have long pathologized gender non-conformity through the use of labels such as Transsexualism and Transvestic Fetishism (see Lev, 2006 for a review).

This history of stigmatization toward the LGBTQ+ community has no doubt contributed to the ongoing discrimination perpetrated by general society today. It was not until the 1920s that LGBTQ+ rights movements made their way into the United States, although this did little to curb the stigma held by White, heterosexual lawmakers. These lawmakers made the rise to equality difficult for the LGBTQ+ activists leading the way – who were largely transgender women of color – and solidified an anti-LGBTQ+ agenda into U.S. politics. However, within the past several years, the LGBTQ+ community has made important strides toward thorough inclusion into society for those whose sexuality was being persecuted. In 2015, "gay marriage" was legalized by the *Obergefell* v. *Hodges* (2015) case, in which the Supreme Court effectively legalized same-sex marriage nationwide. Despite the law change, however, widespread stigma of LGBTQ+ identities still remain (Adamczyk & Liao, 2019; Mink et al., 2014). Suicide attempts and ideation for LGBTQ+ individuals have been found to be highly associated with multiple forms of stigma and the results of that stigma, such as public discrimination, negative reactions to coming out, and LGBTQ+ hate crime experiences (Rimes et al., 2019).

Stigma directed at the transgender and gender non-conforming communities is also based equally in the past as it is in the present. In the past, many Indigenous cultures across the world held a view of transgenderism as something sacred (Bockting & Cesaretti, 2001). Some cultures had more than two genders to allow for natural variation in gender expression, which was instrumental to the society's spiritual foundations (e.g., Muxes in Mexico, Two-Spirit in Indigenous peoples, and Hijra in South Asian cultures). However, with the rise of Christianity and Catholicism, these viewpoints were largely wiped out, leaving only room for two gender options. During World War II, transgender individuals in Nazi Germany were exiled or kept in concentration camps, where they were the subject of cruel experimentation by Nazi scientists. Similarly, transgenderism was outlawed in multiple "developed" countries for hundreds of years. Following the 2016 election, the Trump administration passed a ban on transgender individuals serving in the military, effectively pushing back efforts made by LGBTQ+ activists for transgender inclusivity. Evidence suggests that transgender stigma contributes to health inequalities in transgender communities, as well as increased mental health concerns among transgender individuals (Hughto et al., 2015). Similarly, research suggests barriers exist to employment, housing, and medical treatment for the transgender community due to societal stigma (Mizock & Mueser, 2014). This research is incredibly important due to the increased risk that transgender individuals face for depression, anxiety, suicidality, and other related mental health distress (Valentine & Shipherd, 2018).

Stigma among LGBTQ+ Populations

Before discussing any of the negative health impacts of stigmatization in relation to LGBTQ+ populations, it is first important to examine all the ways in which stigma can present, as well as the different types of stigma that exist. Primarily, mental health stigma is the global term, referring to stigma toward individuals labelled as experiencing or seeking help for a mental illness, or stigma one may have toward themselves and their own adoption of these labels (Ahmedani, 2011). As noted in a previous chapter in this Handbook (see Chapter 3), a key to this definition is that there appears to be unique stigmas related to mental health based on who is stigmatizing (e.g., society, individuals, self) and what is being stigmatized (i.e., having a mental illness, seeking psychological help).

Public stigma is the general term most often used to describe the stigmatizing attitudes and discrimination from others toward someone experiencing mental illness or seeking professional help (Corrigan et al., 2004). Public stigma can occur at the societal level (i.e., general societal norms, attitudes, and beliefs) and at the personal level (i.e., individual attitudes and behaviors toward someone experiencing mental illness; Corrigan & Penn, 2015). When public stigma leads to specific discriminatory behaviors and actions toward others, it is sometimes referred to as *enacted stigma* (Veale et al., 2017). Overall, the negative perceptions help by others and present in society also leads to *structural stigma* or the discriminatory treatment via societal organizations (Corrigan et al., 2004). These include cultural practices, policies, legislation, or structural barriers that hurt those experiencing mental illness and make it more difficult to seek professional help (e.g., cost, distance).

At the personal and internal levels, these different stigmas can also lead to those living with mental illness or seeking professional help to personally experience and anticipate greater discrimination and prejudice. This is called *felt stigma* (Herek, 2016). Experiences and knowledge of felt stigma can lead individuals to anticipate greater stigma if others were to find out about their mental illness or that they sought professional services (Fox et al., 2018) and can be a leading cause of nondisclosure and avoidance of seeking support (Baxter et al., 2016). Furthermore, individuals may internalize the negative perceptions held by society and come to believe these perceptions are true about themselves. This has been termed *self-stigma* (Corrigan & Watson, 2002) and has been shown to negatively impact feelings of self-worth (Corrigan, et al., 2006). Finally, those close to the individual (e.g., family members, friends) may experience *associative stigma* (Verhaeghe & Bracke, 2012), also called *courtesy stigma* Goffman, 1963), as a result of being associated with a stigmatized individual.

These types of mental health stigma are akin to the stigma experienced by LGBTQ+ individuals. In conceptualizing the stigma that LGB communities experience, Herek's (2009) stigma of sexuality theory notes four interrelated types of sexual stigma. At the personal level, Herek (2009) describes sexual discrimination and prejudice (e.g., use of anti-gay epithets, shunning, LGB-related hate crimes) perpetrated against LGB individuals and communities as forms of *enacted stigma*. For example, one study found that almost half of U.S. citizens support the actions of private businesses to openly discriminate against LGBTQ+ people (Kaufman & Compton, 2020). In turn, Herek described the experience and anticipation of sexual discrimination from others and society as *felt stigma*, and notes that LGB members may feel the need to alter their behavior as a means of avoiding enacted stigma. For LGB members, this can be concealment of their sexuality (e.g., "passing," being "in the closet," or "discreet"). Herek (2009) also discusses internalized stigma (i.e., self-stigma) or the way LGB people accept negative attitudes about LGB sexuality. This is the process whereby individuals' self-concept mirrors the negative social schemata from the heterosexual society (Jones et al., 1984). The extant literature has widely examined the concept and consequences of internalized stigma (Mink et al., 2014), and even more researchers have added to our knowledge of this phenomenon by conceptualizing this stigma as internalized homonegativity (Berg et al., 2016). Finally, Herek (2009) describes the presence of *structural stigma*, which describes the stigma that has woven its way into hierarchical structures of our society. This includes government laws, policies, and even officials that are openly anti-LGB.

The different types of stigma experienced by LGBTQ+ individuals can interact with mental health stigmas. For example, the impact of mental health stigma may be compounded within LGBTQ+ communities due to discrimination that negatively impacts the mental health of minority groups (Cyrus, 2017). This reflects an ongoing conceptualization of additive and multiplicative processes of stigma, which will be discussed in later sections. Furthermore, as the potential interactions may differ across the stigma of mental illness and the stigma of seeking psychological help, we will discuss these separately. In addition, as the literature has tended to largely focus on just public and self-stigma, we will report on these specifically. Disentangling these stigma relationships is essential to understanding the pathways through which they interfere with mental health and help seeking and, in turn, to developing effective, targeted interventions that increase help seeking and improve mental health.

Mental Illness Stigma

In understanding mental illness stigma, it important to recognize that marginalized identities endure unique interpersonal and systematic discrimination that impact their psychological and physical health (Meyer, 2003; Meyer & Dean, 1998). Minority stress theory (MST) describes how discrimination and stigma could explain the disparities in physical health ailment, depression, anxiety, substance misuse, and suicidality among LGB populations (Dürrbaum & Sattler, 2020; Goldbach, 2014; Lea et al., 2014; Lick et al., 2013; Mongelli et al., 2019). Those with minoritized identities encounter frequent and distressing social situations that associate with physical and psychological health deficits. These stressful social situations can be conceptualized on a paradigm of distal (e.g., objective experience such as recollection of someone yelling anti-gay epithets) to proximal (e.g., subjective interpretations of these social situations, such as appraising an interaction as homonegative). Though this theory was originally built as a means of examining LGB experiences, researchers have since extended MST to explain the unique development of psychological distress among Trans populations (Bockting et al., 2013; Meyer, 2015; Tebbe & Moradi, 2016), as well as for those with non-binary identities, such as non-binary and genderqueer (Hendricks & Testa, 2012; Lefevor et al., 2019). MST allows us to conceptualize a process that delineates how experiences of discrimination and prejudice (e.g., distal stressors) can be internalized and transformed into damaging self-concepts (e.g., proximal stressors), which can include an increased stigma if one's own mental illness.

For those members of the LGBTQ+ community, approximately 38% report an experience of a serious mental illness in the past year (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). These individuals have to navigate not only the public stigma directed toward the LGBTQ+ community but also the public stigmatization of mental illness, as well as the unique interaction between these two processes. For example, public stigma directed toward the LGBTQ+ community may perpetuate certain social stereotypes about the LGBTQ+ populations' mental health (e.g., being self-destructive, psychologically weaker than straight/cisgender people, prone to engaging in risky behavior) that interact with public stigma of mental illness stereotypes of being out of control, weak, or destructive (Salvati et al., 2019). This could lead to greater negative perceptions of and worse treatment of LGBTQ+ individuals experiencing symptoms of mental illness. Consistent with this, researchers have shown that LGBTQ+ individuals experience a significantly higher rate of depression, anxiety, and somatization that is associated with public stigma (Bostwick et al., 2014a) than do heterosexuals/cisgender people.

Burgess and colleagues (2007) found that those identified as LGBT were likely to experience more distress, more substance use, greater discrimination, and more unmet healthcare needs than heterosexuals. Additionally, for those who identified as LGBT, discrimination was significantly associated with those other variables (e.g., greater experiences of discrimination were related to greater substance use). Interestingly, the mental health and treatment utilization disparity between LGBT and straight participants remained even after controlling for experiences of discrimination. This could potentially be due to anti-LGBTQ+ beliefs held by medical professionals that may lead them to treat LGBTQ+ individuals differently than their cisgender and heterosexual counterparts, in a way that might not feel overtly discriminatory (i.e. microaggression). However, researchers have not assessed both the stigma directed toward the LGBTQ+ community and toward those experiencing mental illness or how they might interact to affect LGBTQ+ individuals in a single study. Therefore, it is important for future research to directly examine if or how the above stigmata compound among LGBTQ+ individuals living with mental illness.

What may also be of particular importance to LGBTQ+ individuals is the role of self-stigma. Accepting and internalizing public stigmata can result in the development and maintenance of self-stigma that has been observed to have a deleterious interpersonal effect on LGBTQ+ individuals (Corrigan & Rao, 2012). This internalization is a key explanation of MST for the negative impact of external stigmas (Meyer, 1995; Meyer & Dean, 1998). Another theory of particular interest/association for LGBTQ+ individuals experiencing mental health concerns, specific to our understanding of self-stigma of mental illness, is the cognitive-behavioral model of self-stigma for concealable minorities (Mak & Cheung, 2010). This theory posits a cyclical pattern between self-stigmatizing cognitions, self-stigmatizing affect, and self-stigmatizing behaviors, which change in parallel to form experiences of self-stigma (Mak & Cheung, 2010). This pattern of interlocking cognitions, emotions, and behaviors can help us understand mental illness stigma among the LGBTQ+ population. For instance, the self-stigmatizing cognitions may extend to endorsement of cognitions about themselves (e.g., "I'm unworthy of better conditions in life"; "It is my fault"; "I'm already seen as inferior, so it must be true"). This may be related to self-stigmatizing emotional responses of shame and embarrassment. Last, these processes may also be related to self-stigmatizing behaviors, where avoidance of talking about experiences occurs. However, the association between LGBTQ+ self-stigma and help-seeking attitudes and behaviors has not been thoroughly researched, leaving us only to speculate how one's internalization of LGBTQ+ stigma impacts their ability to seek help. Therefore, it is important for researchers to continue delineating internalized beliefs that complicate seeking professional help.

Help-Seeking Stigma

Stigma associated with seeking professional help has been conceptually differentiated from, though linked with, the stigma associated with mental illness (Tucker et al., 2013). This is true when examining public stigma of help seeking among LGBTQ+ populations, as both the historically backed stigma against queer identities as "mental illnesses," and the archaic "treatments" imposed on this community, many of which are still legal and in use in the United States, cannot be overlooked. These practices have had and continue to have a lasting effect on how the LGBTQ+ community views treatment. One glaring result, of course, is the reduced use of mental health services due to the expectation and experiences of stigmatization by mental health professionals as compared to their heterosexual counterparts (Shipherd et al., 2010; Whitehead et al., 2016). LGBTQ+ individuals have the same barriers as their straight/cisgender counterparts in receiving physical and mental health care (e.g., accessibility, cost, and insurance); however, these problems are particularly salient for transgender individuals, who experience more difficulty attaining work (Shipherd et al., 2010). On top of these concerns, LGBTQ+ individuals also need to navigate expectations of potential outness and being stigmatized by their healthcare provider, which can lead to individuals further avoiding treatment (McNamara & Wilson, 2020). Therefore, it is important for mental and physical health providers to understand the history of LGBTQ+ stigmatization and how these reflect present-day concerns in an effort to create pipelines for affirmative healthcare for LGBTQ+ individuals.

These long-standing practices also persist in creating and maintaining barriers to care for LGBTQ+ individuals via structural stigma associated with seeking help. This structural stigma operates at the system level and specifically devalues and disregards LGBTQ+ individuals (Steele et al., 2006). Specifically, structural barriers to care can include an inability to access a mental health provider and processes that influence low-quality, inadequate, or unsatisfactory care. For example, research has shown that LGBTQ+ individuals experience less satisfaction with mental health services (Avery et al., 2001). In addition, in a review of the research on transgender care, Stotzer and colleagues (2013) revealed five facets of transgender-oriented help-seeking structural stigma: discrimination and rejection within these services, inadequate treatment and insensitive providers, problems associated with the climate and physical space, limited availability of services and programs, and cultural incompetence. It stands to reason that if the structural stigma were addressed, then a change in individual-level barriers to accessing care may also result. Specifically, creating changes such as including transgender-specific health programs and outreach, transgender-literacy education for health service workers, and changing aspects of services to include transgender identity (e.g., hiring transgender individuals, removing binary "sex" options on forms, including transgender people in advertisements and pamphlets) have all been long implicated (Stotzer et al., 2013).

Self-stigma of seeking help may also play an important role for LBGTQ+ individuals. Researchers have identified barriers to initiating help in the LGBTQ+ community including negative conceptions associated with needing professional help. For instance, LGBTQ+ survivors of suicide attempts have recounted that seeking help is a mark of weakness, because not needing help (e.g., "pushing through") is a mark of strength (Williams et al., 2018). Research also suggests that, rather than seeking help, LGBTQ+ individuals may normalize their emotional distress to the point where they only reach out at crisis points (McDermott et al., 2018). We also may be able to use the cognitive-behavioral model of self-stigma for concealable minorities (Mak & Cheung, 2010) to conceptualize help-seeking stigma among the LGBTQ+ population. For instance, the self-stigmatizing cognitions may extend to endorsement of cognitions about seeking help (e.g., "I don't deserve help," "I'm already seen as inferior, I shouldn't confirm it"). This may be related to self-stigmatizing emotional responses of shame and embarrassment. Last, these processes may also be related to self-stigmatizing behaviors, where reluctance to initiate seeking help or vocalizing a need for help may occur. Similarly, studies point to increased use of friends as supports rather than seeking professional help (Lytle et al., 2017; McDermott et al., 2018).

Pertinent to the processes for LGBTQ+ individuals considering seeking mental health services is the process of disclosure. One way that disclosure has been discussed for LGBTQ+ individuals is the disclosure process model (DPM; Chaudoir & Fisher; 2010). The DPM is a two-tier process in which individuals with a stigmatized identity undergo a decision-making process (e.g., deciding to disclose their stigmatized identity) and an outcomes process (e.g., reactions of the person disclosed to) that predicts likelihood of disclosing their identity in the future. Specifically, the goals and content of the disclosure, in tandem with the outcomes of the disclosure, will result in harm or benefits. In other words, hiding one's sexual identity could deter public stigma and discrimination; however, individuals are still cognizant of and may anticipate the rejection, exclusion, and contempt from the general public. This is similar to the process of seeking help, as individuals may be able to conceal or avoid services as a means of avoiding public stigma; however, this does not mean that they are unaffected by it and may still experience self-stigma. This is particularly salient for LGBTQ+ individuals seeking mental health services, as their disclosure needs can stem from a mental health need, their identity, or, more likely, the interaction of both. Therefore, it may be useful for the mental health professional to facilitate any disclosure through a reflection of an approach goal, or a disclosure initiated with the intent of achieving a positive result (e.g., disclosing one's sexual identity in order to receive more accurate care). For example, a mental health provider can respond to a client's disclosure of identity by reflecting how that identity intersects with the client's concerns by exploring cultural resilience (discussed later in this chapter). Medical professionals can also facilitate similar conversations by using a patient's self-disclosure to assess for medical needs of the patient, such as transgender patients' possible interest in gender confirmation surgery or hormone therapy. Affirming the LGBTQ+ client/patient's desire to disclose their identity is a simple modification any medical or mental health provider can commit to that can have lasting positive implications on those who seek these services.

Expanding Focus of Mental Health Stigma Research and Practice

The work noted above sheds some important light on the role that different stigmas may play in the mental health and help seeking of LGBTQ+ individuals, but additional work is needed. In particular, differences between LGBTQ+ groups need further exploration. For example, mental health stigma researchers have largely focused on monosexuality (i.e., focusing on gay men and lesbian women) and ignored other groups such as asexual communities or those with sexual attraction to more than one gender. For example, bisexual individuals are stigmatized even within the LGBTQ+ community, implicating different mechanisms for which they endure internalization of this stigma, as well as the possibility of different psychological and help-seeking outcomes. According to research, not only do bisexual individuals experience higher rates of suicidal thoughts and attempts than gays/lesbians (Avery et al., 2001), but they also experience a greater difficulty developing their identity due to discrimination from gays/lesbians as well as from straight individuals (Bradford, 2004). Furthermore, bisexual women experiencing suicidal ideation are significantly less likely to seek help than lesbian women (Lytle et al., 2018). This indicates the importance of focusing on similarities and differences between monosexual queer individuals and bisexual/pansexual individuals in their experience and internalization of stigma. Doing so may benefit these populations and can lead to a stronger theoretical foundation to build clinical interventions.

Similarly, the transgender/gender non-conforming community has been largely ignored by mental health researchers. Yet, as many as 31% of transgender individuals experience suicidal thoughts and attempts, with higher rates of poverty and unemployment than their cisgender peers (Avery et al., 2001). Furthermore, transgender people of color are at the greatest risk for being the subject of anti-LGBTQ+ hate crimes, with racial and ethnic minorities experiencing the majority of anti-LGBTQ+ violence (Whitfield et al., 2014). Furthermore, a study done in 2020 indicated that not much has changed in recent years in regard to increased awareness of transgender mental health issues; transgender individuals are still at greater risk for multiple types of health problems, chronic stress, and mental health issues, largely related to minority stress, poor access to healthcare services, and incompetent providers (Mori et al., 2020). Therefore, by including transgender people only as an extension of minoritized sexuality, transgender people may not receive necessary representation in research, clinical implications, or health policies (Abramovich & Cleverley, 2018).

Transgender activism has significantly impacted the manner in which science views and defines transgender identity. There now exists comprehensive transgender physical and mental health care that stems from transgender-focused research (Cicero et al., 2019). Additionally, inaccurate terminology or overgeneralizations within the transgender community can lead to interpersonal conflicts between healthcare providers and transgender patients (White & Fontenot, 2019). Transgender-focused research may thus be more helpful if additional gender or sexuality is also being specified. For instance, a transgender woman can be bisexual, asexual, gay, straight. Additionally, transgender men and women will have different healthcare needs, and these needs can also be impacted by their sexualities. This is particularly true for mental health care providers, as transgender individuals face unique forms of stigma from the larger society, and even the LGB society, as a result of transphobia. Thus, it is imperative to expand this focus in future work.

Models of Intersectionality

There is a need for research and practice to recognize that different people experience discrimination differently due to their unique set of interlocking identities that elicit societal privilege or disadvantage (Cole, 2009). LGBTQ+ individuals are an oppressed social group; however, the impact of this oppression may be different for some members than for others. For example, White/European American LGBTQ+ individuals still benefit from the hegemonic culture that privileges Whiteness, which does not eradicate the homophobia and heterosexism they may encounter, though it allots privilege and resources that other LGBTQ+ members do not have to manage this discrimination. In terms of stigma, it is important to attune to the unique concerns of these identities that create or maintain stigmatic barriers. For example, as discussed earlier, internalized public stigma may elicit more stigma of mental illness among members of the LGBTQ+ community, while at the same time men are also more likely to hold stigmatic beliefs about mental illness due to gender stereotyping (Moss-Racusin & Miller 2016). Therefore, the unique impact of both of these processes within one individual is fundamental in fully understanding the development and impact of mental illness stigma.

Researchers have long debated about the best practices in intersectional research methodology due to the complex nature of this construct (Bauer, 2014). One such method posits an additive approach, such that multiple demographics are incrementally added to a model to determine the unique and overall explanatory power of different identities (Rouhani, 2014). For example, when examining the likelihood of seeking professional help, we can delineate the unique impacts of gender, sexuality, age, ethnicity, and citizenship status, as well as the overall impact. While easy to conceptualize and apply, this approach is limited by the capacity to which identities influence one another, particularly in regard to privilege of social capital. The other view posits a multiplicative approach, such that identities are examined for possible two-way and three-way interaction effects in addition to the format of the additive approach (Rouhani, 2014). Using the same example above, we can see how gender interacts with sexuality and citizenship status to predict seeking professional help. This approach fulfills the theoretical framework of intersectionality, such that identities do not exist independently. There are areas of strength and limitations in understanding the role of intersectionality within the LGBTQ+ population.

Specifically, we offer short reviews of three identities most commonly examined within the mental health literature focused on the LGBTQ+ population, though we acknowledge this is not an exhaustive list and more identities can of course intersect with LGBTQ+ identity.

Gender. Previous studies have linked gender with mental health stigma, such that women are more likely to admit mental health needs and are more likely to seek help, whereas men are less likely to seek help until their concerns have significantly grown (Vogel & Heath, 2016). These findings lead us to consider the role of societal gendered expectations, where women admitting mental health needs is seen as acceptable, and adherence to traditional masculine norms influence men to consider communicating mental health needs as a form of weakness (Berger et al., 2013). However, including an LGBTQ+ lens complicates our understanding of mental illness stigma. In one study (Vogel et al., 2011), an analysis of a community sample of men composed of varying ethnic and sexual identities revealed a link between masculinity and stigma, and stigma and attitudes toward counseling. Whereas a significant relationship between these variables exists for straight men, there is no significant relationship between masculinity and attitudes toward counseling among gay men (Vogel et al., 2011).

Race/Ethnicity. There is a large amount of research accounting for the experiences of those who are a member of the LGBTQ+ population and also a person of color (LGBTQ-PoC). Research has largely used the minority stress model (Meyer, 2003) as a theoretical framework and the multiplicative approach to demonstrate how the interlocking identities of sexuality and race/ethnicity impact well-being (Bostwick et al., 2014b; Ghabrial, 2017; Schmitz et al., 2020). Researchers have examined the unique stressors in the form of messages about sexuality that come from one’s cultural background, as well as racial/ethnic discrimination from within the LGBTQ+ population (Balsam et al., 2011). For example, Ghabrial (2017) conducted a qualitative study that delineated the compounding stressors that interact between one’s sexual and ethnic identities. Specifically, the stress of “coming out” or disclosing one’s LGBTQ+ identity was found to significantly affect LGBTQ-PoC individuals’ mental health, when doing so was in opposition to the strict messages held in one’s ethnic group. Qualitative reports also indicate that LGBTQ-PoC are highly likely to experience some form of discrimination (e.g., due to age, ethnicity, or sexuality) when seeking mental health treatment (Holley et al., 2016). Similarly, quantitative research has shown the impact of experiences of racism and LGBTQ-based discrimination on mental health and suicidality (e.g., Sutter & Perrin, 2016).

However, our current models of minority stress and conceptualizations of risk and resilience may still not accurately account for the marginalization that LGBTQ-PoC experience, nor can one model account for the experiences of all LGBTQ-PoC (Cyrus, 2017). As LGBTQ-PoC have multiple minority identities, it would stand to reason that these individuals have more stressors that impact physical and psychological health. Thus, understanding the intersectional mental health stigma among LGBTQ-PoC is important in reducing the psychological distress this community endures. In particular, it is important to focus on ethnic values and customs, as they may interact with queer identity. Therefore, it may not be one's race or ethnic identity that conflicts with one's sexuality, but rather norms and messages from domains associated with one's ethnic background that conflict with queer identity. For example, a quantitative analysis of LGBTQ+ Latinx young adults revealed a conflict between ethnic and queer identity, specifically when participants held religious ties to their ethnic identity (Schmitz et al., 2020). This same sample also reported strict gender norms that conflicted with their queer identities, also stemming from their ethnic backgrounds, that created hostility between the LGBTQ+ person and their family and community. Furthermore, messages about seeking psychological help are often stigmatized in Latinx populations (Benuto et al., 2019), exemplifying the difficulties in this population navigating structural and cultural stigmata. However, increasing individual health autonomy among LGBTQ+ Latinx is associated with resisting cultural stigma, leading to an increased likelihood of seeking professional help (Schmitz et al., 2020). This posits that intervention strategies could be used to facilitate LGBTQ-PoC self-education, increase health promotion, and challenge negative stigma associated with seeking help.

Similarly, LGBTQ men of color have been observed to be more likely to engage in substance misuse, less likely to utilize professional services, and more likely to have a substance-use disorder (English, et al., 2018). Interlocking oppressions such as racism and heterosexism have been associated with increased mental illness among LGBTQ men of color (Bostwick et al., 2014b). Specifically, these negative experiences seem to be associated with increased emotion regulation difficulties, which lead to substance use as a coping mechanism (English et al., 2018). Additionally, as previously discussed in this chapter, men with greater adherence to masculine norms are more likely to self-stigmatize seeking professional help, as doing so contradicts traditional masculine values such as autonomy and strength (Vogel et al., 2011). It has also been observed that gay and bisexual men experience a normalization process of using substances (Lea et al., 2014). Therefore, it may be that ethnicity, masculinity, and sexual orientation are interacting to result in these health disparities and barriers for LGBTQ+ men of color accessing care.

Religion

Due to a complicated history with the Abrahamic religions (e.g., Christianity, Catholicism, and Islam), it is beneficial to include a section on religious intersectionality. Teachings of the Abrahamic religions have historically condemned "homosexuality" as something that is "sinful." For decades, Christian and Catholic activists such as Anita Bryant and Steven Anderson have demonized the LGBTQ+ community in the name of their religious faith (Bourn, 2016). Large organizations aimed at practicing what is known as "conversion therapy" were founded and devoted themselves to changing LGB individuals into heterosexuals (Bourn, 2016). This labeling of homosexuality as a mental illness by large religious organizations in an effort to “treat” LGB individuals has undoubtedly both increased stigma toward other actual forms of mental illness in religious communities and increased general stigma toward LGBTQ+ individuals. Even in recent years, researchers have found a strong relationship between one’s level of religious fundamentalism and negative perceptions of LGBTQ+ individuals (Rouse, 2020; Willoughby et al., 2006; Worthen, 2012, 2014). Yet, despite this ongoing prejudice, the effects that this stigmatization has on LGBTQ+ individuals is often overlooked by researchers and practitioners.

Some research has indicated that LGBTQ+ individuals raised in a religious home report more suicidal thoughts and attempts than heterosexual cisgender individuals who were also raised in a religious environment (Gibbs & Goldbach, 2015). Similarly, having parents who are more fundamentally religious is associated with increased depression, alcohol use, and substance use among LGBTQ+ individuals (Gibbs & Goldbach, 2015; King et al., 2008). Yet, researchers have only recently started to directly examine how stigmatization of LGBTQ+ individuals due to religious beliefs interplays with mental health stigma in the LGBTQ+ community. One such study revealed that higher levels of parental religiosity was associated with increased experiences of depression and substance misuse among LGBTQ+ individuals, due to a full mediating effect of familial stigma of sexuality (Macbeth et al., 2021). This suggests that religiosity can increase the levels of stigmatization in the home, thereby affecting the mental health and substance use patterns of LGBTQ+ individuals.

Religiosity may also play a role in self-stigma. Outside of the home, an LGBTQ+ individual’s relationship with religion in highly personalized. LGBTQ+ Muslim individuals have reported difficulty reconciling the teachings of their faith with their sexual identities (Siraj, 2012). Similarly, LGBTQ+ Christian individuals acknowledge the anti-gay rhetoric that is prominent in their faith, but feel that their relationship with God is most important and are oftentimes able to reconcile this dissonance for themselves over time (Sumerau, 2017). This indicates that there is a possibility of reconciliation with the faith; however, this does not negate the societal stigma that creates unsafe environments for LGBTQ+ individuals. The effects of religious stigma on LGBTQ+ individuals are simultaneously systemic, interpersonal, and individual. Therefore, the impact of religion on LGBTQ+ individuals’ life experience must be acknowledged and addressed.

Further, the pervasive nature of the structural stigma presented toward LGBTQ+ individuals undoubtedly has an effect on mental health stigmatization. For centuries religious institutions have labeled mental illness as either “sinful” in nature or a result of sinful actions taken by the individuals experiencing mental health concerns (Arboleda-Flórez & Stuart, 2012). This coincides with previous discussion of conversion therapy as an effort to reduce the "mental illness" of identifying as LGBTQ+ and reveals a deeper consistency within religious communities of labeling mental illnesses as inherently "sinful." LGBTQ+ individuals, who already experience mental health concerns at a higher rate than the general population (SAMHSA, 2019), are at the crux of this intersection. For LGBTQ+ individuals in religious communities, not only are their identities seen as mental health problems, but also mental health problems themselves are considered to be the fault of the individual's own religious shortcomings. As such, it is important to acknowledge the ways in which this structural, multi-level stigmatization impacts the mental health of LGBTQ+ individuals, as well as the ways in which this community seeks out mental health services.

Clinical Implications

There are a number of clinical implications to facilitate stigma reduction and quality of care. Past research has posited that increasing health autonomy is a promising method of managing stigma associated with mental health and help seeking (Schmitz et al., 2020). Relatedly, a qualitative investigation of techniques specifically for LGBTQ+ individuals supports empirically supported treatments such as cognitive behavioral therapy that utilize a minority-stress theoretical foundation (Pachankis, 2014). Specifically, Pachankis provides an overview for the specific techniques of consciousness raising, self-affirmation, emotional awareness and acceptance, restructuring of minority stress cognitions, and decreasing avoidance.

Research has also supported the use of stigma resistance strategies, or the adaptive mechanisms to manage the effects of stigma, in reducing stigma and, in particular, reducing self-stigmatization. Specifically, the process of stigma resistance has been used to describe the manners in which individuals with a stigmatized identity, and who are conscious of that stigma, reduce the negative impacts of stigma (Figueroa & Zoccola, 2015). For example, although stigma consciousness has been robustly linked to poor mental and physical health outcomes, particularly mediated by expectations of stigma (Link et al., 2015), psychological hardiness (e.g., intrapersonal characteristic encompassing higher perceived control and readiness for challenge) has been found to mediate the impact of stigma consciousness. Specifically, those with higher psychological hardiness and higher stigma consciousness were less likely to be affected by said stigma (Figueroa & Zoccola, 2015). Clinical implications of this work may extend to focusing on reactions to stigma, with a specific endeavor of bolstering the psychological hardiness by way of increasing internal locus of control, creating positive meaning from stressful events, and adhering to a growth mindset, as means of increasing stigma distress tolerance.

Another important construct to include in LGBTQ+ work and addressing stigma is the role of the nuclear family. Rejection of LGBTQ+ identity has been found to be a common experience and has strong associations with psychological and health outcomes among LGBTQ+ young adults (Ryan et al., 2009). Maladaptive family dynamics are also associated with emotional distress and suicidality among LGBTQ suicide attempt survivors (Klein & Golub, 2016; Williams et al., 2018). Therefore, this implicates an understanding of the internalized messages from the family regarding LGBTQ+ identity and self-concept. It is important that practitioners and clinicians alike understand the integral role that familial stigma plays in the development of identity and mental health concerns in LGBTQ+ individuals in order to provide well-informed treatment.

A key implication for practitioners is the reports that LGBTQ+ individuals experience discrimination and stigmatization when seeking professional help from medical (Goldberg et al., 2019) and mental health professionals (Johnson & Rogers, 2020). Furthermore, miscommunication has been found to be a hinderance to providing services, and the failure to address miscommunication or react negatively can lead to more harm than service (Rachman & Adityo, 2018). These experiences are likely to lead to expectations of more discrimination in the future, and thus highlight the importance of developing culturally attuned and knowledgeable counselors and health providers. Therefore, as means of counteracting stigma and to ensure proper quality of care, there is a need to engage in continuous cultural sensitivity trainings (Williams, 2018). While the concepts of cultural competence and enhanced cultural literacy are helpful, it may be impossible to be educated for all of the unique identities that may present themselves in clients. Therefore, it is important to address conflict in the therapeutic relationship through a person-centered format, highlighting that silence after such a transgression only exacerbates the harm dealt (Rachman & Adityo, 2018). This is particularly salient among LGBTQ+ clients, as shame is a particularly important moderator of the working alliance in LGBTQ+ work (Longhofer, 2013), and unattended induced shame could lead to further stigma.

Including LGBTQ+ identity into practice is another possible intervention to reduce stigma. For example, scholars have asserted that including transgender representation in staff, advertisements, and outreach will assist in mitigating transgender-related structural stigma (Stotzer et al., 2013). In addition, there is a growing amount of research being published about transgender psychological health by transgender psychologists. A basic introduction into this work is advocating for and using terminology to describe trans identity, as well as participating in self-education to become more trans inclusive in research and practice. Abramovich and Cleverley (2018) outline and present a review of various resources to engage in trans-affirmative research and practice. Relatedly, researchers have also implicated the importance of including LGBTQ+ identity in connecting with LGBTQ+ suicide attempt survivors. Specifically, Williams and colleagues (2018) indicated that including a mechanism of peer support alongside psychological treatment facilitates coping skills and protective factors due to the role of relating to another person with shared minoritized experiences (e.g., LGBTQ+ and suicide attempt survivor). This research aligns with the premises of larger outreach and crises services (e.g., Trevor Project and Trans Lifetime; Williams et al., 2018).

Summary and Conclusions

Undoing the stigma toward this community is slow work; however, work can start today. Affirming each client's and patient's identities is essential not only to combat the stigma associated with seeking professional help, but also to increase the quality of care. Additionally, increasing queer visibility in materials intended to boost health literacy (e.g., brochures, posters, social media), in personnel and staff, and in identity-specific care (e.g., "trans-affirmative healthcare," or a therapy group for people who identify as bisexual) assists in undoing the prevalent public stigma toward LGBTQ+ community members seeking professional help.

Ultimately, healing the ruptures in this community put in place by decades of discrimination and forced hardship is going to be a long and difficult process. The stigmatization of LGBTQ+ individuals lies deep in the heart of systemic oppression and has been fortified year after year through willful ignorance and active intolerance. LGBTQ+ children are still being forced out of their homes for living authentically due to religious beliefs systems. LGBTQ+ individuals of color experience more stigmatization, discrimination, and prejudice than either individual identity alone due to a system built on oppressing both LGBTQ+ individuals and people of color. Therefore, it is no surprise that LGBTQ+ individuals feel wary when seeking out physical and mental health care, even when in dire need. It is the duty of all physical and mental health professionals to acknowledge the historical basis for this stigmatization and take action in healing the ruptures it has undoubtedly caused – only then will LGBTQ+ individuals feel comfortable seeking out the healthcare they need and deserve.

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13 Unpacking Cultural Influences on Stigma of People with Mental Illness between Group-Oriented and Individual-Oriented Cultures

Ben C. L. Yu & Winnie W. S. Mak

Stigma toward mental illness is a worldwide phenomenon that cuts across cultures and geographic boundaries (e.g., Seeman et al., 2016; Thornicroft et al., 2009). Over the years, much of the effort in cross-cultural stigma research has been focused on examining the possible differences and similarities in the experiences of stigma and discrimination toward mental illness across countries. For example, the Stigma in Global Context – Mental Health Study (SGC-MHS), spanning 16 countries with 19,508 participants, found that people across countries expressed strong preferences for social distancing from people with schizophrenia and depression, and tended to rate these people as unpredictable, violent, and not suitable for taking care of children (Pescosolido et al., 2013). Thornicroft and colleagues (2009) interviewed 732 individuals with schizophrenia across 27 countries and found that a substantial proportion of them experienced discrimination in making or keeping friends (47%), within their family (43%), and in finding or keeping a job (29%). A high proportion of the participants reported anticipated discrimination related to work and education (64%) and concealment of their diagnosis (72%).

In another world survey on mental illness stigma (Seeman et al., 2016), involving 591,712 respondents from 229 countries, more respondents (15%–16%) from developing countries (Algeria, Mexico, Morocco, China) regarded people with mental illness as being violent, compared with those (7%–8%) from developed countries (e.g., United States, Canada, Australia). Close to half (45%–51%) of the respondents from developed countries also believed that mental illness is similar to physical illness; in contrast, only 12% to 15% of the respondents from developing countries held this belief (Seeman et al., 2016). In another cross-national study of 1,080 participants with a diagnosis of major depressive disorder across 34 countries, experienced and anticipated discrimination toward depression was found to be highest among participants living in countries with a very high human development index (a summary measure produced by the United Nations that taps into the average achievement of a country in terms of life expectancy, schooling, and income;

United Nations Development Programme, 2010) compared with those countries with a high to medium/low human development index (Lasalvia et al., 2015).

These large-scale surveys all pointed to the universality of stigma experience across the world. Despite being a universal phenomenon, its manifestations and experiences often vary cross-culturally (Murthy, 2002). As such, in addition to the descriptive etic studies (i.e., cross-cultural comparisons; Pescosolido et al., 2013; Seeman et al., 2016; Thornicroft et al., 2009), researchers have attempted to explain the observed cultural differences by applying different cultural value orientations and contextual factors into their investigation using more emic (within cultural) conceptualization and design (e.g., Chen et al., 2020; Krendl & Pescosolido, 2020). The application of both etic and emic approaches enables researchers and practitioners to better understand the phenomenon of stigma across cultures by capturing universal patterns and culturally specific experiences of stigmatization, both of which are important to consider in devising anti-stigma programs and campaigns across cultures.

To consolidate these study findings and explain the cultural differences observed in past studies, this chapter summarizes findings on the differences in stigma between East Asia regions/countries (i.e., China, Hong Kong, Korea, Japan) with countries in Western Europe (i.e., United Kingdom, Germany), North America (i.e., United States, Canada), and Australia. This contrast is chosen because these East Asian cultures share geographical proximity and cultural similarity in their emphasis of group harmony and interdependence, whereas these Western countries value independence and autonomy (Hofstede, 1984). For the sake of discussion, we referred to these East Asian cultures as group-oriented cultures and these Western countries as individual-oriented cultures, similar to how Shin and colleagues (2013) characterized them. It is important to note here that this chapter largely focuses on the syntheses of findings from a more etic perspective concerning the differences in stigma between people with different cultural practices across regions. Heterogeneity within a culture or a country, although important, may not be discussed in detail because that falls mostly outside the purview of this chapter.

In the first section of this chapter, we summarize findings on differences in public stigma (i.e., the derogatory stereotypes, prejudice, and discriminatory behaviors that the public holds toward people with mental illness; Rüsch et al., 2005) across three groups of individuals who are (1) living in different countries that are group-oriented or individual-oriented, (2) living in the same country but belong to different racial/ethnic groups that value group-based or individual-based cultural practices, and (3) having immigrated from a country that values group-based cultural practices to a country that espouses individual-based cultural practices with varying levels of acculturation. Specifically, evidence from the first group provided information about differences between countries that have broadly distinct cultural characteristics. The observed cultural difference, however, could be a result of societal factors (e.g., social policies, mental health services system, economic resources) and cultural values.

Evidence from the second group can potentially rule out the effect of societal factors since both groups are living in the same countries, and the overall societal factors may be relatively similar despite local differences. As such, the observed difference may be more attributable to their cultural values or practices. The third group provides evidence on changes in levels of stigma as a result of acculturation or varying levels of influences from two cultures.

In the second section, we discuss three possible factors that might contribute to cultural differences, including supernatural beliefs, face concern, and conformity to or maintenance of group cohesion, that had been frequently mentioned in reviews on stigma in Asian countries (e.g., Abdullah & Brown, 2011; Lauber & Rössler, 2007; Ng, 1997; Yang et al., 2007) and had relatively more empirical evidence and theoretical relevance supporting their application in understanding differences among cultures. In the final section, we discuss the possible role of culture in the internalization of stigma. We discussed how collectivistic-individualistic cultural characteristics might affect the internalization of public stigma as self-stigma, which occurs when people with mental illness hold derogatory perceptions toward themselves (Brohan et al., 2010) and the investigation of affiliate stigma (self-stigma of close associates) and self-stigma in group-oriented cultures that are paid relatively less attention in individual-oriented cultures.

Group-Oriented Cultures versus Individual-Oriented Cultures on Levels of Stigma

Accumulative evidence, from both quantitative and qualitative studies, has converged and points to a phenomenon that people in group-oriented cultures tend to be more stigmatizing against people with mental illness than those in individual-oriented cultures in general, although some exceptions were observed. Furnham and Murao (1999) compared stigma toward people with schizophrenia between people in the United Kingdom and Japan in five domains, including perceived right to be treated with respect, dangerousness, perceived chance to have abnormal behaviors, perceived normality, and chance to be cured. Results showed that, compared to people in Japan, people in the United Kingdom tended to believe that people with schizophrenia have the right to be treated with respect and were less likely to believe that people with schizophrenia are more dangerous. People in the United Kingdom, however, did believe that people with schizophrenia would be more likely to act abnormally than did people in Japan. The two groups showed no differences in the remaining two aspects (i.e., perceived normality and chance to be cured).

Subsequent research comparing college students in the United Kingdom and Hong Kong on their views toward people with schizophrenia found that students in Hong Kong perceived people with schizophrenia as more dangerous and as more likely to act abnormally in public than did British students (Furnham & Chan, 2004). Hong Kong students were also less likely to agree that people with schizophrenia were a part of the society and should be respected and treated equally. Consistent results were also found in a web-based survey comparing levels of stigma between physicians and the general population in Japan and the United States (Richards et al., 2014). Compared to people in the United States, people in Japan kept a greater level of social distance from people with schizophrenia and expressed greater skepticism over the benefits of treatment for people with schizophrenia. However, physicians in the two countries did not show significant differences in stigmatizing attitudes, though both groups of physicians had greater levels of stigma than their respective general populations. It is worthy to highlight that although the U.S. general population was more willing to engage with people with schizophrenia than were their Japanese counterparts, they were more likely to underestimate the abilities of people with schizophrenia than were Japanese respondents (Richards et al., 2014). Findings also suggest that within the same culture, because physicians may have direct experience with people with a mental illness during their most acute phase of illness, their levels of stigma may be exacerbated by their circumstantial experience with the already stigmatized group of people with mental illness.

Apart from survey studies, vignette-based studies have been employed to examine the cross-cultural differences in stigma. Griffiths and colleagues (2006) conducted a study with vignettes designed to compare the difference between people in Australia and Japan on their levels of stigma toward people with major depressive disorder (MDD) with and without suicidal thoughts and early or chronic schizophrenia spectrum disorder. Results showed that in both cultures, people endorsed less public stigma toward MDD than schizophrenia; however, people in Japan were more likely to agree that all four types of disorders are a sign of personal weakness than their Australia counterparts. They were also less willing to employ individuals with these disorders, to vote for a politician with these disorders, and to have close interactions with people with these disorders than were people in Australia. People in Japan also had stronger agreement with the statement that people with schizophrenia spectrum disorder are dangerous than those in Australia.

On the other hand, the reverse pattern was present for suicidal thoughts. Specifically, people in Japan were less likely to agree that other people in their society would perceive people with MDD and suicidal thoughts as dangerous. People in Japan were also less likely to believe that others in their society were less willing to employ people with this disorder, compared to the beliefs of people in Australia. Although the reason for the discrepancy was not explicated by the authors, this finding might be a manifestation of group-based cultural characteristics in which people in Japan are more likely to preserve group reputation of their society and, therefore, perceived their societal members as less stigmatizing.

Cross-cultural investigations on public stigma have also been extended to employers. Corrigan and his colleagues (2008) conducted a qualitative study investigating and comparing employers' attitudes toward five groups of people with stigmatizing conditions (i.e., people living with mental disorder, alcohol dependence, drug dependence, chronic health problem, and HIV) in Chicago, USA, Beijing, China, and Hong Kong. Among these locations, Chicago was deemed the most individual-oriented, whereas Beijing was considered the most group-oriented, with Hong Kong falling in between, given its colonial British background and current status as a special administrative region of China. Consistent with the findings in the general populations between group-oriented and individual-oriented cultures, 13 out of 30 employers in Beijing indicated that they would not hire people with mental illness, compared with 3 out of 40 employers in Chicago and 3 out of 30 employers in Hong Kong endorsing not hiring of people with mental illness.

In another study, consistent results were found on the views of employers toward these groups of people with disabilities in Beijing, Hong Kong, and Chicago (Corrigan et al., 2010). Specifically, compared to employers in Hong Kong and Beijing, employers in Chicago expressed less worry about their own safety or idiosyncratic behaviors of people across these five disadvantaged groups that might upset other employees. Chicago employers also showed greater recognition over the values of the potential employees in these disadvantaged groups, including people with mental illness. These findings together implied that people with mental illness in group-oriented cultures might face greater difficulties in their workplace than those in individual-oriented cultures.

Group-Oriented and Individual-Oriented Populations within the Same Country

In this section, we move on to discuss possible differences in stigma among people who are ethnically different but living in the same country. Broadly speaking, findings in this section may be more attributable to the effects of cultural practices and values because societal factors, such as sociopolitical and economic systems, are expected to be similar in the same country, although we acknowledge heterogeneity within the same ethnic group and across different regions of a country. Whaley (1997) compared community samples of American Indians, Asian Americans and Pacific Islanders, African Americans, Hispanic Americans, and European Americans living in the United States, and found that compared to European Americans, other racial/ethnic groups reported higher levels of perceived dangerousness in people with mental illness, after accounting for previous contact experience. The author also found that earlier contact experience with people with mental illness was not associated with perceived dangerousness among African Americans. Consistent with this study, a more recent survey study showed that Asian Canadians endorsed higher levels of negative stereotypical thoughts, affective responses, behavioral intentions, and social distance against people with depression than did European Canadians (Shamblaw et al., 2015).

In a vignette-based study, Cheng (2015) found that Asian Americans had greater levels of social distance, blame, and anger toward people with depression than European Americans. Asian Americans were also less willing to hire or rent a house to people with depression than European Americans (Cheng, 2015). Georg Hsu and colleagues (2008) also found generally similar results in their vignette-based study comparing the views of Chinese Americans and European Americans on different types of mental disorders (i.e., MDD, MDD with somatic features, and MDD with psychotic features) and physical disorders (i.e., diabetes mellitus). They found that not only did Chinese Americans show significantly greater levels of public stigma toward mental disorders, they also had greater levels of public stigma toward physical health conditions than European Americans. However, they also found that Chinese Americans stigmatized MDD with somatic features less than MDD, whereas the exact reverse pattern was observed in European Americans. The authors explained the findings by indicating that somatic complaints are more acceptable to Chinese Americans than depressive symptoms. This pattern of distress was reported in other studies with Chinese and Chinese Americans (Mak & Chen 2010), suggesting that Chinese and Chinese Americans might adopt a more holistic view of their mind and body and experience a heightened somatosensory response to distress (Mak et al., 2012), and that this might mitigate some perceptions of stigma.

Apart from explicit stigmatizing perceptions, one study by Cheon and Chiao (2012) also examined cultural difference in implicit attitudes toward people with mental illness. Implicit stigma refers to stigmatizing attitudes that exist without conscious knowledge of the respondents (Stier & Hinshaw, 2007). Consistent with findings using explicit measures, Asian Americans showed stronger implicit stigma than European Americans; however, the two ethnic groups did not differ in their implicit stigma toward physical illness (Cheon & Chiao, 2012). This finding suggested that the cultural variation in implicit stigma was only specific to mental illness. It supported the possibility that cultural characteristics can affect both explicit beliefs and automatic implicit responses of individuals toward people with mental illness (Cheon & Chiao, 2012).

Levels of Acculturation to Individual-Oriented Cultures

The evidence summarized in the previous two sections suggests that people who live in group-oriented cultures or are from cultural groups that are more group-oriented tend to express more stigma against people with mental illness than people who live in individual-oriented cultures or belong to cultural groups that are more individual-oriented. One limitation of note here is that these studies did not directly measure cultural orientation of their samples but used cultural group membership and ethnicity as proxies to these underlying cultural value differences.

This section examines whether one's level of acculturation to individual-oriented cultures may affect their levels of stigma toward mental illness. This process of change in cultural practices and values is known as acculturation and enculturation. Acculturation is defined as the extent to which people are adopting the cultural norms of the dominant or host culture, and enculturation refers to the extent to which people are retaining the norms of their heritage culture (Kim & Alamilla, 2017). The assumption of these studies using acculturation or enculturation as a proxy for endorsement of cultural values is that people who came from group-oriented cultures may endorse lower levels of stigma when they became more acculturated to the host culture that is individual-oriented. Conversely, people who are living in an individual-oriented culture but are enculturated in their group-oriented home culture might continue to endorse similar levels of stigmatizing attitudes as those people who remain in the home country.

A study comparing cultural differences between Asian Canadians and European Canadians showed that among the Asian Canadians, acculturation to the Canadian culture was associated with less public stigma in general ($r = -.26$) and lower levels of social distance ($r = .20$; greater level of the scale score indicates lower level of social distance) toward individuals with depression (Shamblaw et al., 2015). Enculturation to the Asian culture was not significantly associated with any stigma-related variables. However, the results also showed that higher adherence to Asian cultural practices (i.e., group-based value) was significantly related to higher levels of public stigma ($r = .17$) but not social distance ($r = .01$).

Mellor and colleagues (2013) conducted a different investigation of this acculturation hypothesis by comparing Chinese immigrants in Australia with Anglo Australians, Australian-born Chinese, and Taiwanese. The cultural groups included in the study presumably represented a spectrum of acculturation with Anglo Australians considered the most individual-oriented, followed by Australian-born Chinese, Chinese immigrants, and lastly Taiwanese, who are assumed to be the most group-oriented as they were living in Taiwan. Results showed that Anglo-Australians had the lowest levels of perceived dangerousness and incompetence toward people with mental illness among the four groups. Anglo-Australians also demonstrated significantly closer social distance toward people with mental illness, compared with Chinese immigrants and Taiwanese but had no significant difference with Australian-born Chinese. Australian-born Chinese also reported significantly closer social distance, lower levels of perceived incompetence, and perceived dangerousness than Chinese immigrants and Taiwanese. These findings supported the argument that if people were more acculturated to individual-oriented culture, they would have lower levels of stigma toward people with mental illness.

This conclusion was further supported by their later analyses conducted only among Australian-born Chinese and Chinese immigrants showing that greater endorsement of mainstream Australian cultural practices was significantly associated with lower levels of perceived incompetence (βs = –.14 to –.18), perceived dangerousness (βs = –.19 to –.23), and social distance (βs = –.23 to –.28) of people with mental illness (Mellor et al., 2013). Adherence to the heritage Chinese culture, however, was associated with higher levels of perceived dangerousness of people with mental illness in both groups. One interesting point to mention is that age was significantly associated with higher levels in the public stigma indicators (i.e., perceived incompetence, dangerousness, social distance, and composite score of all the three stigma indicators; *r*s = .12 to .41) among Chinese groups but not Anglo-Australians. Specifically, the older the Australian-born Chinese, Chinese immigrants, and Taiwanese were, the more stigmatizing they were. Older Chinese may have longer exposure to group-oriented cultural beliefs and practices that are less favorable toward people with mental illness or that younger adults may be more accepting of diversity as a result of exposure to different cultural values and beliefs from the Internet and social media.

Findings converged to suggest that people who live in group-oriented cultures or who are more group-oriented tend to express greater levels of stigma toward people with mental illness than people who live in individual-oriented cultures or who are more individual-oriented. That being said, heterogeneity within each culture should not be overlooked. Individuals in East Asian and Western cultures may vary in their endorsement of individualistic and collective values (Tse & Ng, 2014).

In the studies reviewed, group- or individual-based cultural orientations were not directly measured. Country of origin, race/ethnicity, and acculturation levels were used as proxies for cultural orientation, and cultural influence may be overgeneralized. Heterogeneity within country, race/ethnicity, and acculturation levels should be accounted for to tap into the fine differentiation within and across groups. Future studies are suggested to directly measure specific cultural value orientations in order to unpack the cultural differences observed. In addition, despite the overall pattern of cultural differences observed, findings varied by how stigma is measured. For instance, although social distance is a widely used stigma instrument to measure behavioral intention across cultures (Link, 1987), to account for the densely packed living environment with multiple apartments on the same floor with many high-rise buildings constituting a community in Hong Kong, Mak et al. (2014) added items to reflect these living situations to better approximate the distance that respondents prefer to have with someone having mental illness. This points to the importance of using culturally sensitive measures of stigma and to develop emic measures in addition to using etic measures across cultures (Yang et al., 2014). In this way, cultural nuances in the expression of stigma can be more finely delineated.

Mechanisms behind Differences in Stigma

In the previous section we reported on studies suggesting that people from group-oriented cultures are more likely to endorse higher levels of stigma toward people with mental illness than are people from individual-oriented cultures. The next logical step is to find out what accounts for this cultural difference. In this section, we attempt to address this question and focus on three factors, namely, supernatural beliefs, face concern, and conformity to or maintenance of group cohesion.

Supernatural Beliefs. Causal attribution of mental illness to supernatural beliefs has been commonly documented in people with an Asian background (Abdullah & Brown, 2011; Lauber & Rössler, 2007; Yang et al., 2014), and indeed throughout the world (see Mathison et al., Chapter 17, in this Handbook). In the literature, supernatural beliefs encompass a wide range of ideologies, including beliefs in the formation of mental illness as a result of punishment from a supreme existence, karma, possession by demons, and other religious reasons. In the 1980s, research showed that Chinese views on etiologies of mental illness included ancestral inheritance of misconduct, wrath of gods and ancestors, and possessions by spirits and demons (Lin & Lin, 1981; Ng, 1997).

Because supernatural beliefs often implied that mental illness is a result of bad deeds done by the individuals with mental illness (in their past life) or their family and ancestors (Wong et al., 2004), these beliefs might incur blame to people with mental illness and therefore worsen stigma. Previous research conducted among Hong Kong Chinese showed that attribution of cause of mental illness to cultural lay beliefs, which encompasses a wide range of supernatural beliefs, including *fengshui*, retribution of past deeds, possession by ghosts or spirits, and fate, was associated with lower perceived controllability ($r = -.21$), lower acceptance ($r = -.15$), higher public stigma ($r = .24$), and higher social distance ($r = .18$) from people with mental illness (Mak et al., 2014).

Despite the positive relationship between supernatural beliefs and stigma, fewer East Asians are endorsing these beliefs over time. In the 1990s, only 3% of the sample of people with mental illness and the general population surveyed in Hong Kong found supernatural influence to be the cause of psychotic symptoms of people with mental illness (Chung et al., 1997). Mak and colleagues (2014) found that among the different causal attributions, cultural lay beliefs were the least endorsed, compared with biological and psychosocial causes. No significant difference in the endorsement of superstitious beliefs as the cause of mental illness was found between Hong Kong Chinese and the British (Furnham & Chan, 2004). The findings suggested that although supernatural beliefs are associated with greater levels of stigma, it may not explain the differences in stigma observed between group-oriented and individual-oriented cultures.

Face Concern. Among various cultural lay beliefs and practices, face concern still plays a prominent role in interpersonal relationships among Chinese and other East Asian societies that are influenced by Confucian culture (Lam et al., 2010). Within face concern, Hu (1944) further differentiates it into social face (*mianzi*) and moral face (*lian*). Whereas social face refers to the prestige and reputation of an individual garnered through performance of one's social roles and achievements, moral face refers to the basic integrity of one's adherence to social standards and mores in order to be accepted by society (Mak et al., 2015). Having mental illness may pose a threat to both social and moral face, as individuals may lose their ability to perform their expected social roles, and the symptoms displayed and behaviors associated with mental illness may violate the cultural expectation of self-cultivation and filial piety (Yang et al., 2007; Yang et al., 2013).

Both social and moral face concern were found to be positively related to moral emotions (shame and guilt) and rumination, which were positively related to self-stigma and negatively related to mental health in Hong Kong Chinese with substance use problems (Mak et al., 2015). However, face concern is not only relevant to Chinese and East Asians. In a sample of European Americans, Chinese Americans, and Hong Kong Chinese, although face concern was found to be significantly stronger in Chinese Americans and Hong Kong Chinese than in European Americans, face concern was found to be positively related to public stigma toward mental illness (rs = .20 to .29) and perceived barriers to help seeking (rs = .27 to .33) among European Americans and Chinese Americans (Chen et al., 2020). Among Hong Kong Chinese, face concern was positively related to public stigma ($r = .21$) but not to perceived barriers to help seeking ($r = .09$). The study also found face concern mediated the relationship between the cultural groups and public stigma as well as between the cultural groups and perceived barriers to help seeking (Chen et al., 2020). Specifically, compared to European Americans, both Hong Kong Chinese and Chinese Americans showed greater associations between public stigma toward mental illness and perceived barriers to help seeking through greater face concern. Given face concern cuts across the entire family, research on Hong Kong Chinese caregivers of people with mental illness found face concern to be related positively to affiliate stigma, which is related to caregivers' distress and subjective burden (Mak & Cheung, 2012).

Conformity or Maintenance of Group Cohesion. Preference for group cohesion or independence is asserted to be one of the most salient features that differentiate group-oriented cultures from individual-oriented cultures. Shin and colleagues (2013) have directly investigated this phenomenon and provided supporting evidence that relative to Northern Europeans, East Asians reported less preference for uniqueness but stronger preference for behavioral conformity. The study also found that uniqueness, but not behavioral conformity, mediated the relationship between culture and stigma against people in tribal outgroups (i.e., people of different race, immigrants, foreign workers) and outgroups with "blemished character" (homosexual individuals, people with heavy drinking or drug addiction). Findings of this study supported the hypothesis that compared to people in individual-oriented cultures, the preference for conformity over uniqueness among people in group-oriented cultures might lead to greater stigma for members of social minority groups that are deemed to be different or unacceptable by the mainstream or dominant group.

In cross-cultural studies of stigma on mental illness, people in group-oriented cultures were more stigmatizing than people in individual-oriented cultures due to their preference to preserve group harmony and adhere to group norms (e.g., Papadopoulos et al., 2013). In contrast, people in individual-oriented cultures are expected to be more accepting of diversity since they are more likely to appreciate the uniqueness of every individual (Papadopoulos et al., 2013). Hence, people with mental illness might be less stigmatized in individual-oriented cultures, relative to group-oriented cultures. In a study by Shamblaw and colleagues (2015), Asian Canadians endorsed higher levels of perceived norms and familial shame than did European Canadians, and both of these constructs were associated with higher levels of stigma for and social distance from people with mental illness. Perceived norms and familial shame were found to have the largest associations with stigma-related variables when compared with social dominance orientation and conservative beliefs.

Role of Culture in the Internalization of Stigma

While the previous section has suggested some cultural factors that may contribute to differences in stigma between group-oriented and individual-oriented cultures, this section moves on to discuss how cultures may affect people to internalize stigma, or self-stigma. Self-stigma is considered to be a product of socialization in which public stigma is internalized through a process of stigma recognition, agreement, and concurrence (Corrigan et al., 2011; Link et al., 1989). It has been found to share greater association with poor mental health and help-seeking attitude than public stigma (e.g., Cavelti et al., 2012; Rüsch et al., 2019; Vally et al., 2018; Vogel et al., 2007). Given that culture can impact the socialization process, it is important to bring a cultural lens to our understanding of the internalization process from public stigma to self-stigma.

Theories. Modified labeling theory (Link et al., 1989) is one of the classic theories that attempts to explain the internalization process. The theory proposed that when the label of mental disorder is being attached to people, they will begin to associate the public's stigmatization perceptions to themselves and these stereotypes and prejudice will foster negative self-perceptions and emotional responses. Furthermore, these perceptions and emotional responses will lead to anticipated stigma that the public may reject them, thus triggering behavioral responses such as concealment, social withdrawal, or self-advocacy (Kroska & Harkness, 2008).

More recently, additional models on the self-stigma internalization process have been proposed (see Corrigan et al., 2011; see also Sheehan et al., Chapter 2, in this Handbook). In line with modified labeling theory, these theories all suggest that the awareness of public stigma is the first step leading to successive steps in the internalization process. Self-stigma might result in the reduction of self-worth, which may further hamper people's recovery and quality of life (Corrigan et al., 2011, 2019; Göpfert et al., 2019; Mak et al., 2017; Watson et al., 2007; Yu et al., 2021).

Role of Collectivism. Given public stigma is a tipping factor that may bring forth self-stigma, understanding the cultural factors that can exacerbate or attenuate the internalization process might provide insights into how to reduce the impact of stigma on people with mental illness, given that stigma experience is contextualized. Among the cultural factors, conformity to group norms could be a contributory factor leading to differences in public stigma between group-and individual-oriented cultures. The same rationale can be applied to understand differences in the stigma internalization process across cultures. Specifically, because people who are more group-oriented are more susceptible to group norms and have stronger face concern than their individual-oriented counterparts (Mak et al., 2009; Shin et al., 2013), they might view the public's negative perceptions as a blow to their own and their family's social reputation, which could exacerbate their self-stigma (Mak et al., 2015).

Although research that investigated the role of culture on the internalization process has only recently been examined, a recent meta-analytic study has brought a preliminary investigation into this question (Yu et al., 2021). The study employed meta-analytic structural equation modeling to examine the internalization model of stigma and how the model is associated with various aspects of recovery of people with mental illness. Specific to the purpose of the present chapter, the study also investigated how collectivism might moderate the relationships between experienced stigma or perceived stigma and self-stigma.

In the meta-analytic study (Yu et al., 2021), collectivism was coded based on the practice score for societal ingroup collectivism from the Global Leadership and Organizational Behavior Effectiveness (GLOBE) research project (House et al., 2004). GLOBE was developed based on items focusing on cultural practices that people have toward their family and close ingroups. Results of the study showed that both experienced stigma ($r = .56$) and perceived stigma ($r = .28$), both considered indicators of public stigma, were significantly correlated with self-stigma cross-culturally, which supported the universality of the internalization process across both group- and individual-oriented cultures. The results also showed that experienced stigma (i.e., felt or direct experience of stigma) was more strongly associated with self-stigma than perceived stigma (i.e., perceived stigma held by other), implying that experienced stigma contributes more to the internalization of stigma across cultures. As to the role of culture, collectivism was found to significantly moderate the correlation of experienced stigma ($B = 0.06$, $R^2 = 0.08$) and perceived stigma ($B = .11$, $R^2 = .15$) with self-stigma. Specifically, the more collectivistic a culture is, the greater the association between experienced stigma or perceived stigma and self-stigma. This provided support to the argument that people who are more group-oriented will be more likely to internalize stigma than people who are more individual-oriented.

Affiliate Stigma

Although much of the research on self-stigma has focused on the internalization process of people with mental illness, evidence showed that family members and caregivers also experience the internalization of stigma across cultures (Shi et al., 2019). Referred to as affiliate stigma with its measurement developed originally among Chinese in Hong Kong (Mak & Cheung, 2008), it is defined as the extent to which close associates of people with mental illness (e.g., family members, caregivers) have affective (e.g., feeling helpless and distressed), behavioral (e.g., minimizing contact and keeping a low profile), and cognitive (e.g., feeling inferior and incompetent) responses related to having a family member or close loved one with mental illness. Affiliate stigma was found to be positively related to psychological distress ($\beta = .34$) and subjective burden ($\beta = .67$) after controlling for the effect of face concern, and mediated the linkage between face concern and negative consequences with Chinese caregivers (Mak & Cheung, 2012). Although developed in group-oriented cultures, affiliate stigma has been investigated widely across cultures. Indeed, more research in the past decade has come from group-oriented cultures (e.g., Hong Kong, Taiwan, Japan, Sri Lanka, India, Ethiopia, Brazil); nevertheless, studies conducted in individual-oriented cultures (United States, United Kingdom) also found similar relationships between affiliate stigma with psychological distress and burden (Bassirnia et al., 2015; Greenberg et al., 1997). This suggests that the detrimental impact of affiliate stigma on caregivers of people with mental illness may be universal across different cultures.

Conclusion

In this chapter, we have discussed differences in levels of public stigma between group- and individual-oriented cultures. Generally speaking, the evidence converged and suggested that people who live in group-oriented cultures or who are more group-oriented are more likely to have higher levels of stigma toward people with mental illness than are people who live in individual-oriented cultures or who are more individual-oriented themselves. Studies using samples with varying levels of acculturation further supported this hypothesis that people with stronger affiliation with group-oriented cultures endorsed higher levels of public stigma than those who are more acculturated to individual-oriented cultures. It is worthy to note that cultures are dynamic and human behaviors are nuanced depending on context. Thus, overgeneralization based on broad cultural categorization should be avoided. Future studies should pay attention to how stigma is defined and manifested at different settings by different groups of individuals within and across cultures so that both etic and emic expressions of stigma and its consequences can be captured.

Although we attempted to explicate this cultural difference using three culturally salient factors, namely, supernatural beliefs, face concern, and conformity or maintenance of group cohesion, caution should be exercised as most of these studies are cross-sectional in nature. Research with experimental design is warranted to draw causality; longitudinal studies are needed to investigate nested changes between cultural factors and stigma over time; measures that account for cultural nuances (e.g., Collective Public Stigma Scale, Brenner et al., n.d.) should be included to unpack cultural influences on stigma in the future.

The support for cross-cultural explanation of stigma internalization was even more scarce. While a recent meta-analytic study lent support to collectivism moderating the association between experienced stigma and self-stigma (Yu et al., 2021), more research is needed to validate and replicate the results. In particular, researchers should directly measure the level of group- and individual-orientation to investigate the effect of these variables on stigma endorsement for the public and internalization of stigma among people with mental illness. Cross-cultural or emic research should also be extended to the phenomenon of affiliate stigma to investigate the cultural mechanisms that may explain the internalization of stigma among family members. In addition to individual and group orientation, other culturally salient constructs (i.e., face concern and adherence to group norms) should be taken into account simultaneously in order to test the relative contribution of different culturally salient factors in the stigma process.

Moreover, in addition to investigating the extent to which people endorse self-stigmatizing thoughts, which drive most of the research on stigma, research should also pay attention to how frequently and automatically individuals think about the self-stigmatizing thoughts, as both stigma content and process have found to affect well-being independently (Chan & Mak, 2017). Using the Self-Stigma Scale and the Self-stigmatizing Thinking's Automaticity and Repetition Scale that were both developed using an emic approach among Chinese in Hong Kong, research shows that although self-compassion moderated the relationship between self-stigma content and life satisfaction among people living with HIV, mindfulness moderated the relationship between self-stigma process and life satisfaction among people with mental illness (Yang & Mak, 2017). The differential roles of stigma content and process on well-being and their differential moderating factors point to the need to address both self-stigma content and process in future well-being enhancement and stigma-reduction efforts for people with mental illness.

The present chapter mainly synthesized findings between East Asian and Western countries. Attention should be extended to other countries that may also endorse such group versus individual cultural orientation, for instance Arabic cultures (e.g., Heath et al., 2016; Vogel et al., 2017; Zolezzi et al., 2018) and investigate other culturally salient factors that may provide etic or emic explanation to the stigma experience across and within cultures. Heterogeneity within culture and intersectionality of various cultural characteristics must also be taken into account. Despite these caveats, we hope that the synthesis and discussion here could contribute to the development of cross-cultural research of stigma in mental illness and pave the way to pay closer attention to how specific cultural characteristics may inform stigma reduction efforts in the future.

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14 All the World's a Stage

Men, Masculinity, and Mental Health Stigma

Stephen R. Wester

In her qualitative meta-ethnographical study of men's perspectives on help seeking, Hoy (2012) concluded that the "most common barrier expressed by men was social stigma – a concern over the perceived negative judgments of friends and family" (p. 202). Hoy (2012) further described how her participants' decisions to seek psychological services were most affected by the potential for stigma expressed by other men. Although Vogel and Heath (2016) later grounded their discussion of stigma and help seeking in a broader discussion of the health beliefs model, Hoy's (2012) findings are consistent with their description of how people protect their interpersonal identities as a way of coping with stigma (see also Goffman, 1963). To wit: If help seeking is indeed perceived by men as a threat to their identity, then it stands that such men would be most concerned with the reactions of other members of their social group. They would then alter their behavior, in this case avoid seeking psychological help, as a method of managing the impression had by other men.

Stigma scholars call this a process of "label avoidance" (e.g., Corrigan, 2016, p. 68), defined in this case as an individual not seeking out mental health treatment to avoid being assigned the scarlet letter associated with such an act (e.g., Corrigan, 2014, 2016). This begins what some masculinity scholars have defined as a vicious circle; because men come to expect the stigma associated with a violation of the socialized male gender role by seeking treatment for mental health concerns (e.g., DeLenardo & Terrion, 2014), they ongoingly adjust their behaviors to conform to the socialized traditional male gender role regardless of the interpersonal and/or psychological consequences (see Vogel & Heath, 2016). Essentially, the short-term goals of stigma avoidance and identity protection override the longer term (and potential more adaptive) goal of adjusting a behavior to meet the demands of a situation regardless of how well it does or does not conform with traditional masculinity. Consequently, men suffer the ongoing physical and psychological distress so clearly associated with rigid adherence to traditional masculinity (e.g., Levant & Wong, 2017; Wong & Wester, 2016).

The author thanks, in alphabetical order, Karaline Fusco, Kirsten Kjar, Charlotte Shanaver, and Kirsten Thiemke for their editorial considerations, database compilations, and narrative suggestions in support of this manuscript.

What follows is a summary of the predominant theories of masculinity, as well as an exposition of how those theories might be linked to our current understanding of mental health stigma. The next section is an overview of the empirical literature linking mental health stigma to men, masculinity, and a variety of outcomes. Finally, this chapter concludes with a discussion of the broader implications these concepts have for both mental health stigma research and the psychology of men as well as areas needing further research.

Masculinity

It is important to note that there is not a single theoretical perspective governing the psychology of men. As of this writing, scholars have not presented a "unified field theory" under which masculinity research could grow into the twenty-first century. In general, however, it is presumed that masculinity is learned within a social environment. Stigma is part of this process, as its application teaches young boys to avoid behaviors not considered adaptive or appropriate. For our discussion here the label to be avoided (e.g., Corrigan, 2014, 2016) is that of help seeker. Children are highly attuned to shaming responses levied by caregivers while at the same time being emotionally unable to cope with the stigma and rejection implied by such shame. Needing to ask for help means admitting weakness in a society that often shames those that display such a characteristic. More specifically, the behavioral patterns into which boys are socialized (e.g., stoicism, toughness, emotional restriction) makes it that much more difficult for them to identify with the shame, or with the stigmas associated with the event and/or the behaviors that produced it. As such, young boys growing into men go to great lengths to defend against the experience of shame (e.g., Krugman, 1995).

Another presumption within the extant literature is the existence of societal-based proscriptions regarding behaviors that are acceptable for men as well as behaviors that are unacceptable. Society rewards those that are acceptable and stigmatizes those that are not acceptable. These proscriptions constitute what many has been labeled by the scholarly literature as "hegemonic masculinity" (Connell & Messerschmidt, 2005, p. 829). Enactment of these standards serves as identity protection via label maintenance (e.g., Goffman, 1963), and subsequently produces acceptance by the greater society, privilege, and belongingness. Violation of these standards, conversely, produces label avoidance, both as one grows into adulthood and during that adulthood. Interestingly, although Blazina (e.g., 2001, 2004) did not directly mention stigma, he has argued that the defense against shame is the primary force behind the development of what society considers to be a masculine identity. Indeed, because of the stigma associated with violations of the traditional male role, the process through which shame might be processed, understood, and grown from (i.e., disidentification) cannot occur appropriately. As such, the more men are exposed to messages of traditional masculinity, the more likely it is that they will experience shame, depression, and other psychological consequences if they perceive themselves as existing in a manner not consistent with the stereotype (Blazina & Bartone, 2016).

Gender Role Strain

In one of the theories regarding the psychology of men, Pleck (1995) described how men are socialized to adhere to the male gender role regardless of the personal, psychological, or societal consequences. Euro-American society, for example, emphasizes independence and self-reliance, to the exclusion of collaborative efforts; toughness and aggression are prized, as are a stoic demeanor and the restriction of emotional expression. Pleck's (1995) theory of gender role strain (GRS; see also Levant & Richmond, 2016) focuses on the negative consequences experienced by an individual when they face incompatible behavioral expectations associated with their masculine role, as well as the behavioral impossibility of achieving the gender role ideal itself. Pleck concluded that masculinity, socially defined role or not, was not positive for men in contemporary society. Not only did the men suffer the consequences associated with their attempts to adhere to the socialized male gender role, but they also suffered broader consequences imposed on society by the gender role itself – typically in the form of restrictions placed upon their behavior as well as the sexist restrictions placed upon people in their lives. From this perspective, men are stigmatized at three key points in their lives – as their behavior is shaped into conforming to the male gender role, when they fail to fulfill the expectations of this gender role, and when their fulfillment of the male gender role has a negative impact on themselves and on society.

Precarious Manhood

As a more recent entry into the extant literature on the psychology of men, the theory of precarious manhood approaches the study of masculinity not by examining the specific attitudes, behaviors, or characteristics that men are socialized to display but by the nature of it as a social status (Vandello et al., 2008). Simply put, men must be granted the label of "masculine" by their society, but at the same time even once it is earned it is, in fact, fleeting – as a socially bestowed status it can be lost or taken away. As such, masculinity requires consistent and public demonstrations of proof on the part of men. For example, current masculinity is structured around an avoidance of femininity such that a traditional masculine identity can only develop if boys sufficiently disidentify with characteristics considered to be more feminine. Throughout adulthood, therefore, men are expected to demonstrate their "real" man status by eschewing femininity from their behavioral, linguistic, and emotional repertoires (Levant & Richmond,

2016) – essentially by constantly engaging in the process of label avoidance (Corrigan, 2014) lest stigma be experienced. To wit: men are manly until they are not, and there are many trials and tribulations on the path through to adulthood that can lead to social consequences including that status being taken away.

The theory of precarious manhood has interesting implications for stigma research, especially if one considers the impact of stigma from the perspectives of identity protection and label maintenance/avoidance (e.g., Goffman, 1963). Recall, please, how Hoy (2012) described the degree to which her participants' decisions to seek psychological services were most affected by the potential for stigma expressed by other men. Her work confirmed this concept of precariousness in that the potential exclusion by one's peer group matters more than exclusion in general. But, as is the case with many of the more recently developed theories surrounding masculinity, those implications have not been empirically explored. Certainly, boys are stigmatized for their violations of the socialized gender role, bullied, or called feminine if they do not, in fact, act in the way society demands. They therefore conform their behavior to the standard of traditional masculinity in order to avoid being assigned negative labels such as wimp, queer, or pansy regardless of the social and/or interpersonal consequences. Life devolves into a series of tests in which a "single feminine or unmanly act can temporarily reverse a man's gender status regardless of how many times he has proven it" (Vandello & Bosson, 2013, p. 113).

Gender Role Conflict

Gender role conflict (GRC) theory (e.g., O'Neil, 2015, see also O'Neil & Denke, 2016) considers the degree to which masculinity can often be incompatible with the behavioral demands of any given situation (e.g., see O'Neil et al., 2017). Said another way, when considering the broader impact of socialized masculinity, the study of GRC incorporates the role of specific situational demands and the degree to which they conflict with the socialized male gender role expectations (e.g., Wester, 2008; Wester & Vogel, 2012). Stigma occurs, from this perspective, when men are not able to adapt their behaviors to the nature of any given situation. Some men's learned tendency to restrict the expression of emotion, for example, may be adaptive in situations such as work, school, or interpersonal interactions requiring quick action and response (see Danforth & Wester, 2014). At the same time, however, this tendency toward emotional restriction may conflict with the situational demands associated with returning home and being emotionally available to spouses and children. Other examples include the expression of tender emotions between men – fathers and their male children is a notable case – as well as men putting their career success ahead of their interpersonal needs. When men struggle to employ an adaptive response to the disparate expectations of differing situations, GRC and the stigma associated with failure occur.

Fragile Masculine Self

The theory of a fragile masculine self (Blazina 2001, 2004) would seem quite consistent with the potential role played by stigma in the maintenance of stereotypically masculine behaviors. Sinclair and Huntsinger (2006), for example, demonstrated how members of stigmatized groups will often dramatically alter their behavioral presentation to be consistent with social expectations. More recently, Pietilä and colleagues (2016) demonstrated how men suffering from an extreme form of cancer reframed for themselves the need to seek treatment in a manner designed solely to protect their masculine self. As a more general example, consider this: men are expected to become successful and important in their lives, to be strong, independent, and in control of their own situations. Many will live up to this standard despite the significant interpersonal and intrapersonal consequences (e.g., Jampel et al., 2020), even in the face of understanding the benefits of seeking psychological help (Wester et al., 2010; see also Vogel & Wester, 2003) because to do anything less would threaten their identity.

Context and Functionality

Addis and Mahalik (2003; see also Addis & Hoffman, 2019) offer a social constructionist perspective to understand the development of masculinity. This “gendered social learning” (Addis et al., 2010, p. 78) takes an approach similar to that taken by Vandello and Bosson (2013) by moving away from understanding masculinity as a mere collection of attitudes and behaviors and instead considering the importance of a man’s environment in which he constructs his understanding of what it means to be a man. From this perspective, men do not learn a socially defined masculine role in isolation but instead learn to enact gendered repertoires of behavior to achieve particular social means and ends. There is not a singular, hegemonic masculinity under which men are socialized; rather, there are “competing masculinities that are continuously being constructed and contested” (Addis & Cohane, 2005, p. 640). Addis and his colleagues (2010) would call this a pragmatic, functional understanding of masculinity. Pragmatic refers to the need to evaluate masculine gender role socialization only in relation to how adaptive it allows men to be in the world. A functional approach, in turn, frames the consequences of masculine gender role socialization considering both the historical goals of that socialization and the contexts in which those consequences occurred.

My colleagues and I extended this functional conceptualization of masculinity by proposing that masculinity be considered as just another label society has given to a basic heuristic category (see O’Neil et al., 2017). Heuristics are mental shortcuts that increase the speed of decision making, thereby producing a solution deemed by the individual (not society) as satisfactory. The more frequently an individual utilizes a heuristic, the more likely it is to be activated. Heuristics represent a practical approach to problem solving; it is not intended to be a perfect approach, but instead can be considered a "good enough" method of meeting one's immediate goals. Because of this, one can think of the stigma associated with experiencing the psychological distress of seeking mental health services as outcomes of the competing and conflicting heuristics activated to guide men's behavior in each context. Here is an example: "Do I adhere to what I was taught about being a man and avoiding any disclosures of my weaknesses or needs, or do I seek out the help I very much need?" Answering yes to either of these questions carries significant interpersonal and psychological consequences for men (e.g., Levant & Wong, 2017; Wong & Wester, 2016), and unfortunately the stigma associated with the more adaptive response often leads men to choose the opposite, thereby continuing their experienced distress.

Summary

While there is not one unified approach to understanding the nature of masculinity and how it affects men, there are commonalities across the theories to which stigma is linked. First, for example, masculinity seems learned within a social environment. Whether this occurs through developmental, dynamic forces, or traditional social learning is being debated, but stigma is clearly part of this process. Also, the extant literature agrees on how a hegemonic masculinity (Connell & Messerschmidt, 2005) shapes the social environment so as to dictate behaviors that are either acceptable or unacceptable for men. Again we see the role of stigma; society rewards men for those behaviors that are acceptable and stigmatizes those behaviors that are unacceptable.

Research

The extant literature on stigma and masculinity can be divided into three categories. The first category contains the work examining the role played by stigma on understanding men's help-seeking behaviors (e.g., Addis & Mahalik, 2003). The second contains research examining efforts to increase help-seeking behaviors by addressing stigma. The third category of research explores the nature and experience of stigma had by men exhibiting certain diagnostic characteristics. Also, to be clear, for the purposes of this discussion, stigma has been operationalized into two components. The first, labeled social or public stigma, is more formally defined as the stigma that develops around an attitude, behavior, or characteristic when a society concludes that said attitudes, behaviors, or characteristics deserve to be excluded (e.g., Crocker et al., 1998). The second component of stigma has been labeled self-stigma, which occurs when individuals who have been excluded by the larger society because of their attitudes, behaviors, or characteristics internalize the stigma that society forces upon them (e.g., Vogel et al., 2006). Men "appear to be particularly prone to internalizing stigma as a negative self-statement about their identity" (Vogel &

Heath, 2016, p. 692). Many boys, for example, are socialized to avoid the expression of tender emotions and avoid all things considered feminine by their peer groups (e.g., Vandello & Bosson, 2013). To avoid these processes, many men strive to perform and portray to the world a masculine self regardless of the interpersonal consequences. This is the very definition of identity protection: in effect, managing the impressions others will have of their behavior to both achieve their goals while also avoiding further stigmatization.

Help Seeking

The extant literature on masculinity and help seeking most often treats stigma, either self-stigma or public-stigma, as a variable that mediates linkages between masculinity and outcomes such as help seeking. Mediation refers to the fact that there is a linear, temporal relationship in which masculinity leads to stigma which in turn leads to attitudes about and/or decisions to seek psychological help. Pederson and Vogel (2007), for example, demonstrated clear mediation when they determined that although higher levels of male gender role conflict (GRC) predicted decreased likelihood of seeking psychological help, the subsequent inclusion of self-stigma in that equation accounted for a larger portion of predictive variance than GRC alone. In essence, a linkage between greater masculinity and decreased likelihood to seek psychological help was better explained by understanding how masculinity first predicted stigma, and how that stigma worked in concert with masculinity to account for men's decreased likelihood of seeking psychological help.

This pattern has been repeated consistently in the literature (e.g., Vogel & Heath, 2016), and while it holds for masculinity as a whole (e.g., Levant et al., 2013), it has also been shown to be the strongest when those aspects of masculinity that deal with restricted emotionality or avoidance of femininity are considered. Shepherd and Rickard (2012), for example, demonstrated that stigma mediated the linkages between higher levels of gender role conflict and decreased willingness to seek help. Subsequently, Vogel and colleagues (2014) determined that greater levels of specific aspects of GRC, in this case restricted emotionality and restricted affectionate behavior between men, were predictive of greater stigma as well as a decreased willingness to seek help for one's own problems and refer friends to seek help. Similar results regarding stigma and help seeking have been demonstrated with populations as diverse as athletes (e.g., Steinfeldt et al., 2009; see also Ramaeker & Petrie, 2019), members of the armed forces (e.g., Heath, Seidman et al., 2017), law enforcement (Wester et al., 2010), and those in rural versus urban living conditions (Hammer et al., 2013).

At the same time, however, Heath and colleagues (e.g., Heath, Brenner et al., 2017) demonstrated that GRC was not associated with stigma for men experiencing high levels of psychological distress. However, for men reporting low-to-moderate psychological distress, increased GRC did indeed predict increased stigma. Vogel and his colleagues (2011; see also Hammer et al., 2013) conducted a study that involved over 4,000 men from different sexual orientations, racial identities, and ethnic backgrounds in which they confirmed that the general pattern described above held across the different groups. But they also noted key differences in the strength of those predictions based on demographic differences. For gay men, for example, self-stigma fully mediated the linkages between masculine norms and help seeking, but for heterosexual men that same self-stigma only partially mediated the linkages. Also, while both African American men and Asian American men expressed greater overall endorsement of masculine norms than European American men, that endorsement was less predictive of stigma.

It therefore seems as if the interconnectedness of masculinity, stigma, and help seeking differs across demographic groups, and even across situational demands and contextual events. Levant and colleagues (e.g., 2013), for example, were testing models of multiple mediators and moderators. They demonstrated the mediation relationship that has become quite established in the literature, while also noting that linkages between traditional masculinity and stigma were mediated by the nature of the experienced psychological disorder (e.g., depression) as well as perceived external barriers to seeking psychological help. Wester and colleagues' (2010) finding regarding law enforcement demonstrated that the linkage between masculinity and stigma was partially mediated by an awareness of the risks associated with therapy while Vogel and colleagues (2005) had previously identified outcome expectations as a variable in the equation. Heath, Brenner, and colleagues (2011) confirmed that self-compassion, defined as the ability to show oneself kindness, moderated the relationship between masculine norm adherence and self-stigma (see also Wasylkiw & Clairo, 2018). Booth and colleagues (2019) confirmed this finding; high levels of self-compassion can be a protective factor for men in that it buffers the linkages between masculinity, stigma, and seeking help, but at the same time self-coldness, defined as an extremely negative and critical view of self, increased the stigma of help seeking regardless of their endorsement of masculine norms.

Taken together, it seems that, although the extant literature supports the existence of a linear, temporal relationship in which masculinity leads to stigma which in turn leads to attitudes about and/or decision to seek psychological help, the specific nature of this linkage has yet to be fully understand. Demographic, identity, and even situational variables alter demonstrated relationships, and often in a contradictory fashion. It should also be noted that most of the published works in this area treat masculinity as a collection of attitudes and ideals, as well as subscriptions to specific behavioral rules. As of this writing, theories that consider masculinity as ether a social status or a simple heuristic have not been utilized to test the connections between stigma, masculinity, and help-seeking behaviors. What meaning does the act of seeking help have for men, for example, and how is that related to masculine self-concept? How do men choose between heuristics, such that they see help seeking in a positive or a negative light? What variables are they using to make this choice, and how do their experiences after making the choice effect subsequent decision making?

Efforts to Overcome Stigma

Any summary of the research surrounding efforts to increase men's likelihood of seeking psychological help via the amelioration of stigma must start with the foundational efforts of psychology of men scholars Sam Cochran and Fred Rabinowitz (e.g., 2000). Their efforts in the late 1990s to identify and publicize what they labeled "masked depression in men" were among the first to quantify the degree to which men's lives were significantly, negatively, impacted by the interaction of masculinity, stigma, and mental illness. Their work also set the stage for a National Institute of Mental Health campaign, *Real Men Real Depression*, that ran from 2003 to 2005 and had as its goal to both educate the public on how men experience depression and to de-stigmatize the depression that men were experiencing. Often this campaign involved stories of men in the public eye who might be labeled by society as traditional, manly men, telling their stories about their depression and how they overcame it – in essence men giving other men permission to be depressed as well as to ask for help with that depression. Given how we now understand how vulnerable men are to the stigmas associated with seeking help, especially as it might be applied by other men, the success of these techniques is understandable.

Early efforts to overcome men's stigma toward help seeking applied some of the lessons learned by the *Real Men Real Depression* campaign. In general, that work involved presenting psychotherapy in a manner consistent with the socialized male gender role. Rochlen and O'Brian (2002a), for example, evaluated two contrasting career counseling approaches and demonstrated that, although collegians holding traditional attitudes expressed higher stigma toward career counseling compared with those holding less traditional attitudes, collegiate men overall preferred a more directive approach to career counseling over a more contextual, emotionally oriented approach (see also Rochlen & O'Brian, 2002b). McKelley and Rochlen (2010) later confirmed this pattern when they demonstrated that men with higher conformity to masculine norms had higher stigma toward seeking help and viewed traditional therapy as less favorable. Indeed, Cole and colleagues (2018) showed that although masculinity, self-stigma, and help-seeking attitudes negatively predicted willingness to engage in most forms of psychotherapy, when given a choice, however, men in their study expressed a preference for a positive psychology-based masculinity therapy over other forms. Syzdek and colleagues (2016) examined a gender-based motivational interviewing (MI) program designed to increase mental health service use in college men. This program incorporated gender-specific messages within the framework of MI, and it was demonstrated to have a positive impact on attitudes toward seeking help from men's parents and mental health professionals.

However, as it turns out, the presentation of psychotherapy as an activity congruent with the socialized male gender role is not always enough to overcome the stigma associated with help seeking; empirical results are often mixed. Rochlen and colleagues (2002), for example, demonstrated that there were no differences in men’s responses to a career counseling brochure targeted toward men and one written in more general terms. Yet at the same time Hammer and Vogel (2010) demonstrated the successful use of a male-sensitive brochure addressing stigma, counseling, and help seeking for depression. Kantamneni and her colleagues (2011) went so far as to develop a video advertisement aimed at specifically countering the stigmas men might associate with counseling and psychotherapy. However, they also found no differences between that and a more general video advertisement extoling the virtues of counseling. More recently, Erentzen and colleagues (2018) found that incorporating light humor into a campaign designed to destigmatize psychotherapy helped to reframe help seeking in a less threatening way for men.

These later two findings can be taken to mean that more fundamental changes to men’s understanding of the psychotherapeutic process may be required for men to fully destigmatize it as an option. Syzdek and colleagues’ (2016) finding regarding the positive impacts of a gender-based MI program did not extend to the friends of partners of participants. Seaton and colleagues (2019), for example, argued that efforts to promote mental health in male-dominated industries should be tailored for the unique needs of men, not just be traditional techniques repackaged. As Corrigan (2016) described, “beating stigma is more than changing words” (p. 67). Indeed, Robertson and colleagues (2018) summarized the results of an expansive review of the techniques successful in promoting mental health services to men. They noted that settings and activities that created safe male spaces acted to promote trust, reduce stigma, and normalize men’s engagement in psychological interventions. Holding male positive attitudes and values engendered a therapist’s familiarity with men’s coping styles and interactional preferences, which consolidated that trust, and the use of male sensitive language and activity-based approaches allowed for positive expressions of emotions, facilitated social engagement, and provided a base for open communication.

Mental Health Disorders

The idea that individuals experiencing various forms of psychological distress and/or mental illness experience stigma is not exactly new, nor is the idea that variables such as sex and gender impact the nature of that stigma. However, most of this extant literature focused on the degree to which women experienced the stigmatization of their gender role as well as significant stigmatization of their psychological distress because of the sexist, patriarchal nature of society. It is only recently that this relationship has been examined as experienced by men. In fact, it was not until the success of the NIMH *Real Men Real Depression* campaign that the possibility that men too could experience stigma associated with their experiences of mental illness was taken seriously. Indeed, it is only within the past decade that scholars have begun to empirically explore the nature of that stigma and how it specifically intersects with masculinity as well as variables such as symptom severity, diagnostic category, and socialized gender role expectations.

Boysen and colleagues (2014) demonstrated that the stereotypes for all these categories can in fact intersect. Across two studies they confirmed that people view specific disorders as being either stereotypically masculine or stereotypically feminine. The masculine disorders included examples such as addictions and paraphilias whereas the feminine disorders included examples such as eating disorders and body dysmorphia. Most relevant to this narrative, Boysen and colleagues (2014) also showed that the participants' perception of disorders as masculine was positively correlated with the stigma associated with having such a disorder. In fact, that correlation held not just for the full diagnostic category but for specific symptoms as well. Boysen and Logan (2017) extended this finding to confirm that the masculine disorders elicited significantly more stigma, but at the same time said stigma was largely independent of the sex of the person with the disorder. To clarify this inconsistency, later that same year Boysen (2017) showed that symptoms occurring externally, such as behavioral problems, elicited more stigma than symptoms occurring internally, such as depression. Furthermore, those symptoms associated with negative gender traits, such as violence or aggression, elicited more stigma than positive gender traits, such as strength or independence.

Boysen's work can collectively be taken to suggest that it is not just men or the broad category of their masculinity that are subject to stigma, but rather the specific makeup of the behaviors associated with that masculinity. At the same time, their findings regarding gender atypicality stand in contrast to the larger body of work demonstrating that men face significant stigma for exhibiting psychological disorders that contradict the socialized male gender role. As a recent example, Siegel and Sawyer (2020) identified how men suffering from eating disorders, one of the disorders Boysen and colleagues' (2014) participants labeled as feminine, were afraid that news of their diagnosis would leak and that they would experience significant stigma and backlash for their failure to live up to the male gender role. A similar pattern of results was demonstrated by Griffiths and colleagues (2015); individuals suffering from anorexia nervosa were more stigmatized than individuals suffering from muscle dysmorphia, which is the concept classically associated with men and body image issues (e.g., Murnen & Karazsia, 2017). Griffiths and colleagues further determined that said stigma was applied more heavily by male evaluators, and that individuals with anorexia nervosa were perceived as less masculine than those with muscle dysmorphia.

Similar results, with similar explanations rooted in men's failure to live up to the socialized male gender role, have been demonstrated with disorders as diverse as severe hemophilia (Reinicke et al., 2019), depression (e.g., Cole & Ingram, 2020; Scholz et al., 2014), substance use by male athletes (Ramaeker

& Petrie, 2019), and prostate cancer (e.g., Fergus et al., 2002), as well as with behaviors as wide ranging as parenting (Holmes et al., 2020; Rochlen et al., 2010), career choice (e.g., Fouad et al., 2016; Rochlen et al., 2009), requesting family and medical leave (e.g., Rudman & Mescher, 2013), and engaging in environmental activism (Swim et al., 2019). Subsequent linkages between the fears of stigma and backlash to seeking help for one's disorder have been demonstrated by male victims of sexual assault (Hlavka, 2016), and by men reporting same-sex attractions and risky sexual behaviors (e.g., Parmenter et al., 2019).

Summary and Critique

The linkage between masculinity, stigma, and help seeking is clear; men are socialized to avoid seeking either psychological or physical help because such behavior is seen as a weakness in violation of the traditional male role. Stigma, whether experienced as self-stigma, public stigma, or a combination of both, clearly accounts for a large chunk of this process; public stigma allows society to leverage power to protect a socially desirable group identity (Smith, 2007) by excluding those behaviors not seen as appropriate to that identity. Thus, we might conclude that although some aspects of society seem to be calling for men to grow beyond their socialized male role, other aspects of society see value in keeping men constrained to that role. Furthermore, if men were indeed to transcend the limits of their socialization, they would experience the self-stigma that comes with violating their gender-role expectations in addition to the demonstrated interpersonal consequences of such adherence (see Levant & Wong, 2017; O'Neil, 2015; Wong & Wester, 2016 for reviews).

It also seems as if an important component of overcoming men's reluctance to seek psychological help is a presentation of the helping activity in a manner consistent with the socialized male gender role. However, at the same time research also demonstrates that groups of men often react differently to these presentations based on their own collection of experiences, demographics, and situational stressors such that merely repacking therapy using masculine language is not always sufficient (e.g., Corrigan, 2016). Furthermore, the current state of the literature would suggest that demographic characteristics such as age, ethnic background, and social class clearly alter any relationship between masculinity and stigma, and men can develop coping strategies such as impression management, self-compassion, or identity protection that allow them to mitigate the effects of stigma. Indeed, although Vogel and colleagues (2011) called for a rejection of a one-size-fits-all understanding of help seeking in men, little empirical progress has been made on an intersectional understanding of these variables in the psychology of men extant literature.

Last, most of the individuals researching men, masculinity, and stigma do not fall into the groups they are trying to understand with their work. The bulk of this work has therefore been conducted "from the vantage point of theories that are uninformed by the lived experiences of the people they study" (Link &

Phelan, 2001, p. 365), and it thereby fails to fully comprehend the significant impact had by stigma. I do not exempt myself or my research from this criticism. For all the traditional male trappings in my life: a strong, independently minded self-sufficiency orientation as well as hobbies involving classic cars, Star Trek, martial arts, and prepping for the zombie apocalypse, I have in many ways grown beyond my traditional male gender role socialization. Looking back, I realize I had to do so; otherwise, I would not have overcome my own challenges as well as been blessed with 30 years of a successful marriage, two great children (now grown), and a close circle of friends and colleagues. As this was occurring, however, I was surrounded by people and was part of a profession that both encouraged and allowed for that growth. I experienced little to no stigma because of my changes, and I was even praised for my courage and tenacity. How can I understand the depth of the stigma men experience today for violating their socialized gender role if I have not, in fact, also experienced it?

Implications and Areas for Future Research

Certainly, stigma as a construct has been clearly linked not only to masculinity as well as associated behaviors and outcomes – most notably the act of seeking psychological help (see Addis & Mahalik, 2003), but also men's experiences with psychological distress, their expectations about psychotherapy, and even their experiences with specific psychological disorders. Unfortunately, as of this writing, stigma has only been treated as a variable in an equation, one related to yet clearly distinct from masculinity. Classical masculinity theories like GRC or GRS have presumed stigma as an operating force on men's behaviors, but they have not fully integrated its developmental processes or its theoretical underpinnings into an understanding of how masculinity develops, is enacted, and is maintained. Newer theories, such as precarious manhood or the fragile masculine self, have clear linkages to Goffman's (1963) early concepts of impression management, yet these have not been incorporated into the psychological study of men, masculinity, and stigma. Vogel and Heath's (2016) use of the health beliefs model to fully conceptualize the research on men's help seeking is intriguing, but it too has not yet begun to penetrate the psychology of men literature, nor has the basic social psychology of stigma, stereotyping, and oppression (e.g., Barreto, 2015). Also unexplored is the possibility that mental health professionals themselves are complicit (e.g., Demetriou, 2001) in the stigmatization of men, their behavior, and their reluctance to seek psychological help. Indeed, Hoy (2012) reported that the second most common help-seeking barrier for men was the fear and apprehension related to health professionals. It is unclear if this fear was an extension of the socialized masculine identity of avoiding weakness or a more specific fear of being afraid of mental health professionals and their judgments about their behavior, such as those demonstrated by Heesacker and colleagues (1999).

It is also important to note that, as of this writing, the extant literature in the psychology of men proceeds from the pedagogical assumptions inherent to the dominant culture – read Caucasian, cisgender, upper middle class, educated, and with access to resources. Certainly, much has been written about men of color and men of different sexual orientations (see Part II of Wong & Wester, 2016, as well as Wong et al., 2017; Parent & Bradstreet, 2017 for reviews), but scholars have only recently begun to empirically examine the intersectional nature of a multicultural masculinity, and that examination has not yet grown to include the role played for minority men by stigma. That current state of the literature seems to conclude that men who exist outside the majority group, be it in terms of race, class, sexual orientation, or ethnicity, develop a conceptualization of themselves as men in relation to how both the dominant culture and their culture of origin defines masculinity. It stands to follow, therefore, that those men must develop and enact that conceptualization in a world that, because of discrimination, stigmatizes their efforts to successfully define an identity and obstructs any chance for ultimate success.

Conclusion

All the world's indeed a stage
And we are merely players
Performers and portrayers
Each another's audience
Outside the gilded cage
Rush, 1981

In 1981, the Canadian rock band Rush released a song, "Limelight," which is reported to be about the behavioral changes forced upon band members because of being famous (Peart, 1981). The song paraphrases the opening lines of William Shakespeare's play *As You Like It* (Scene 2, Act 7), in which the Bard compares life to a stage and humans to actors in a play. Those actors go through life playing their assigned parts for the benefit of those around them while at the same time never living life for one's own purpose. In essence, both were waxing lyrical about humankind's tendency to structure their lives around what some scholars have labeled a process of "identity protection" (Vogel & Heath, 2016, p. 692) or even label avoidance (e.g., Corrigan, 2014; Goffman, 1963). Indeed, society stigmatizes "those individuals whose characteristics and actions are seen as threatening or hindering the effective functioning of their groups" (Neuberg et al., 2000, p. 34). Men and boys are susceptible to this stigmatization, especially when it is leveraged by other men. Clearly, as Blazina (2004) detailed, they will go to great lengths to avoid such an outcome, typically managing the impressions others have of them by adjusting their behavior to conform to the expectations of their social group regardless of circumstances, situational demands, or interpersonal consequences.

The degree to which stigma significantly explains men's unwillingness to seek psychological help above and beyond their subscription to the male gender role is clear. We are also learning more about how that relationship can be affected by variables such as context, diagnosis, age, race, ethnicity, and self-care. Further, there is a growing body of evidence to suggest that those mental health providers seeking to work with men need to consider efforts beyond advertising if they wish to overcome the stigma associated with men seeking their services. At the same time, however, more work needs to be done to fully understand how stigma theory can be incorporated into the psychology of men so as to understand both how and why, in fact, stigma works to shape the developmental experiences of men across a wide range of situational variables. Indeed, as I compiled this chapter, I came to wonder: Does stigma also have a more subtle effect on the lives of men? Link and Phelan (2001) go so far as to argue that "stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination" (p. 367) as a specific way of maintaining what dominant society has labeled a socially desirable group identity (Smith, 2007). I admit, it is difficult to think of men as subject to any form of stereotyping or discrimination given the power and privilege historically associated with traditional masculinity. However, given our current social conditions and concerns over so-called toxic masculinity, might it not be time to examine the male gender role in light of Link and Phelan's assertions? Is it possible that, for all the efforts currently aimed at helping men overcome the limitations of their socialized male gender role, there are also forces working to maintain the status quo, because keeping men limited to that gender role serves a broader social purpose?

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15 Understanding and Reducing the Stigma of Mental Health Problems and of Treatment among Military Personnel

Thomas W. Britt & Zachary P. Klinefelter

The stigma of having a mental health problem and seeking treatment for that problem is pronounced in the military due in part to a focus on remaining psychologically and physically resilient in the face of a multitude of traumatic events. The importance of resilience is instilled in military personnel from basic training onward, as is the importance of being psychologically and physically healthy in order to contribute to the success of the mission. Given the potential for high levels of stigma in the organizational culture of the military (Britt & McFadden, 2012), a large amount of research has been conducted on the stigma of having a mental health problem and especially seeking treatment for that problem. The greater focus on the stigma of seeking treatment for mental health problems derives from a recognition that it is the organization's responsibility for ensuring military personnel receive treatment for problems connected to their military service. Better understanding of the role of stigma among military personnel is also necessary in order to design interventions and training to reduce the prevalence of stigma and thereby facilitate treatment seeking.

The present chapter is designed to provide a thorough analysis of how the stigma of mental health problems and treatment has been conceptualized and assessed in the military, the antecedents and consequences of mental health stigma for service members, and the effectiveness of training and interventions designed to reduce the stigma of mental health problems and treatment seeking. The chapter concludes with important areas for future research to address limitations in the research on mental health stigma in the military.

Conceptualization and Assessment of Mental Health Stigma in the Military

Research on mental health stigma in the military has grown substantially in the past few decades, leading to a vast literature base. This growth has been spurred by national attention in the media and military leadership recognition and has occurred alongside growth in non-military mental health stigma research (Acosta et al., 2014). With this growth has come a large and varying set of definitions of different types of stigma and methods for assessing stigma within mental health and military contexts. The study designs used to address mental health stigma in the military range from qualitative inquiries like interviews and focus groups (e.g., Coleman et al., 2017; Zinzow et al., 2013) to survey measures (e.g., Hoge et al., 2004; Kim et al., 2011).

Conceptualizing Types of Stigma

Definitions and assessment of mental health stigma among military personnel vary on two main dimensions: target and context (see Table 15.1). Some studies address individual attitudes toward others with mental health issues, some address perceptions of organization-level attitudes toward those seeking mental health treatment, and still others address individual, self-perceptions of treatment seeking and/or having a mental health disorder, to give a few examples. Indeed, a 2014 report on mental health stigma in the military reported that the measures currently in use in this area vary widely in terms of the target specified and the context or level of the stigma examined (Acosta et al., 2014).

In general, there are two targets of interest in mental health stigma research in the military: individuals with mental health disorders and individuals who seek mental health treatment. While these two targets are undeniably linked, examining them as distinct targets is critical. Research has shown that the perception of an individual with a mental health disorder who decides not to seek treatment but instead handle it on their own is quite different from the perception of an individual with a mental health problem who seeks mental health treatment (Tucker et al., 2013). Additionally, we know from this research that both the treatment-seeking behaviors and the mental health diagnosis can be individually stigmatized.

In addition to the target of the stigma, the context of the stigma is similarly important to consider (Skopp et al., 2012). Vogel and colleagues (2007) showed that while mental health stigmas operate at public, institutional, and social levels, the impact of those stigmas is moderated by stigma at the individual level (i.e., self-stigma). Applied to an example of military mental health stigma, this means that while stigma at the social level (i.e., within one's unit or circle of friends) may lead an individual to believe others will perceive them differently if they seek treatment or are diagnosed with a disorder, the impact of this stigma on treatment seeking is exacerbated by self-stigma, wherein one who seeks treatment will devalue themselves (Vogel et al., 2007). In the following sections we organize existing measures of stigma into these four groups: perceived stigma from others for seeking mental health treatment, perceived stigma from others for having mental health issues, self-stigma toward mental health treatment, and self-stigma of having mental health issues.

Perceived Stigma from Others for Having Mental Health Issues

This section refers to the perceived stigma by others as a result of having a mental health issue. Though this stigma may occur at multiple levels

Table 15.1 *Terminology and measures used in military mental health stigma research*

Type	Stigma term	Definition	Citation(s)	Measure used	Sample Item	Response scales
Mental health issue stigma from others	Stigma	A multifaceted phenomenon that involves stereotypes, prejudice, and discrimination, which has been identified as a prominent barrier to mental health care.	Weeks et al., 2017	Mental Health Experiences Scale (Stuart et al., 2014)	How much have those negative opinions or unfair treatment affected your life? Respondents answered this question for six life domains (e.g., family, relationships).	1 *Not affected* to 10 *Severely affected*
	Public or Enacted Stigma	Shared cultural beliefs held by the general public (or the military) about the attributes of those with mental illness that can lead to discrimination.	Thornicroft, 2008; Rüsch et al., 2005	Not measured in military, but discussed theoretically with military research.	N/A	N/A
	Public Stigma	Participants' perceptions of the	Seidman et al., 2019;	The Stigma Scale for Receiving	"People tend to like less those who are	1 *Strongly disagree* to

Treatment seeking stigma from others		stigma people have toward those who seek psychological help.	Held & Owens, 2013	Psychological Help (Komiya et al., 2000)	receiving professional psychological help.”	4 *Strongly agree*
	Perceived Stigma for Career	Concern that getting treatment would harm a soldier’s career.	Britt et al., 2015	Items pulled from Britt et al., 2008 and Kim et al., 2011	“Getting mental health treatment would hurt my chances of getting promoted.”	1 *Strongly agree* to 5 *Strongly disagree*
	Perceived Stigma of Different Treatment from Others	Concern that soldiers would be viewed and treated differently by fellow soldiers if they received treatment.	Britt et al., 2015	Items pulled from Britt et al., 2008 and Kim et al., 2011	“Members of my unit might have less confidence in me if I received mental health treatment.”	1 *Strongly agree* to 5 *Strongly disagree*
	Self-Stigma from Seeking Treatment	The internalization of stigmatizing perceptions of soldiers who seek treatment.	Britt et al., 2015	Items pulled from Self-Stigma of Seeking Help (SSOSH) scale (Vogel et al., 2006)	“It would make me feel inferior to ask a therapist for help.”	1 *Strongly agree* to 5 *Strongly disagree*
	Public Stigma	Perceptions held by others toward an individual.	Skopp et al., 2012	Created for study	“My peers would think less of me if they knew I was getting help from a mental health provider.”	1 *Definitely disagree* to 4 *Definitely agree*
	Stigma		Britt, 2000	Created for study		

Table 15.1 (*cont.*)

Type	Stigma term	Definition	Citation(s)	Measure used	Sample Item	Response scales
Self-stigma of treatment seeking		The belief that an individual will be viewed or treated in a stigmatizing way if their mental health problem or help seeking becomes known.			"In the military, service members who admit having a psychological problem may cause their coworkers to spend less time around them."	1 *Strongly agree* to 5 *Strongly disagree*
	Self-Stigma	Public stigma that has been internalized.	Skopp et al., 2012	Created for study	"Seeking psychological help would make me feel less intelligent."	1 *Definitely disagree* to 4 *Definitely agree*
	Self-Stigma	How individuals perceive themselves if they seek counseling.	Seidman et al., 2019; Held & Owens, 2013	The SSOSH scale (Vogel et al., 2006)	"If I went to a therapist, I would be less satisfied with myself."	1 *Strongly agree* to 5 *Strongly disagree*
Other military mental health stigmas	Medication Stigma	Concern that others view participants' medication taking negatively.	Boyd et al., 2015	Created for study	"Others judge me for taking psychiatric medication."	Unknown
Stigmatizing Perceptions of Soldiers who Seek Treatment	Concerns about the reliability and operational readiness of soldiers seeking treatment as an impediment to treatment seeking.	Britt et al., 2015	Created for study	"Soldiers who seek mental health treatment are just trying to get out of work."	1 *Strongly agree* to 5 *Strongly disagree*	

(i.e., social, organizational; Acosta et al., 2014), most studies of "other" stigma do not specify the level and include survey items that vary from close social contexts such as friends or colleagues to broader public ones such as organizational leaders. Research outside the military, covered in other chapters in this Handbook, has shown that mental health conditions or concerns are linked to a number of negative perceptions such as "violent," "unstable," and "weak" (Ahmedani, 2011). Within the military context, this stigma tends to be assessed in the form of research participants reporting on perceptions that they are being stigmatized by others for their mental health issue (e.g., Weeks et al., 2017). For example, Weeks and colleagues (2017) assessed this type of stigma in both civilian and military samples in Canada. The researchers used the Mental Health Experiences Scale (Stuart et al., 2014). This scale indexes how severely, on a scale of 1 to 10, six different domains of life (e.g., Family, Relationships, Work) have been affected by this stigmatization. One item from this measure is, "During the past 12 months, did you feel that anyone held negative opinions about you or treated you unfairly because of your past or current emotional or mental health problem?"

Perceived Stigma from Others for Seeking Mental Health Treatment

Distinct from stigma toward individuals who have mental health issues, stigma can also be directed toward individuals who seek mental health treatment. Research has shown that though many avoid mental health treatment for fear of being stigmatized as mentally ill, the act of obtaining mental health treatment may also carry some potential stigma (Britt, et al., 2015; Corrigan, 2004). This stigma can, for example, take the form of individuals linking those who seek treatment with attributes like being weak and unable to persevere, which can then lead to discriminatory behaviors. Britt and colleagues (2015) assessed four forms of stigma in trying to examine the relationship between different forms of stigma and actual treatment-seeking behaviors and treatment dropout in a military sample. Labeled "stigma perceptions" in their study, the researchers examined perceived stigma for career, perceived stigma of different treatment from others, self-stigma from seeking treatment, and stigmatizing perceptions of soldiers who seek treatment. The first two of these subscales fall into this category in which the stigma is occurring at the level of *other* and specifically targeting individuals who seek treatment. For example, in the perceived stigma for career subscale, one item read, "Getting mental health treatment would hurt my chances of getting promoted."

Self-Stigma toward Mental Health Treatment

This category includes stigma that individuals have internalized regarding their seeking of mental health treatment. That is, individuals are aware of stigma that others hold toward those who seek mental health treatment and believe seeking mental health treatment links themselves to the perceptions that others hold toward treatment seekers (e.g., weak, incompetent; Britt et al., 2015; Skopp et al., 2012). Seidman and colleagues (2019) examined this form of stigma in their study with the goal of linking multiple types of stigma (other and self levels) with actual treatment-seeking behaviors in military personnel. To measure self-stigma targeting the seeking of mental health treatment, they utilized a previously developed and validated scale, the Self-Stigma of Seeking Help (SSOH) scale (Vogel et al., 2006), which was developed for a similar purpose but in non-military samples. One example item is, "If I went to a therapist, I would be less satisfied with myself." The items in this scale attempt to capture the extent to which participants have internalized beliefs about individuals who seek mental health treatment, as well as the extent to which participants would perceive themselves differently (i.e., more negatively) if they were to seek treatment.

Another example of self-stigma toward treatment-seeking behaviors is the Negative Beliefs about Treatment Seeking subscale of the Endorsed and Anticipated Stigma Inventory (Vogt et al., 2014). This measure was originally developed for research on military and veteran samples, and the subscale was used by Williston and colleagues (2020) to assess treatment-seeking self-stigma in a sample of female military veterans. The eight items of this subscale assess the extent to which participants agree with commonly held beliefs about treatment-seeking behavior (e.g., "I would think less of myself if I were to seek mental health treatment").

Self-Stigma of Having a Mental Health Issue and Other Forms

To our knowledge, no studies examining military samples have been conducted addressing self-stigma of having a mental health issue. This type of stigma, theoretically, would involve individuals linking themselves to known societal attributions (e.g., violent, unstable) because of their mental health issue. Despite this lack of research, there are a few related but distinct types of mental health stigma that have been studied in military samples and don't fit into the above categories. For example, one study examined self-stigma toward taking medication for psychological issues (Boyd et al., 2015). One sample item from their measure of stigma toward medication for mental health issues was, "I am embarrassed about the psychiatric medication that I am taking." Another type of stigma that has been studied was called stigmatizing perceptions of soldiers who seek treatment. While this stigma is at the level of *other*, and is targeted at *treatment-seeking behaviors*, the subscale is unique because it captures an individual's own stigma toward others, rather than the more traditional opposite. One sample item from this measure is, "I would not trust a soldier to have my back if I knew he or she were receiving mental health treatment."

Critiques of Stigma Conceptualizations

As can be seen, researchers have developed multiple measures to assess some of the different types of stigma military personnel may face related to mental health treatment and diagnoses. However, there are some notable gaps in the literature. First, no research has examined self-stigma toward mental health diagnoses. So, while we are beginning to understand that individuals can stigmatize themselves for seeking treatment (or considering seeking treatment), and we know that individuals can perceive stigma toward mental health diagnoses from others, we have yet to learn whether this stigma toward the diagnoses can be internalized. Understanding whether this type of stigma exists is critical to helping military personnel who suffer from mental health issues.

Another notable gap is the lack of focus on actual perceptions of others with mental health issues or who seek treatment. With the exception of Britt and colleagues (2015), researchers have only focused on individuals' perceptions of how others perceive (i.e., stigmatize) them. However, as shown by Britt and colleagues (2015), examining whether military personnel hold these stigmatizing perceptions toward others is important for understanding the extent to which these stigmas actually exist (as opposed to being perceived to exist). Although, importantly, perceptions of stigma have been shown to affect individuals regardless of whether they actually exist (Britt et al., 2015). In other words, the fear of discrimination or being perceived unfavorably is part of the stigma process, even if no one is actually exhibiting discriminatory behaviors. However, understanding the extent to which individuals actually perceive others differently due to a mental health diagnosis or treatment-seeking behaviors may highlight potential areas of intervention to reduce stigma and fear of being stigmatized in the military.

Antecedents and Consequences of Mental Health Stigma in the Military

Research conducted on mental health stigma in military samples often includes additional variables that are conceptualized as either antecedents or consequences. In reviewing research in this area, we make clear whether a longitudinal or cross-sectional design has been examined to identify antecedents and consequences of mental health stigma. Figure 15.1 serves as a descriptive framework for organizing the research that has been conducted on the correlates of mental health stigma among military personnel. Although no studies have examined all the components of this model in a single study, many studies do address multiple components.

Antecedents of Mental Health Stigma

Mental Health Symptoms. The most consistent antecedent of all forms of mental health stigma in the military is higher levels of mental health symptoms (e.g., Barr et al., 2019; Britt et al., 2008; Heath et al., 2017; Hoge et al., 2004; Wright et al., 2014). In their widely cited research on stigma and mental health problems among military personnel returning from Afghanistan, Hoge and

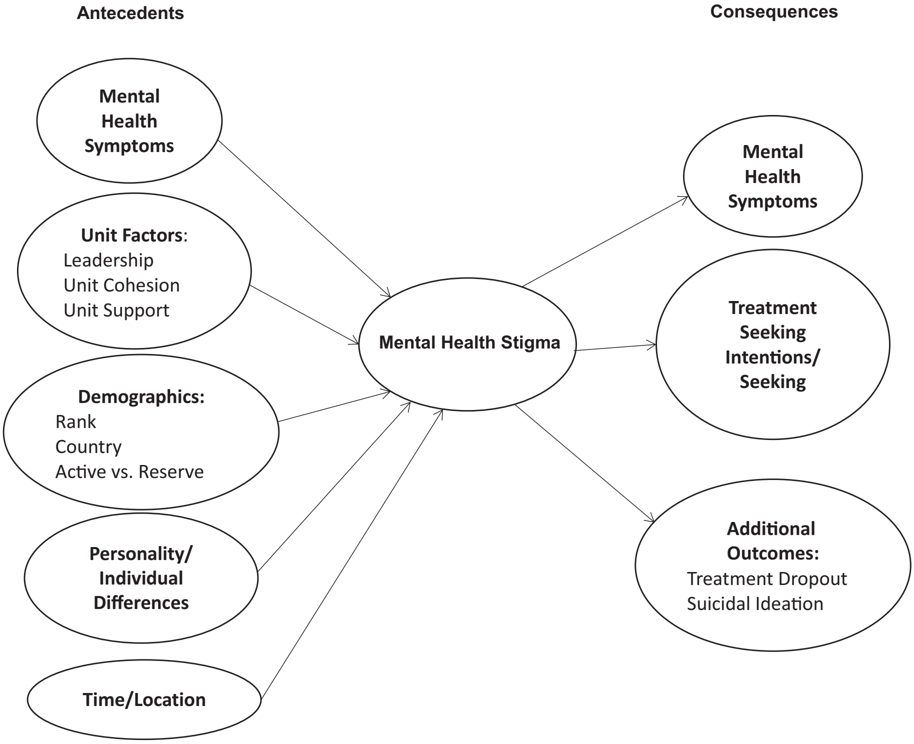

Figure 15.1 *Mental health stigma framework.*

colleagues (2004) found that reports of career (e.g., concerns with not getting promoted if getting treatment) and differential treatment (e.g., concerns with being ostracized by others if getting treatment) stigma were twice as large among military personnel screening positive for a mental health problem. More recently, Barr and colleagues (2019) reported that post-traumatic stress disorder (PTSD) symptoms were linked to higher levels of self-stigma, and Heath and colleagues (2017) found that help-seeking stigma was related to psychological distress. Finally, Britt and colleagues (2015) found that, compared to those who did not, those screening positive for a mental health problem were more likely to report four different mental health stigma perceptions: career stigma, differential treatment stigma, self-stigma, and stigmatizing perceptions of others with mental health problems.

Greene-Shortridge and colleagues (2007) argued that the associations between mental health symptoms and stigma associated with treatment seeking were a function of the costs of seeking treatment becoming more apparent when military personnel are experiencing mental health problems and start to consider getting treatment for that problem. However, it is also possible that perceptions of stigma exacerbate mental health symptoms among service members. As discussed in more detail in the outcomes section, Wright and colleagues (2014) found support for a broad measure of barriers to mental health treatment (including stigma) as a predictor of future mental health symptoms. Therefore, it is likely that mental health symptoms are both an antecedent and outcome of mental health stigma in the military.

Unit Factors. An additional antecedent of mental health stigma in military samples involves a number of unit factors associated with a climate of support and closeness among service members. Wright and colleagues (2009) examined perceptions of unit leadership and cohesion as predictors of treatment-seeking stigma among a sample of active duty soldiers who had been deployed to Iraq. The authors found an interaction between positive leadership and unit cohesion in the prediction of treatment-seeking stigma, finding that soldiers who reported high levels of leadership and cohesion were especially likely to report low levels of stigma. Britt and colleagues (2012) examined positive and negative leader behaviors by non-commissioned officers (NCOs) and officers as predictors of treatment-seeking stigma over the course of three months. Consistent with the reality that NCOs have a more immediate impact on military personnel, perceptions of NCO leadership were especially predictive of treatment-seeking stigma. Positive leader behaviors by NCOs were related to lower perceptions of treatment-seeking stigma, and negative leader behaviors were associated with higher perceptions of stigma.

In contrast to research focusing on general unit factors as predictors of mental health stigma, Britt and colleagues (2020b) examined the unit climate of support for mental health (e.g., “Soldiers in my squad would support unit members who want to seek mental health treatment”) as a predictor versus outcome of different types of stigma among a sample of active duty military personnel from an Infantry division. Career stigma, differential treatment stigma, and unit climate of support for mental health were all measured at two time periods separated by three months. The results of structural equation modeling revealed that unit climate of support for mental health at Time 1 was predictive of decreased career and differential treatment stigma at Time 2 even after controlling for the two types of stigma at Time 1. These results provided strong evidence for a positive unit climate surrounding mental health treatment being related to reduced perceptions of mental health stigma among active duty soldiers.

Demographic Variables. With the exception of mental health symptoms and unit factors, other antecedents of mental health stigma have been examined more sporadically in prior research. Britt and colleagues (2020a) recently examined differences in career and differential treatment stigma items as a function of gender and rank among a large sample of soldiers (over 2,000) from an active duty Brigade Combat team. Interestingly, there were no gender differences in the endorsement of items related to career and differential treatment stigma for seeking help, including “It could harm my career,” “Members of my unit might have less confidence in me,” and “I could be seen as weak.” Female soldiers were less likely to endorse the response to seeking mental health treatment “I could be seen as ‘broken’ by my unit.” The general lack of gender effects on reports of career and differential treatment stigma for treatment seeking are consistent with the findings of Elnitsky and colleagues (2013), who found few gender differences in the endorsement of treatment-seeking stigma among a large sample of active duty combat medics deployed to Iraq.

Britt and colleagues (2020a) did find differences in perceptions of career and differential treatment stigma as a function of rank. Officers were more likely than either junior enlisted personnel or NCOs to endorse the items "Members of my unit might have less confidence in me," "It could harm my career," and "I could be seen as broken by my unit." These differences in rank were likely a function of the perception that higher-ranking officers are not supposed to seek treatment for mental health problems if they are going to be in leadership positions. Few studies we are aware of have examined differences in mental health stigma as a function of rank.

Researchers have also examined mental health stigma as a function of the country of origin. Gould and colleagues (2010) examined career and differential treatment stigma among military personnel from the United States, United Kingdom, Canada, Australia, and New Zealand. The authors found a high degree of similarity among the military personnel from different nations. The most frequently endorsed stigma items were "My unit leadership might treat me differently," "I would be seen as weak," and "It would harm my career." These results suggest the military culture may outweigh the culture of the country in affecting the stigma of seeking treatment for mental health problems. However, this study did not include military personnel from Eastern cultures with a more collective value orientation.

The final demographic variable to be examined as a predictor of mental health stigma is whether military personnel are from the Active or Reserve component (including the Reserves and National Guard). Military personnel in the Reserve component generally participate in military service one weekend a month and two weeks in the summer close to their civilian home location, in addition to being deployed in support of larger military operations. Kim and colleagues (2010) examined differences in career and differential treatment stigma as a function of component in a sample of over 10,000 soldiers from active duty and National Guard units in the U.S. Army. The authors found higher levels of mental health stigma in active duty soldiers in comparison to National Guard soldiers. The lower levels of stigma in National Guard soldiers are likely a function of the less total amount of time spent in military service, thereby decreasing the opportunity to experience stigma.

Personality/Individual Difference Variables. A couple of studies have examined personality variables as predicators of mental health stigma among military personnel. Heath and colleagues (2017) examined masculine norms for restrictive emotionality and overall distress as predictors of help-seeking self-stigma among male service members. The authors found that restrictive emotionality and distress were both positively correlated with self-stigma. In addition, the two variables interacted to predict self-stigma, such that restrictive emotionality was a predictor of self-stigma primarily for those personnel reporting high distress. This pattern of results is consistent with the argument that concerns about the stigma of seeking help may become especially relevant for service members with active mental health symptoms (Greene-Shortridge et al., 2007).

Mindfulness is another individual difference variable examined as a predictor of self-stigma among military personnel. Barr and colleagues (2019) examined the associations between mindfulness, PTSD symptoms, and self-stigma with a large cross-sectional sample of military personnel. The authors found that mindfulness was negatively related to self-stigma and PTSD symptoms, and that PTSD symptoms were also a mediator of the relationship between mindfulness and self-stigma.

Time and Location. In addition to individual and unit attributes associated with mental health stigma, researchers have also examined how stigma has varied over time and across the phases of a military operation. Quartana and colleagues (2014) examined changes in career and differential treatment stigma over the course of multiple assessments from 2002 to 2011, and whether these changes were associated with changes in treatment seeking. The others found that stigma decreased over the course of the time period, with less endorsement of items assessing the costs of treatment seeking, such as “It would harm my career” and “Members of my unit might have less confidence in me” in later years. The authors pointed out that the decreases in stigma were relatively modest for many items. The authors also found increases in mental health treatment utilization, but still noted that a majority of service members with mental health problems had not sought treatment.

Another aspect of time examined by researchers involves fluctuations in stigma along the course of a military deployment. Osório and colleagues (2013) examined changes in career and differential treatment stigma in a sample of over 23,000 UK military personnel during and multiple points after deployments to Iraq and Afghanistan. Overall, the authors found that perceptions of stigma were highest during the deployments. The authors suggested it may be especially difficult for military personnel to get mental health treatment in operational environments.

Consequences of Mental Health Stigma

Help-Seeking Intentions. The most heavily studied outcome of mental health stigma in the military involves treatment seeking/treatment-seeking intentions. For example, Brown and Bruce (2016) examined currently serving soldiers and veterans of Operation Enduring Freedom and Operation Iraqi Freedom and found that stigma reflective of career concerns was a predictor of willingness to seek treatment after controlling for symptoms and the other types of stigma. Jensen and Bowen (2020) also examined how career stigma and differential treatment stigma were related to help-seeking intentions using a large cross-sectional sample of U.S. Air Force personnel. The authors found that career stigma was associated with intention to seek treatment, and that social support was related to intentions to seek treatment partly through the negative association between social support and career stigma.

Actual Help-Seeking Behavior. A relatively large number of studies have examined different types of mental health stigma as predictors of actual treatment seeking among military personnel. Both cross-sectional and longitudinal designs have been conducted, as well as quantitative and qualitative designs. Considering the use of cross-sectional research designs, in a large cross-sectional sample of active duty personnel from an Infantry brigade, Britt and colleagues (2016) found that among personnel who recognized they had a mental health problem, career stigma, differential treatment stigma, and stigmatizing perceptions of others were each associated with a reduced likelihood of reported treatment seeking for that problem. These associations remained after controlling for different mental health symptoms and functional impairment. Similarly, Kim and colleagues (2016) found that career stigma and differential treatment stigma were associated with receipt of treatment from a mental health provider among those screening positive for a mental health problem. Williston and colleagues (2020) also recently found that treatment-seeking stigma was negatively associated with using mental health treatment among a sample of female veterans.

Among studies using longitudinal designs, some have found support for mental health stigma as a predictor of treatment seeking, whereas others have not. Seidman and colleagues (2019) examined the extent to which self-stigma and public stigma for treatment seeking predicted actual outpatient behavioral visits over the course of two years using an active duty sample of military personnel who were initially examined for mild traumatic brain injury. The authors found that after controlling for prior behavioral health use, self-stigma for seeking treatment was negatively related to outpatient visits over the course of the next two years, whereas public stigma was not related to treatment seeking.

Another prospective study examined a sample of Veterans Affairs primary care patients with probable major depression. Campbell and colleagues (2016) defined mental health stigma within the context of depression as a desire to avoid the label of depression. A sample item in the stigma measure was "If your doctor told you [that] you had depression, you would accept that." The authors found that after controlling for severity of depressive symptoms and demographic measures, those endorsing higher levels of stigma at baseline were less likely seven months later to have taken medication for an emotion problem, scheduled a primary care visit to address an emotional problem, or reported a visit with a mental health provider.

Other longitudinal studies have failed to find mental health stigma as a predictor of future treatment seeking. Adler and colleagues (2015) examined perceived stigma for treatment seeking, among other variables, as a predictor of treatment seeking eight months later. The authors found that although perceived stigma was not a predictor of treatment seeking, a preference for self-management of mental health difficulties was associated with a reduced probability of treatment seeking. The authors noted that providing service members with opportunities for self-care may be an effective alternative to mental health treatment for military personnel who prefer to manage difficulties on their own.

Another prospective study included a large sample of VA patients with a diagnosis of post-traumatic stress disorder. Rosen and colleagues (2011) included a measure of mental health stigma combining elements of self-stigma (e.g., "I would think less of myself for needing help"), public stigma (e.g., "I don't want to look stupid for not knowing how to figure these problems out") and privacy concerns ("I'm concerned that other people might find out information in my VA medical records"). The authors found that the measure of perceived stigma was not prospectively related to documented behavioral health visits for the disorder. Instead, initiating mental health treatment was predicted by degree of impairment and an explicit statement of wanting help.

Other studies examining how mental health stigma is linked to treatment seeking in the military have examined pathways through which stigma may be linked with lower service utilization. In a longitudinal study of post-9/11 veterans, Fox and colleagues (2018) examined internalized stigma, anticipated stigma, and symptom severity as predictors of treatment seeking. The authors found support for a mediational relationship in which anticipated stigma at Time 1 was related to internalized stigma 18 months later at Time 2, which was related to reported treatment seeking at Time 2. These results suggested that internalized stigma was a mediator of the relationship between anticipated stigma from others and treatment seeking. Similar findings of self-stigma mediating the relationship between public stigma and help-seeking intentions were obtained in a small cross-sectional military sample by Wade and colleagues (2015).

This review of research on the role of mental health stigma in treatment seeking suggests some inconsistent findings regarding whether stigma is invariably an antecedent of getting help for mental health problems among military personnel. Recent systematic reviews of the research focused on mental health stigma as a correlate of treatment seeking among military personnel shed light on the state of research findings in the area (Cerully et al., 2018; Clement et al., 2015; Coleman et al., 2017). Cerully and colleagues (2018) noted that the small number of longitudinal studies conducted on mental health stigma as a predictor of future treatment seeking prevents conclusions regarding the role of stigma in help seeking. However, this review did not include the strong longitudinal study conducted by Seidman and colleagues (2019), in which self-stigma was prospectively linked to documented behavioral health visits in the medical record over the course of two years.

Clement and colleagues (2015) conducted a systematic review of quantitative and qualitative studies examining how different types of mental health stigma are linked to treatment seeking, placing less of an emphasis on whether the associations were cross-sectional or longitudinal. The authors found support for an overall negative relationship between stigma and treatment seeking ($d = -.27$), with a larger difference for self- or internalized stigma. The authors also summarized the results of qualitative studies examining the role of stigma and treatment seeking, noting that concerns regarding disclosing a mental health problem were the most frequently endorsed barrier to treatment, with stigma-related concerns coming in as the fourth most-cited barrier. The authors argued that different forms of stigma predict treatment seeking, along with other enablers and disablers of getting help.

Finally, Coleman and colleagues (2017) conducted a systematic review of qualitative studies examining mental health stigma and help seeking in the military. The authors identified eight studies involving focus groups and interviews regarding various factors that military personnel believe are associated with treatment seeking, six of which met the standards for effective qualitative data analyses. The authors found that stigma-related concerns were frequently identified as factors influencing help seeking in the military, with elements of public stigma, self-stigma, and career concerns being represented.

In evaluating the extant research examining mental health stigma and treatment seeking among military personnel, one additional factor to consider is the likely presence of additional mediational connections that have not been thoroughly examined. For example, research has shown that self-management/self-reliance is a primary correlate of treatment seeking (Adler et al., 2015). One reason military personnel may report a preference for self-management is the stigma associated with getting help from a mental health professional. As another example, negative attitudes toward treatment emerged as a predictor of treatment seeking (Kim et al., 2011). One reason military personnel may have a negative attitude toward mental health treatment is because of the stigma that treatment entails. Therefore, it is likely that mental health stigma may be indirectly linked to treatment seeking through multiple mediators that have yet to be examined.

Additional Outcomes of Mental Health Stigma. As indicated in Figure 15.1, mental health stigma has been examined as an antecedent not only to treatment seeking, but also to a number of additional outcomes. In addition to predicting mental health treatment seeking, mental health stigma has also been linked to dropping out of mental health treatment. Jennings and colleagues (2016) examined four different stigma perceptions as correlates of treatment dropout in an active duty military sample, including career stigma, differential treatment seeking, self-stigma, and stigmatizing perceptions of others who seek treatment. The authors found that all four of the stigma perceptions were linked to a greater likelihood of dropping out of treatment before completion. When all four stigma perceptions were included in the same logistic regression as predictors of treatment dropout, only self-stigma emerged as a unique predictor of dropout, suggesting self-stigma might mediate the relationships between the other stigma perceptions and dropout.

A few longitudinal studies have been conducted examining the extent to which mental health stigma is prospectively related to higher levels of mental health symptoms. Wright and colleagues (2014) conducted a three-month longitudinal study examining the relationships between a broad measure of barriers to mental health treatment and indices of mental health symptoms (PTSD and depression). In this study, the barriers to mental health treatment were a latent variable indexed by a measure of stigma of treatment seeking (differential treatment and career concerns), practical barriers to care, and negative attitudes toward treatment. After controlling for combat exposure, gender, and rank, barriers to mental health treatment were predictive of changes in mental health symptoms over the course of the three-month time period, whereas mental health symptoms were unrelated to changes in barriers to mental health treatment across the same time period.

In a study with a similar methodology as Link and colleagues (1997), Boyd and colleagues (2016) examined internalized stigma of mental illness assessed at baseline as a predictor of different mental health symptoms three and six months later among a sample of homeless military veterans. The authors found that after controlling for baseline depression and psychotic symptoms, internalized stigma was associated with higher levels of both symptoms at both the three- and six-month time periods. These results suggest mental health stigma can exacerbate mental health symptoms among different military samples.

Researchers have argued that mental health stigma also has the possibility of increasing risk for suicide as a result of individuals not getting help for serious difficulties, as well as increasing the likelihood of suicide if such stigma extends to suicidal feelings possessed by military personnel (Pompili et al., 2003). Additional research has examined the relationship between internalized stigma and suicidal ideation. Wastler and colleagues (2020) assessed the relationship between internalized stigma and suicidal ideation in a sample of military veterans, and whether the relationship would be particularly strong for those veterans who did not feel they belonged to important groups. The results supported the hypotheses, suggesting that internalized stigma might be particularly problematic for suicidal thoughts among military personnel who lack a sense of belonging to important relationships.

Interventions to Reduce Mental Health Stigma in the Military

Given the prevalence and potential implications of mental health stigma in the military, researchers have examined the effectiveness of several interventions designed to reduce stigma and encourage seeking treatment for mental health problems. Zinzow and colleagues (2012) reviewed a number of interventions and adaptations to mental health treatment meant to address the broader barriers to service members receiving mental health treatment. These and more recent interventions vary along a number of dimensions, including modality, duration, and whether a particular type of stigma is targeted during the intervention or training. This section provides a description of these interventions and evidence for their effectiveness. Importantly, the effectiveness of interventions has been examined over a relatively short time period.

Before discussing interventions specifically targeted toward reducing mental health stigma, we review a study examining the impact of mental health treatment on perceived stigma toward help seeking and attitudes toward help seeking. Reger and colleagues (2020) examined the impact of exposure therapy on stigma and attitudes among a sample of military personnel receiving treatment for PTSD or a waitlist control group. The authors examined perceived stigma for attitudes toward help seeking before therapy started, after five sessions of therapy, and after the tenth and final session of therapy. The authors found that exposure therapy resulted in improved attitudes toward seeking help and reduced symptoms of PTSD five sessions into therapy, and these changes were related to lower perceived stigma for seeking help after ten sessions of therapy. These results suggest that changes in attitudes toward help seeking may precede reductions in perceived stigma, as well as support the role of mental health symptoms as an antecedent to stigma portrayed in Figure 15.1.

Given the importance of self-stigma for outcomes among military personnel, Lucksted and colleagues (2011) developed an intervention to reduce self-stigma among military veterans with serious mental illness. The "Ending Self-Stigma" (ESS) intervention took place over nine sessions in a group setting. A variety of techniques were utilized throughout the nine sessions to decrease the internalized stigma associated with mental illness, including cognitive behavioral principles, increasing belongingness, and strengthening positive views of the self. The authors found that internalized stigma scores decreased and perceived social support increased from baseline to immediately after the ESS intervention. The authors characterized their results as preliminary, recognizing the need for a longer-term evaluation of the effectiveness of the program.

Cornish and colleagues (2019) also examined an intervention to decrease self-stigma among military personnel. Their intervention involved a brief video and brochure designed to reduce self-stigma. Both the video and brochure highlighted various military personnel discussing the courage it takes to seek psychological help, which was hypothesized to reduce the stigma of thinking less of oneself for seeking treatment. A control group was also employed that received a video and brochure that focused on military training and general military life but did not mention mental health treatment. The authors examined self-stigma of help seeking immediately before and after the intervention. Results showed a larger decrease in self-stigma for military personnel in the intervention group than in the control group. Interestingly, those military personnel who reported high distress and high self-stigma at baseline spent the least time viewing the intervention video, suggesting a need to engage individuals most in need when attempting to reduce stigma.

Taking a different approach toward reducing the stigma associated with mental health treatment, Stecker and colleagues (2011) examined the effects of cognitive behavioral training to modify negative beliefs military personnel had about seeking treatment. Using a small sample of military personnel with a diagnosed mental health problem, the authors found that the cognitive behavioral training resulted in an increased likelihood personnel would seek mental health treatment, which presumably occurred in part as a function of reduced stigma associated with getting help.

Another novel approach to reducing the stigma of receiving mental health treatment among military personnel involved the use of standup comedy to introduce de-stigmatizing content to service members. Jones and colleagues (2014) randomly assigned military personnel from the United Kingdom to watch a standup comedy show that either did or did not include mental health information. The comedy show with mental health information included 15 different messages surrounding the incidence of mental health problems, the stigma that exists and how getting help should actually be viewed as a strength, the effectiveness of mental health treatment, and how using alcohol is not an effective coping strategy for dealing with mental health problems.

Jones and colleagues (2014) assessed perceptions of career and differential treatment stigma immediately before the show, immediately after the show, and then three months later. The authors found that measures of stigma decreased from before to immediately after the comedy show with mental health information but increased slightly in the comedy show with no mental health information. Unfortunately, the relatively low response rate to the three-month survey resulted in a failure to detect the presence of reduced stigma at the follow-up. The authors argue for the importance of finding novel ways of combatting the stigma of mental illness in the military.

A final intervention to reduce mental health stigma among military personnel involved unit training among active duty soldiers to increase support for fellow unit members with mental health problems by targeting stigma and improving attitudes toward treatment. This training was labeled LINKS to reinforce the central tenets of the training: **L**ooking for signs of mental health problems in fellow soldiers, **I**ncreasing awareness of benefits of mental health treatment, **N**eutralizing barriers to care, **K**nowing your role in providing support to unit members, and **S**upporting help seeking when fellow soldiers make the decision to go to treatment. Building on the training developed by Britt and colleagues (2018), Start and colleagues (2020) conducted a group-randomized trial comparing LINKS training to an active control group of nutrition training on key barriers to mental health treatment, mental health knowledge, and treatment seeking. The authors also created one- and two-hour versions of each training. Soldiers from eight platoons were randomly assigned to one of the four interventions and were assessed before the training, immediately after the training, and then three months later.

Results indicated that both versions of the LINKS training resulted in lower differential treatment stigma immediately after the training, whereas decreased stigma was not observed in the active control groups. In addition, both versions of the LINKS training resulting in decreased concerns with career impact stigma immediately after the training that remained at the three-month follow-up, whereas these changes were not observed in the active control groups. Additional effects of the LINKS training included greater mental health knowledge that remained at the three-month follow-up, as well as more positive attitudes toward mental health treatment immediately following the training.

Future Research Recommendations

Although much has been learned about mental health stigma in military personnel, there are plenty of directions for future research in order to improve our understanding of stigma and inform interventions and recommendations for policy. Research on stigma within the military is characterized by a large array of measures designed to assess different stigma-related constructs, with researchers not settling on a particular instrument or set of measures. The lack of a standard assessment of mental health stigma makes comparisons among subpopulations within the military difficult and creates challenges for assessing whether communication campaigns within the military to reduce stigma are having desired effects. When Quartana and colleagues (2014) examined changes in mental health stigma over a ten-year time period, they examined changes in the endorsement of individual items that were completed by select samples, and were not able to use studies or assessments that administered different measures. In moving forward, researchers should not create any new measures without ensuring existing measures are insufficient for their particular research question. The more standardized use of existing measures should facilitate comparisons between studies regarding overall levels of stigma and whether broad campaigns are effective at reducing stigma.

Furthermore, measures of mental health stigma in the military often combine the stigma associated with having a mental health problem with the stigma of seeking treatment for the mental health problem. Most research examines the latter among military personnel. Researchers should provide justification for the particular type of mental health stigma being examined, and whether the target construct is self-stigma, perceptions of how the service member will be treated by others, or negative perceptions personnel have of others with mental health problems or who seek treatment for those problems.

Finally, researchers have only begun to address the extent to which unit-level variables are related to mental health stigma and the extent to which stigma itself may possess unit-level properties (Britt et al., 2016). Future research should examine the extent to which perceptions of mental health stigma are shaped by multilevel influences at the different levels within which service members are nested (e.g., squads, platoons, companies, battalions, brigades). For the most part, mental health stigma has been conceptualized at the level of the individual service member, which is surprising given how much we know about the importance of the unit to service members.

Conclusion

In many ways research on mental health stigma in the military mirrors research conducted with civilian populations. Numerous terms and measures have been used to assess different types of mental health stigma, researchers have devoted attention to examining both the antecedents and consequences of stigma, and attempts have been made to reduce the extent to which individuals with mental health problems experience stigma when considering how to address issues that are negatively affecting their lives. Of course, military personnel find themselves in a much different occupational culture than many individuals, a culture where the expectation for resilience is inculcated from basic training and continued throughout the service member's career (Britt & McFadden, 2012). Experiencing a mental health problem is often interpreted as a failure to demonstrate resilience rather than as a normal reaction following exposure to repeated traumatic events. Therefore, continuing to examine mental health stigma in the military and ways to reduce the stigma experienced are important to the health and wellbeing of service members and their families.

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16 Stigma of Seeking Mental Health Services and Related Constructs in Older versus Younger Adults

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Mental disorders are common and leading causes of the global burden of disease (Demyttenaere et al., 2004; Vigo et al., 2016). Unfortunately, most people suffering from them do not seek professional help and older adults (typically those 65+) are the least likely age group to seek treatment (Mackenzie et al., 2012). Why are older adults especially unlikely to seek professional mental health services? Historically, research addressing this question was limited by the assumption that stigma toward seeking help was the culprit. Surely, this was true given that older adults grew up in an era when seeking professional help for emotional concerns was uncommon. This assumption was so strong that without referring to research evidence, a World Health Organization and World Psychiatric Association consensus statement suggested that "stigma and discrimination against older people with mental disorders are widespread and their consequences are far-reaching" (Graham et al., 2003, p. 678). Similarly, a *Lancet* commentary indicated that "stigma of mental illness is perhaps the most fundamental reason why elderly people are not treated" (Katona & Livingston, 2000, p. 91). Our first objective is to bring evidence to bear on this question, primarily by reviewing research that examines age differences in stigmas, attitudes, and intentions. Our second objective is to discuss what is currently known about best practices and opportunities for reducing stigma and improving access to mental health services in later life. Before addressing these objectives, we provide a cautionary note about interpreting age differences, define the kinds of stigmas we focus on, and place this work within a theoretical model which readers of earlier chapters in this handbook will recognize.

Definitions and Theoretical Framework

Given that the focus of this chapter is on stigma and mental health in later life, and differences in stigma and related constructs between younger and older adults, it is important to distinguish between age, cohort, and period effects (Glenn, 2007). When we discuss research pointing to differences in stigma, attitudes, or intentions between younger and older adults, it is tempting to interpret them as being due to aging – to biological, psychological, and social changes that take place as we grow older and accumulate knowledge and experiences. This interpretation may not be correct, however, because different age groups belong to unique birth cohorts (i.e., cohort effects) who have different experiences and may have lived through distinct historic periods in time (i.e., period effects). For example, if a cross-sectional study found that younger adults were more likely to devalue and discriminate against people with mental illness than a group of older adults, we cannot assume that the younger group will perceive less stigma as they age. Perhaps the older group in this study reported lower levels of stigma because they lived through the period of de-institutionalization of people with severe mental illness in the 1950s and 1960s (Fuller Torrey, 1997). This cautionary note should be kept in mind when reading this chapter, with the understanding that any age differences we report may be the result of age, cohort, and/or period effects.

The National Academies of Sciences, Engineering, and Medicine (2017) publication on ending discrimination against people with mental health problems defines stigma as “a dynamic, multidimensional, multilevel phenomenon that occurs at three levels of society – structural (laws, regulations, policies), public (attitudes, beliefs, and behaviours of individuals and groups), and self-stigma (internalized negative stereotypes)” (p. 4.). Whereas this definition includes important structural forms of stigma, our focus, and indeed the focus of most mental health stigma research, is on public stigma (also referred to as social stigma; defined as our perceptions of what others think of people with mental disorders) and self-stigma (also referred to as internalized or felt stigma; defined as our perceptions of how we feel about our own mental health problems). In addition to broad distinctions between structural, public, and self-stigmas, the National Academies definition acknowledges that each of these is multidimensional. With respect to public stigma, Griffiths and her colleagues (2008) differentiate personal public stigma (i.e., personal perceptions of people with mental health problems) from perceived public stigma (i.e., how we believe others perceive people with mental health problems). Another important distinction is between public stigma of mental illness and public stigma of seeking help Self-stigma also comprises both self-stigma related to having a mental illness and self-stigma related to seeking professional help. Although these terms have been used synonymously, they are both conceptually and empirically distinct (Tucker et al., 2013).

Vogel and colleagues (e.g., 2007), building on the work of Patrick Corrigan, have done important theoretical work in terms of clarifying mechanisms through which public and self-stigmas of seeking help can be barriers to seeking mental health services. According to their internalized stigma model depicted in Figure 16.1, public stigma of seeking help can be internalized as self-stigma of seeking help. Self-stigma of seeking help subsequently has a negative effect on attitudes toward seeking help, which in turn negatively affects intentions and willingness to seek professional help. There is good empirical support for this

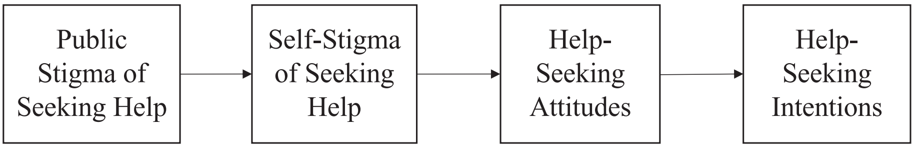

Figure 16.1 *Theoretical internalized stigma of seeking help model.*

model, and evidence that self-stigma of seeking help is a stronger predictor of help-seeking attitudes and intentions than self-stigma of mental illness (Tucker et al., 2013).

How Age Affects Components of the Internalized Stigma Model

This section of the chapter is organized around the theoretical model presented in Figure 16.1, beginning with a review of how age affects various types of public stigma, and progressing through age influences on self-stigmas, attitudes, and intentions. These sections include information on age differences in each construct, research focusing exclusively on older adults, and in some cases a discussion of other psychosocial factors that interact with age. In addition, we frame our review by first presenting our own data on stigma, attitudes, and intentions from a large, national, cross-sectional online survey of 5,712 Canadian adults ranging in age from 18 to 101 (Mackenzie et al., 2019a).

We measured public stigma of seeking help with the 5-item Stigma Scale for Receiving Psychological Help (SSRPH; Komiya, et al., 2000). Each item (e.g., “It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems”) is rated on a 0 (*strongly disagree*) to 3 (*strongly agree*) scale with higher scores indicating greater public stigma. We measured self-stigma of seeking help with the five negatively worded items from the 10-item Self-Stigma of Seeking Help (SSOSH) scale (Vogel et al., 2006). Participants responded to each item (e.g., “My self-confidence would not be threatened if I sought professional help”) using a 1 (*strongly disagree*) to 5 (*strongly agree*) scale that we: (a) reverse coded so that higher scores indicate greater self-stigma, and (b) transformed to a 0–3 scale so that responses would be on the same metric as the other measures. We measured help-seeking attitudes with the six highest loading items from the Attitudes Toward Seeking Professional Help Scale short form (ATSPPHS-SF) (Elhai et al., 2008). Participants rated each item (e.g., “If I believed I was having a mental breakdown, my first inclination would be to get professional attention”) on a 0 (*disagree*) to 3 (*agree*) scale so that higher scores indicate more positive attitudes. Finally, we measured intentions to seek professional help with the following item from the National Comorbidity Survey Replication: “People differ a lot in their feelings about professional help for emotional problems. If you had a serious emotional problem would you: (0) *definitely not go for*

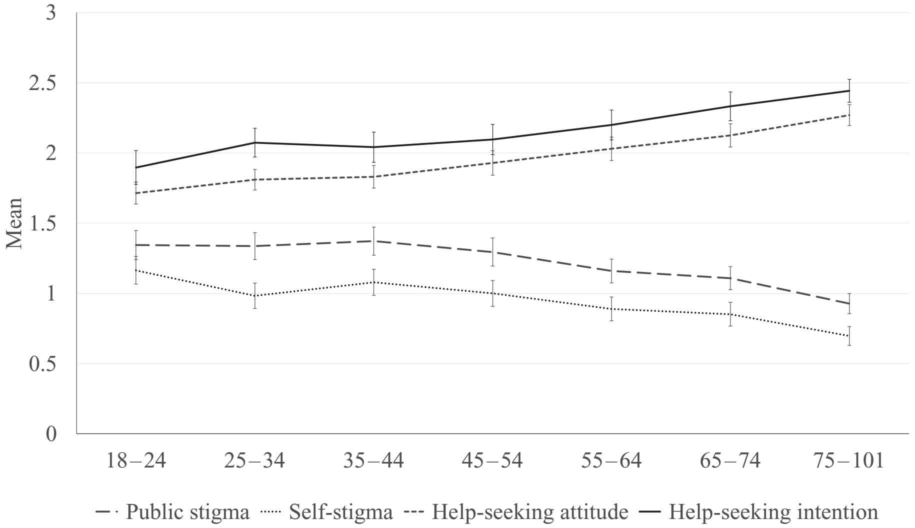

Figure 16.2 *Measures of public stigma, self-stigma, help-seeking attitudes, and intentions to seek help across seven adult age groups. Error bars represent 95% CIs.*

professional help, (1) *probably not go for professional help*, (2) *probably go for professional help*, or (3) *definitely go for professional help*" (Kessler et al., 2004).

Public Stigma. Our own data from Figure 16.2 indicate that public stigma of seeking help appears quite flat across the three youngest age groups, and then decreases linearly with the lowest level of stigma among the oldest age group. This is represented by a significant negative correlation between age and stigma of –.18 (Mackenzie et al., 2019a). Similarly, a small negative correlation of $r = -.13$ between age and public stigma of seeking help was found in a sample of 104 Veterans Administration outpatients with depression (Pyne et al., 2004). Although these studies suggest that public stigma of seeking help decreases with age, a qualitative study of 42 older African Americans who recently experienced a major depressive episode suggests that public stigma of seeking help was an issue for them. Stigma was one of six themes that emerged from interviews with a majority of participants saying that they experienced prejudice and discrimination as a result of their mental health, and hid these problems from friends and family because they felt people in their social networks would not encourage help seeking (Conner et al., 2010b).

In contrast to the relatively small body of research examining age differences in public stigma of seeking help, much more work has been done with respect to associations between age and public stigma of mental illness. One way to approach this topic is to see whether public stigma of mental illness varies depending on whether the attitude target is younger versus older. A study from the mid-1990s with undergraduates who viewed vignettes of younger versus older adults with a variety of stigmas found that older depressed targets elicited less anger than younger depressed targets (Menec & Perry, 1995). Similar findings emerged in a study published 25 years later based on phone interviews with 393 adults. In vignettes describing a younger or older person with depression, the older targets were viewed with less stigma (with the exception of pity) across cognitive, emotional, and behavioral dimensions (Werner & Segel-Karpas, 2020). The authors of this study conclude that levels of public stigma, especially with respect to older adults, were relatively low. Yet this conclusion appears to depend on the kind of mental health problem we perceive people to be struggling with. In a vignette study of older targets with anxiety, depression, or schizophrenia, 101 community-dwelling older adults rated the target with psychosis as the most dangerous and dependent, and the target with anxiety as most responsible for their emotional difficulties (Webb et al., 2009). This vignette-based research seems to suggest that older adults with mental health problems would be less likely to be on the receiving end of public stigma than their younger counterparts.

What does the literature on public stigma of mental illness have to say about how it differs across the adult life span? Most of the research addressing this question comes from three sources: (1) large population surveys of stigma that included analyses of age differences, (2) studies more explicitly comparing younger and older adults on stigma measures, or (3) studies examining age differences in perceptions of vignettes describing individuals with mental disorders. Also, some of this research measures personal public stigma (e.g., I believe people with depression are weak), other research measures perceived public stigma (e.g., I believe that others perceive depression as a sign of weakness), and some include both kinds of measures.

We begin with research examining associations between age and personal public stigma (i.e., how we think of others' disorders). Angermeyer and Dietrich (2006) reviewed research from 45 studies mostly focusing on vignettes describing people with various mental disorders and measuring reactions to them. They found that respondent age was associated with greater personal public stigma in 32 studies, less stigma in 1 study, and that age was unrelated to stigma in 10 studies. Studies published since this review tend to support its conclusion of mixed findings but predominantly greater personal public stigma in later life. This was the case among a representative general population survey of 4,011 German adults where age had a positive ($r = .18$) effect such that older adults had more negative evaluations of people with depression than younger adults (Coppens et al., 2013). Similarly, in a national sample of 1,001 Australian adults, age was significantly and positively associated with personal public stigma ($B = .35$; Griffiths et al., 2008). In contrast, age was unrelated to personal public stigma of depression in a community sample of 3,047 Canadians ages 18–74 (Cook & Wang, 2010). We studied public stigma of depression among 900 adults who responded to an online survey about depression and suicide among men (Mackenzie et al., 2019b). Older adults reported less public stigma of men with depression than did younger adults, but this age effect was only found among male participants (there were no age differences among female participants).

If the evidence suggests that older adults tend to view others with mental health problems more negatively, what influence does age have on perceived public stigma (i.e., our perceptions of what others think of those with mental disorders)? In the studies by Coppens and colleagues (2013) and Griffiths and colleagues (2008) discussed in the previous paragraph, in which personal public stigma was positively associated with age, associations between perceived public stigma and age were not significant in the former study and significantly negative ($B = -.15$) in the latter. Similarly, in a study of 92 depressed adults who were newly admitted to outpatient treatment, the younger group reported greater perceived public stigma in comparison to the older group (Sirey et al., 2001). In a study of 171,572 White, Black, and Hispanic middle-aged and older adults from the Behavioral Risk Factor Surveillance System (BRFSS) survey, the older (65+) group was significantly less likely than the 55-to-64 age group to report perceived stigma of mental illness, although this age advantage was evident for White and Black, but not Hispanic participants (Min, 2019). Similarly, age was negatively associated with perceived public stigma among 248 White and Black depressed adults ranging in age from 60 to 90+ ($r = -.15$; Conner et al., 2010a). Mixed but generally negative associations between age and perceived public stigma were also found in a study of 1,725 adults interviewed following the Changing Minds anti-stigma campaign in Great Britain (Crisp et al., 2005). In contrast to the studies just reviewed suggesting reductions in perceived public stigma with age, in the Eurobarometer study of 29,248 adult participants from 30 European countries adults 65+ were more likely to endorse public stigma related to dangerousness and blame than younger adults (Mojtabai, 2010).

In conclusion, the research reviewed in this section and summarized in Table 16.1 suggests that older adults with mental health problems are less likely to be stigmatized in comparison to their younger counterparts. Older individuals also appear to be less likely to stigmatize others who seek mental health services. In contrast to these positive effects of age, older age tends to be associated with greater personal public stigma. That age has opposite effects on different types of public stigma is interesting and worthy of future research attention. It is curious, for example, that older adults tend to be more likely to view others with mental health problems negatively (e.g., as dangerous and to be fearful of them), but are less likely to stigmatize them for seeking help. It is worth noting that some of the research reviewed suggests moderators of associations between age and public stigma. Black versus White race/ethnicity did not moderate age associations with public stigma in studies by Min (2019) and Conner et al. (2010a). However, culture had a strong effect on public stigma among older adults in a survey study of 1,094 older patients attending primary care clinics in Korea, Russia, and the United States (Turvey et al., 2012). This study found that only 6% of U.S. patients believed that depression makes people weak, compared to 78% of Korean and 61% of Russian patients. Finally, as noted earlier, the type of mental health problem appears to affect age differences in stigma (Crisp et al., 2005; Phelan et al., 2000; Webb et al., 2009).

Table 16.1 *Summary of whether age has negative (–), positive (+), or neutral associations with different types of public stigma*

Study	Study N	Public stigma of seeking help	Personal public stigma	Perceived public stigma
Angermeyer and Dietrich (2006)	45 studies		+	
Cook and Wang (2010)	3,047		neutral	
Coppens et al. (2013)	4,011		+	neutral
Conner et al. (2010a)	248			–
Crisp et al. (2005)	1,725			–
Griffiths et al. (2008)	1,001		+	–
Mackenzie et al. (2019b)	900		– (men), neutral (women)	–
Mackenzie et al. (2019a)	5,712	–		
Min (2019)	171,572			–
Mojtabai (2010)	29,248			+
Pyne et al. (2004)	104	–		
Sirey et al. (2001)	92			–

Note: Personal public stigma refers to personal perceptions of people with mental illness; perceived public stigma refers to how we believe others perceive people with mental illness.

Self-Stigma. Our data from Figure 16.2 suggest that age has similar associations with self-stigma of seeking help as it did with public stigma of seeking help. Rates of self-stigma are relatively flat for the three youngest age groups, decreasing linearly thereafter, resulting in a significant negative correlation of –.17 (Mackenzie et al., 2019a). A similar correlation of –.18 between age and self-stigma of seeking help was found by Barney and colleagues (2010) in the development of their self-stigma of depression scale that includes a help-seeking inhibition subscale. Finally, similar results were found in a study using data from the 2002 National Survey on Drug Use and Health that included 2,680 adults 18+ who responded yes to “During the past 12 months, was there any time when you needed mental health treatment or counseling for yourself but didn’t get it?” (Ojeda & Bergstresser, 2008). Linear decreases in stigma were found from the youngest (18–25) group ($M = 28.0$) to the oldest (50+) group ($M = 15.7$).

Although these studies suggest that self-stigma of seeking help decreases with age, it may still be a barrier to treatment for older adults. Two qualitative studies focusing on depression in later life reported themes related to self-stigma of seeking help. Polacsek and colleagues (2019) recruited 32 older adults with a mean age of 71 who were receiving treatment for moderate depression. A subtheme emerged in which participants discussed self-stigma in relation to their use of antidepressants representing a failure or character flaw. Similarly, in a qualitative study of 42 older African Americans with major depression a theme of “seeking treatment as a last resort” emerged from interviews. Most participants had not sought professional help for reasons exemplified by an older man who was reluctant to seek help because "you know a man's (not) supposed to be weak" (Conner et al., 2010b, p. 271).

As was the case with public stigma, there is more research available with respect to age differences in self-stigma of mental illness (i.e., viewing yourself negatively for having emotional problems) in comparison to self-stigma of seeking help (i.e., viewing yourself negatively for seeking help for emotional problems). We begin with a systematic review (N = 127 published articles) and meta-analysis (N = 45 published articles) of self-stigma (Livingston & Boyd, 2010). None of the sociodemographic variables in this review had consistent associations with self-stigma, although of those they examined (gender, age, education, employment, marital status, income, and ethnicity) age had the strongest effects. Most studies (64%) with significant age effects reported less self-stigma among older adults. Two subsequent studies based on national adult samples also suggest that age has a modest but generally negative association with self-stigma. The first is a multi-site, cross-sectional survey of 1,082 adults with depression ($M_{\text{age}} = 44.9$, $SD = 15.1$) from 35 countries. Age was significantly negatively correlated with self-stigma in univariate models, but was not significant (although still negative and trending with $p = .08$) in the final multivariate model that included variables such as previous treatment, marital status, education, and employment (Lasalvia et al., 2013). The second study showing lower self-stigma among older participants came from a national sample of 360 Canadian adults who completed the self-stigma of depression scale. Comparisons of four age groups (18–24, 35–49, 50–64, and 65–83) revealed a significant linear decrease in scores across these groups (Mackenzie et al., 2019b). In contrast to this evidence of lower self-stigma of mental illness in later life, a study of 247 Taiwanese outpatients with depression who ranged in age from 14 to 87 ($M = 43.9$, $SD = 14.3$) found no age differences on a measure of self-stigma of mental illness (Yen et al., 2005).

In conclusion, our review suggests that self-stigma tends to decrease with age, at least among White North Americans and Europeans. In addition to studies examining age differences in self-stigma among adults across the life span, several studies have looked at the effect of age within older adult samples. One such study examined the psychometric properties of the Internalized Stigma of Mental Illness scale among 419 Spaniards ranging in age from 65 to 85. Age was not correlated with self-stigma in this study, or in Conner and colleagues' (2010a) study of 248 older White and Black Americans with depression who ranged in age from 60 to 93.

Help-Seeking Attitudes. The third step in Vogel et al.'s (2007) model depicted in Figure 16.1 is attitudes toward seeking professional help. Attitudes are defined as psychological tendencies to view a specific entity with some degree of favor or disfavor (Eagly & Chaiken, 2007), and help-seeking attitudes are defined as an evaluative reaction to seeking help for mental health problems (Mackenzie et al., 2004). Before reviewing age differences in help-seeking attitudes, it is worth noting that although they are conceptually distinct from stigmas, there is potential for overlap and confusion. For example, some help-seeking attitude questionnaires measure a single general attitude toward help seeking, such as the ATSPPHS-SF (Fischer & Farina, 1995), whereas other help-seeking attitude measures are multifactorial and include subscales that tap into attitude components that are similar to intentions to seek help and stigma of seeking help (Mackenzie et al., 2004). In addition, researchers sometimes develop their own items measuring stigma, attitudes, and intentions, but refer to them collectively as help-seeking attitudes (Currin et al., 1998). Finally, several national mental health surveys measure attitudes toward seeking mental health services with the following three questions, only the first of which technically refers to attitudes with the others measuring self-stigma of seeking help and help-seeking intentions: (1) How comfortable would you feel talking about personal problems with a professional? (2) How embarrassed would you be if your friends knew you were getting professional help for an emotional problem? (3) If you had a serious emotional problem, would you go for help? (Mackenzie, et al., 2008; Ten Have et al., 2010).

With respect to age differences in help-seeking attitudes, our data in Figure 16.2 suggest a strong, relatively linear increase across age groups. The correlation between attitudes and age (r = .25) was stronger than age correlations with stigmas (Mackenzie et al., 2019a). Several other studies also suggest that help-seeking attitudes are more positive among older than younger adults. One study compared 474 older adults living in a Florida retirement community to a nation-wide sample of 1,001 younger adults (Robb et al., 2003). A significantly greater percentage of older adults (51%) than younger adults (44%) strongly agreed with the statement that people should seek professional help when they have mental health problems. In another study of 155 men in Florida ranging in age from 18 to 88, age had a moderate positive correlation (r = .29) with attitudes toward seeking help (Berger et al., 2005). We examined age differences in attitudes using data from the National Comorbidity Survey (NCS), coding whether people would feel comfortable speaking with a mental health professional as either positive or negative. The youngest (18–24) group had the lowest percentage with positive attitudes (75.4%), increasing to 82.1% to 84.4% of adults 55–74, and then decreasing again to 75.9% in the oldest (75+) group (Mackenzie et al., 2008).

In contrast to research suggesting more positive help-seeking attitudes among older adults, one study of 2,023 Japanese adults ranging in age from 20 to 89 found the opposite (Yamawaki et al., 2011) and a number of others have found no age differences. First, age was not associated with answers to the same "comfort" question from the NCS described in the previous paragraph in a sample of 8,796 adults from five European countries (Ten Have et al., 2010). Second, in a previously described study of 2,680 Americans reporting unmet need for mental health from the 2002 National Survey on Drug Use and Health, age had no effect on five questions about treatment being unnecessary and helpful, and not going to treatment because of being too stubborn/prideful, too self-reliant, and unmotivated (Ojeda & Bergstresser, 2008). Finally, age was unrelated to ratings of the acceptability of antidepressant medication and mental health counseling in relation to a depressed person described in a vignette among 490 White and African American primary care patients (Givens et al., 2007).

The research reviewed in this section thus far has considered help-seeking attitudes as a single construct. In contrast, three studies have examined age differences using the 3-factor Inventory of Attitudes toward Seeking Mental Health Services, with similar results (James & Buttle, 2008; Mackenzie, et al., 2006; Ward et al., 2013). All three studies found that older adults scored higher on the help-seeking propensity subscale (i.e., evaluations of willingness and ability to seek help), none of them found age differences on the indifference to stigma subscale (i.e., concern about what important others might think about your seeking help), and two of the three found that older adults scored lower on the psychological openness subscale (i.e., people's openness to acknowledging psychological problems and to the possibility of seeking help for them; James & Buttle, 2008; Ward et al., 2013). A similar pattern of age being negatively associated with psychological openness, but not with the other two facets, was seen in a sample of 156 adults ranging in age from 60 to 92 (Kessler et al., 2015).

As indicated in Table 16.2, a number of studies have also examined sociodemographic factors in addition to age that influence help-seeking attitudes. Characteristics that have been associated with more negative help-seeking attitudes in later life across numerous studies include rural living (e.g., Karlin et al., 2008; Kessler et al., 2015), male gender (Kessler et al., 2015; Mackenzie et al., 2006; Yamawaki et al., 2011), and non-White race/ethnicity (Ojeda & Bergstresser, 2008; Tieu & Konnert, 2014).

Intentions to Seek Professional Help. In this section we review literature concerning associations between age and the final step in the internalized stigma

Table 16.2 *Summary of characteristics associated with greater public stigma and more negative help-seeking attitudes*

Study	Study N	Culture	Psychosis vs other	Rural/ urban	Male gender	Non-White race/ethnicity
Public Stigma						
Phelan et al. (2000)	1,005		X			
Webb et al. (2009)	101		X			
Crisp et al. (2005)	1,725		X			
Turvey et al. (2012)	1,094	X				
Help-Seeking Attitudes						
Karlin et al. (2008)	38,132			X		
Kessler et al. (2015)	156			X	X	
Mackenzie et al. (2006)	206				X	
Ojeda and Bergstresser (2008)	2,680					X
Tieu and Konnert (2014)	149					X
Yamawaki et al. (2011)	2,023				X	

model represented in Figure 16.1. It is worth noting that ideally the final step would be actual help seeking, but that intentions are often examined instead because: (a) actual treatment seeking is a relatively rare event in later life and, therefore, requires large samples to capture it, and (b) intentions are typically the strongest predictor of actual behavior (Ajzen & Fishbein, 2005). For the final time we turn to Figure 16.2 and note essentially the same pattern of results that we found with stigmas and attitudes – that intentions are increasingly positive across older age groups. These data are consistent with research suggesting that at least 80% of older adults are willing to seek professional help for mental health problems, although they prefer to do so from a general medical practitioner than a mental health professional (Arean et al., 2002; Mackenzie et al., 2008).

Numerous additional studies mirror the finding from our own data that help-seeking intentions are more positive among older age groups. Barney and colleagues (2006) asked 1,323 Australians between the ages of 18 and 89 how likely they would be to seek help from five sources if they were to experience clinically significant depression. Age had a positive influence on intentions to see a psychologist, psychiatrist, complementary and alternative medical practitioner, and especially a general practitioner (GP). We published a study that same year with similar methods and findings. In our sample of 206 adults also ranging in age from 18 to 89, age had no influence on intentions to seek help from a mental health professional for mental health problems, but older adults reported greater intentions to discuss mental health concerns with their GP (Mackenzie et al., 2006). Two other studies with nationally representative samples also found greater intentions with age. First, the previously described Eurobarometer study of 29,248 Europeans included a question about willingness to seek support from a "health professional" if participants were struggling emotionally. In comparison to the young (15–24) reference group, those 55–65 had an odds ratio of 2.25, and the oldest age group (65+) had an odds ratio of 2.08, indicating that the oldest participants were more than twice as willing to seek help in comparison to their younger counterparts (Mojtabai, 2010). Second, we examined the percentage of respondents from the National Comorbidity Survey Replication who reported that they would be willing to seek professional help for emotional difficulties. Willingness to seek help increased from 76.1% of the youngest (18–24) group to 87% of the middle-aged (45–64) group and then decreased slightly among those 65–74 (85.5%) and 75+ year-olds (82.2%; Mackenzie et al., 2008).

As was the case in our reviews of age differences in stigmas and attitudes, some mixed evidence exists that counters the idea that intentions to seek help for mental health problems are greater among older in comparison to younger age groups. No significant age differences were found in a study comparing willingness to seek professional psychological help among 96 younger (17–26) and 79 older (60–95) adults (Segal et al., 2005), or in a study of intentions to seek psychological help from a mental health professional among 173 general medical practice patients between the ages of 18 and 76 (Bayer & Peay, 1997). Two additional studies employing large, nationally representative samples found lower intentions to seek help among older participants. Yoon and Jang (2020) examined willingness to seek help among 600 Chinese American, 520 Vietnamese American, and 508 Filipino American adults as part of the 2002 National Latino and Asian American Study (NLAAS). Correlations between willingness and age were negative across all three groups, but only significantly so for Chinese Americans. Intentions to seek professional help were also negatively associated with age among the 8,796 adult participants from the European Study of Epidemiology of Mental Disorders (Ten Have et al., 2010). Finally, it is interesting to note that older rural adults in Australia had limited awareness and low intentions to use internet-delivered mental health treatments (Handley et al., 2015). This is an important topic for future research with evidence of rapidly increasing rates of internet use among older adults, and also significant disparities in internet use for health reasons among subgroups of older adults (Hunsaker & Hargittai, 2018; Yoon et al., 2020).

Summary of Age Associations with Stigmas, Attitudes, and Intentions. Except for personal public stigma of mental illness, findings from the literature tend to align with the positive findings in Figure 16.2, which suggest that older adults are: (1) less likely than their younger counterparts to experience public stigma of seeking help, perceived public stigma, self-stigma of seeking help, and self-stigma of mental illness; and (2) more likely to report positive attitudes and intentions to seek help. It is important to note that our review has examined associations between age and each component of Figure 16.1 separately. But according to the theory represented by the figure, the components interact and are causally related. We examined the moderating influence of age on a simplified version of the internalized stigma model in Figure 16.1 that excluded intentions (Mackenzie et al., 2019a). We were interested in whether this mediation model worked the same way for younger and older individuals, or if the internalization of public stigma and its downstream consequences differed according to participant age. Interestingly, we found that although older adults had less stigma and more positive attitudes, the indirect effect of public stigma of seeking help on help-seeking attitudes through self-stigma of seeking help was strongest for them. That is, older adults who perceived public stigma were more likely than younger adults to internalize it, and self-stigma of seeking help was more likely to negatively affect attitudes toward seeking help in older individuals. This study suggests that although interventions aimed at reducing internalized stigma of seeking help for mental illness are perhaps less important in general for older adults because they are less likely to endorse stigma, such interventions may nonetheless be especially effective for those older adults who do perceive public stigma because they are especially likely to internalize it.

Interventions to Reduce Stigma in Later Life

This Handbook includes several excellent chapters from leading scholars working at the forefront of designing and evaluating programs to reduce stigma to promote mental health (see Chapters 18–22 of this Handbook). In this section we focus on whether age impacts the effectiveness of these anti-stigma interventions, and what intervention work has been done with a specific focus on older adults.

Older adults are noticeably underrepresented in attitude and stigma intervention research. The mean age of samples in three meta-analyses of interventions to reduce public stigma (Corrigan et al., 2012; Morgan et al., 2018) and self-stigma (Mittal et al., 2012) ranged from the teenage years to the 50s, with most in their 20s and 30s. Furthermore, in reviews of interventions with long-term outcomes (Mehta et al., 2015) and intergroup contact interventions to reduce stigma (Maunder & White, 2019), most of the samples consisted of school- or college-age participants. Some of the studies included in these various reviews and meta-analyses may have included at least some older adults, but few if any focused on them.

Despite the lack of stigma intervention research with older adults, some of these reviews and meta-analyses have examined age effects, normally comparing adolescents and young adults with middle-aged adults. Corrigan and colleagues (2012) found that contact-focused interventions (i.e., that provide contact with members of the stigmatized group) were more effective at reducing stigma for adults, whereas education-focused interventions (i.e., that challenge inaccurate stereotypes about mental illness) were more effective for adolescents. This finding of differential effectiveness of interventions based on age was also found in reviews by Maunder and White (2019) and Pettigrew and Tropp (2006), both of which found greater improvements in university student samples than in adult community samples. Finally, this same finding was reported in a study of 4,122 participants who attended a contact-based educational program in California that was delivered as a statewide initiative to reduce discrimination and mental illness stigma. This study examined the moderating influence of age, gender, and race/ethnicity on pre-post changes in stigma. Although each of these factors affected intervention success, younger adults showed the greatest improvements (Wong et al., 2018).

Researchers have suggested two hypotheses for why anti-stigma interventions appear to be more effective for younger versus middle-aged adults. The first is that college students are more open to change in comparison to older adults (Corrigan et al., 2012; Maunder & White, 2019; Pettigrew & Tropp, 2006). We are skeptical of this hypothesis given that in a sample of 1,267,218 individuals between the ages of 10 and 65, openness to new ideas increased from age 20 to 65, suggesting that if there are age differences in openness to change based on anti-stigma interventions, they should favor older individuals (Soto et al., 2011). The second hypothesis for explaining why adolescents and college-age individuals experience greater improvement as a result of anti-stigma interventions is that young adults show greater variance in response to stigma measures and, therefore, have greater room for change (Corrigan et al., 2012). This hypothesis makes more sense to us considering that we have shown and concluded that younger adults report greater internalized stigma, less positive attitudes to seek mental health services, and less positive intentions to seek professional psychological help if it is needed in comparison to older adults. This broad body of literature, therefore, provides strong support for this second hypothesis that younger adults are more likely to benefit from interventions because they begin them with greater room for improvement. Nonetheless, the very small body of research examining anti-stigma interventions for older adults suggests that they can have an important impact, perhaps even more so than for younger adults in some situations.

Given the large body of research exploring anti-stigma interventions, readers may be surprised to hear that we are aware of only two interventions that focus on older adults. The first of these is the Treatment Initiation Program (TIP) developed by Sirey and colleagues (2005; 2020). This intervention is not explicitly described as an anti-stigma intervention; instead, it consists of three 30-minute meetings and two follow-up calls designed to target older adults' attitudes about depression and its treatment to reduce barriers and increase willingness for treatment. The intervention has been shown to improve treatment adherence and depression outcomes, but unfortunately the research team did not formally test the effect of TIP on attitudes or stigma.

A second intervention for reducing public and self-stigma of mental illness was developed by Conner and colleagues. Their peer educator (PE) intervention consists of older adult facilitators with lived experience with depression who received 20 hours of training to provide motivational enhancement, education about depression and its treatment, and social and emotional support. A total of 21 adults with depression over the age of 60 (M = 65, SD = 3.6) showed significant and clinically meaningful improvements in perceived public stigma and self-stigma of mental illness, with greater improvement among participants who had at least four contacts with the peer educator (Conner et al., 2018). Interviews with study participants following the intervention suggested four potential mechanisms through which it worked: (1) Providing a social connection with a same-age peer educator with whom they could relate; (2) working with a peer educator who had a history of dealing with depression and therefore understood them and their challenges; (3) improved mental health literacy; and (4) mutual support between participants and the peer educators (Conner et al., 2015).

Conclusions and Future Research Recommendations

We began this chapter with an objective of reviewing evidence on age differences in stigmas, help-seeking attitudes, and intentions to seek help because these constructs were assumed to be "worse" in later life and therefore likely reasons why older adults are especially unlikely to seek mental health services (Graham et al., 2003; Katona & Livingston, 2000). The evidence we reviewed largely refutes this hypothesis. However, many questions remain about the contributions of these constructs to low rates of treatment seeking in later life. First, most of the age comparisons in this chapter favor older adults; the one exception to this is personal public stigma wherein older adults were more likely to perceive others with mental disorders in negative ways. Perhaps this finding is due to the focus of public stigma research on serious mental illness such as schizophrenia (Angermeyer & Dietrich, 2006), which is more likely to elicit perceptions of dangerousness and desire for social distance among older adults in comparison to more common disorders such as depression and anxiety (Webb et al., 2009). Research is also needed to better understand how various types of public stigma are internalized among different age groups, and what the consequences are in terms of attitudes and intentions. Furthermore, there is a noticeable lack of research extending the processes in Figure 16.1 to include treatment seeking behaviors in general, and for older adults in particular.

A second direction for future research has to do with the exclusive use of cross-sectional designs in the research we reviewed. As a result, we currently have a poor understanding of whether the age differences we reviewed are the result of aging, variability among people from different birth cohorts (i.e., cohort effects), and/or from younger and older adults having experienced unique historical events (i.e., period effects). Longitudinal designs are needed to tease these effects apart, and it would be interesting to examine the effect of age on stigma, attitudes, and intentions using measurement burst designs. In such studies, bursts of intensive repeated measurements occur within days or weeks, perhaps throughout the process of managing mental health problems, and may be repeated annually (Stawski et al., 2015). These kinds of relatively new and exciting designs would allow stigma researchers to examine short-term variability, long-term change, and individual differences in outcomes.

A third general area for future research includes interventions to improve stigmas, attitudes, and intentions among older adults. The extensive body of intervention research with young and middle-aged adults suggests paths forward here, but as we have shown throughout this chapter, we should not assume that stigmas, attitudes, and intentions have the same influence on older adults, or work in the same way. A focus on older adults in stigma intervention work would help address the lack of diversity in stigma intervention samples (Guruge et al., 2017).

A final important direction for future research on mental health stigmas and interventions in later life is to better understand factors that magnify or dampen their influence (i.e., moderators). Table 16.2 lists moderators of age differences in public stigma and attitudes, but the list is small, focused on sociodemographics, and is missing potentially important psychological moderators, such as personality and mental health literacy.

Conclusion

In conclusion, our focus in this chapter is on stigmas and related constructs as they relate to older adults' mental health. This is a topic of growing importance given that the number of adults 60 years of age and older worldwide in 1950 (estimated at 200 million) tripled by 2000, and will continue growing to an estimated 2 billion by 2050 (United Nations, 2009). Although aging tends to result in improvements in emotional health (Scheibe & Carstensen, 2010), when older adults do struggle emotionally they are especially unlikely to seek help. There is not a simple explanation for why this is the case, and our review suggests that it is not because older individuals have especially negative mental health stigmas, attitudes, and help-seeking intentions. There is, however, additional work to be done to understand how age interacts with these constructs, and how to improve them through intervention work. These efforts have the potential to improve the lives of a large and quickly growing segment of our population.

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17 Stigma and Mental Health in the Abrahamic Religious Traditions

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Much research on mental illness and help-seeking stigma has focused on the general population without looking at factors that may be unique to specific subcultures. Although the general population may be hesitant to use mental health services, those in religious communities underutilize them even more (Mayers et al., 2007; Ng et al., 2011; Trice & Bjorck, 2006). While many factors account for this treatment gap, one influence comes in the form of mental illness and help-seeking stigma unique to those communities. Common religious beliefs, particularly among the Abrahamic traditions, indicate that the main causes of mental illness are moral weakness, sin, or unfaithfulness with religious practices such as praying, reading scripture, or worshiping (Hartog & Gow, 2005; Trice & Bjorck, 2006). In this chapter, this stigma will be referred to as religious mental health stigma.

Although some evidence suggests many different religious communities experience religious mental health stigma (e.g., Nguyen et al., 2012), we focus on the Abrahamic religious traditions in this chapter. The Abrahamic traditions typically include Judaism, Christianity, and Islam; the term references their shared lineage to the prophet Abraham. Although there is much that differentiates these traditions, there are commonalities as well. Furthermore, the bulk of the help-seeking stigma research has been focused on people of these faith traditions. Finally, given the limited space, a full review of stigma among all of the major religious traditions of the world is well beyond the scope of a single chapter (for a brief discussion of spiritual beliefs and stigma among East Asians, see Chapter 13, in this Handbook). We strongly urge other researchers to build on this work by exploring these phenomena in a variety of other religious and spiritual traditions.

Definition of Key Terms

To start, understanding religion and spirituality is central. Following Hill et al. (2000), we define religion as the experiences related to the search for the sacred that occur within and are endorsed by a specific community. Spirituality would be the broader concept as the search for the sacred that

Portions of this chapter were based on the work of the first author's master's thesis.

may or may not occur within or be validated by a particular community (Hill et al., 2000). Understanding different forms of stigma is also crucial. According to Tucker and colleagues (2013) stigma and mental health can be organized into four categories based on the intersection of two levels of stigma (public and self) and two reasons to be stigmatized (for having a mental illness or for seeking psychological help). This results in four types of stigma: public stigma of mental illness, public stigma of seeking help, self-stigma of mental illness, and self-stigma of seeking help (see also Chapter 3, this Handbook). We are interested in the ways that religious and spiritual communities and traditions promote or inhibit these types of stigma.

Historical Background

Prior to discussing the research on religion and stigma, we provide information on their historical background and context. This context is important for understanding the various contributing factors and influences related to stigma that emerge from religious or spiritual traditions (or people) regarding mental illness and seeking psychological help. Specifically, we explore the role religious leaders have historically played in providing mental health care, the use of religious/spiritual explanations of mental illness, and psychology's historical antagonism toward religion.

Religious Leaders as Counselors/Therapists

To understand stigma, it is crucial to understand how religion shaped our understanding of modern mental health care. Long before Anna O. described her cutting-edge psychotherapy with Breuer as the "talking cure" (Freud & Breuer, 1895/2004, p. 34), religious and spiritual leaders were providing care to their communities that in many cases foreshadowed or outright laid the path for modern psychotherapy (Ehrenwald & Ehrenwald, 1976). In the West, the divide between the religious/spiritual and the psychological did not emerge until the eighteenth or nineteenth century. Instead, caring for the religious/spiritual needs of one's community included the relational, emotional, and psychological needs as well. When faced with depression, anxiety, trauma, despair, and grief, people turned to their rabbis, priests, and imams; to their religious communities; and to the healers and nurturers in their families. In fact, this still happens today; clergy are often called on to offer counseling and mental health services to the communities they serve (Koenig, 2012). Thus, mental illness, help seeking, psychotherapy, and stigma cannot be divorced from the religious and spiritual roots of mental health care.

Religious/Spiritual Explanations of Mental Illness

Another important aspect of religion and stigma is an understanding of the ways in which religion has provided explanations for mental illness. What we call mental illness in modern, Western parlance was (and still is) considered something altogether different in other cultures and times.[1] Behavioral manifestations that we often label as psychological or psychiatric symptoms (e.g., seeing or hearing things that others do not see/hear or are not physically present, debilitating sadness, extreme forms of worry) have been described in various ways by different cultural groups, but often center on religious or spiritual explanations. The often-described explanation for symptoms that look like mental illness is some form of spiritual possession. This is seen in Western (e.g., Leavey, 2010; Mercer, 2013), African (Umoren, 1990), and Asian (Nguyen et al., 2012) religions. Other explanations abound, however, including lack of harmony between the physical and spiritual planes, attack from ancestors or the gods, blocked energy flow, misfortune, and punishment for misdeeds by fate or the dead (Nguyen et al., 2012).

These explanations can have real implications for the stigma related to mental illness or the pursuit of treatment for those symptoms. To the degree that a community is likely to blame an individual without providing means for resolution, those symptoms could come with a heavy degree of stigma. A classic example of this is the explanation for mental illness throughout much of northern European cultures from the Middle Ages until the eighteenth century (Ehrenwald & Ehrenwald, 1976). Symptoms of mental illness were often explained as demon possession or as the result of someone engaging in witchcraft, and the solution was often torture or death by burning. However, it is important to note that not all religious or spiritual explanations of mental illness lead to greater stigma (e.g., among religious leaders; Stefanovics et al., 2016). Likewise, explaining mental illness with a biogenetic model (i.e., mental illness is caused by a biological or genetic cause) does not necessarily lead to less stigma (Larkings & Brown, 2018).

Psychology's Historical Antagonism toward Religion

The third important part of the historical background to religion and stigma is understanding how modern psychology has held often pejorative and antagonistic views toward religion and spirituality. Many prominent figures in psychology became outspoken opponents of religion. For example, Freud referred to religion as "the universal obsessional neurosis of humanity" (Strachey, 1961, p. 43) and Ellis (1980) argued that religion was symptomatic of a disturbed and irrational mind. Others in this period supported a strictly naturalistic perspective within the behavioral sciences and contended that religion had no positive role in explaining human behavior (Richards & Bergin, 2005).

At the end of the twentieth century, this began to change. Researchers asserted that there are benefits of recognizing the wisdom of religion, and that

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[1] We acknowledge that we are taking a Western frame for this discussion and admit that our analysis starts first with our values and worldview, which is steeped in a modern, Euro-centric, and medical view of mental illness. We do not mean to imply that our way of seeing the phenomena that we collectively call "mental illness" is the only or best way to view these human experiences.

a strictly naturalistic perspective of the world and human behavior is incomplete (e.g., Bergin, 1980; Campbell, 1975). Others conducted empirical studies that showed that the practice of religion was positively associated with a host of physical and mental health benefits (e.g., Koenig et al., 2012; Sanders et al., 2015). Despite these generally positive findings, the early roots of stigma and hostility have resulted in several significant difficulties at the intersection of mental health and religion that can still be found today.

First, and most notably, some religious individuals have reported concerns with seeking secular professional help. These individuals worry about a secular practitioner criticizing their religious identity, encouraging them to engage in behaviors that contradict their beliefs, and viewing them pathologically because of their beliefs (Richards & Bergin, 2014). Second, despite acknowledging the importance of working sensitively with clients' religious beliefs, many practitioners express discomfort discussing religious topics in treatment (Rosmarin et al., 2013; Wade et al., 2014). This may lead religious individuals to assume that even if they have religious/spiritual issues exacerbating their mental health, they cannot get help for it from their mental health provider.

A third difficulty has been a remarkable lack of training on religious/spiritual issues and diversity. Richards et al. (2015) found that only 10% –25% of graduate training programs systematically addressed religion or spirituality or provided adequate training in this area. Brawer et al. (2002) found that 16% of clinical psychology programs accredited by the American Psychological Association (APA) did not address the topic of religion/spirituality in treatment at all. A lack of training in any domain can result in practitioner perceptions that a given domain may be inappropriate in treatment, and religion/spirituality is no exception (Walker et al., 2004). Consequently, practitioners may be more likely to avoid discussing these issues with their clients, view religion/spirituality as inappropriate topics in treatment, or feel incompetent to effectively work with religious clients.

This discussion on the historical issues and context delineates several of the key issues that contribute to religious mental health stigma. Fortunately, the stigma of help seeking among religious individuals in the United States seems to have diminished the past several decades (Pargament et al., 2013). This has happened as professional organizations have written religious/spiritual diversity into codes of ethics (e.g., American Counseling Association [ACA], 2014; APA, 2017), practitioners have increasingly acknowledged religion/spirituality as a valuable and beneficial component of clients' identity, support, and healing (Richards & Bergin, 2014), and religious clients have become more willing to pursue professional help when needed and vocalize their preference for treatment that is "sensitive to the spiritual dimension" (Pargament et al., 2013, p. 227).

Stigma and Mental Health in Religious Communities

Turning from the historical context, we now review stigma related to mental health as it is experienced in the lives of religious/spiritual people and within their communities. Mental health stigma in religious communities has only been researched in a roundabout way. For example, in a systematic review of the literature, only four of 1,423 articles identified through various PsycINFO searches dealt directly with mental health stigma in religious communities (Mathison & Wade, 2014). These are discussed in more detail in the sections that follow. In addition, research on related areas, such as religious beliefs about the etiology of mental illness, accepted methods of treatment for mental illness in religious communities, religious leaders' understanding of and training in mental health issues, and the differences in belief across race and ethnicity, provides valuable background knowledge that can inform our understanding.

The Continuum of Beliefs about Mental Illness

It is important to note that not all religious individuals hold the same beliefs about mental illness. Jewish, Christian, and Muslim people's beliefs fall on a continuum. On one end some individuals strongly endorse the biomedical model of mental illness, view psychological and psychiatric problems as illnesses, and encourage and value professional treatment. On the other end of the continuum some individuals strongly endorse a spiritual or religious conceptualization of mental illness (Hartog & Gow, 2005). Praying, reading scripture, participating in healing ministries, and even exorcisms are examples of treatments that may be deemed appropriate (Al-Krenawi & Graham, 1997; Borras et al., 2007; McLatchie & Draguns, 1984; Stanford, 2007; Trice & Bjorck, 2006). Of note is the significant within-group variation; we cannot say any definitive statements about all Jews, Christians, or Muslims. Instead, findings need to be understood as local and contextual to the people to which they refer and may not necessarily translate to other communities (or individuals) that share their name: Jewish, Christian, or Muslim.

Beliefs about the Causes of Mental Illness

The most fundamental difference between secular and religious mental health stigma is the difference in beliefs about the causes of mental illness. The ways in which those of the Abrahamic faiths understand the causes of mental illness have direct implications for treatment and for the development or abatement of stigma.

One of the most dramatic spiritual explanations of mental illness is demonic/jinn influence. It is important to note that demonic influence does not exclusively refer to demonic possession, although it can include it. Demonic influence is understood broadly as the impact that Satan, spirits, demons, or jinn might have on an individual. A Christian described the role she believed demonic influence played in her depression: "Satan took advantage of a time when I dove off a cliff of closeness with God to coax me into a pit of despair, confusion, and depression" (Webb et al., 2008, p. 703). In some Muslim communities, jinn – invisible, spiritual beings with free will to act good, neutral, or bad – are thought at times to be responsible for altered moods and mind states, such as depression, anxiety, delusions, and hallucinations (Al-Krenawi & Graham, 1997).

The more intrusive demonic possession itself is believed to be a cause of mental illness within some Christian communities such as Pentecostals, Catholics, and Anglicans. In Jewish traditions, the souls of dead people, or dybbuk, were believed to be able to possess people and thereby cause symptoms of mental illness (Bilu & Beit-Hallahmi, 1989). Likewise, jinn are believed to be able to fully possess someone in the Muslim faith (Al-Krenawi & Graham, 1997). Deliverance, or exorcism, is believed to be one appropriate way to eradicate a demon, dybbuk, or jinni. This eradication is believed to free the person from the demon and as a result from their symptoms and afflictions. However, deliverance rituals can, at times, have unintended negative consequences. In fact, the deliverance ritual itself can be a traumatic experience, resulting in the victimization or re-victimization of the person receiving the deliverance. At times, injuries and even deaths have resulted (Mercer, 2013).

Demonic possession has been named as a possible cause of psychotic symptoms in some Muslim communities. One author pointed to the similarities between descriptions of demonic possessions and some psychotic behaviors. For example, "They put thoughts in my mind that are not mine" or "My feelings and movements are controlled by others in a certain way" (Irmak, 2014, p. 775). Muslim traditional healing, or Koranic healing, is common in some cultures in the Middle East. Koranic healers use scripture from the Koran in a healing ritual to exorcise evil spirits, or jinn (Al-Krenawi & Graham, 1999). A faith healer in Turkey reported that three months after expelling evil spirits, patients with schizophrenia were symptom free (Irmak, 2014). It is worth noting that Koranic healers have a good reputation among the public and Islamic scholars (Al-Krenawi & Graham, 1999). Prominent social work, medical, and psychological scholars have advocated the use of Koranic healers (e.g. Irmak, 2014; Al-Krenawi & Graham, 1999).

Beliefs about the causes of mental illness have serious theological implications as well. For Christians, a popular doctrine posits that if one has enough faith, prays or is prayed for correctly or enough, reads the Bible dutifully, and regularly attends worship services, then one will have a sound mind, free of fear and emotional problems (Webb et al., 2008). This set of beliefs was referred to by one author as the "emotional health gospel" (Carlson, 1998, p. 29).

Webb and colleagues offered a revealing depiction of the emotional health gospel through a qualitative analysis of Christian self-help bestselling books (2008). The popularity of these books reveals their impact. For example, the Joyce Meyer Ministries (2020) website reports *Battlefield of the Mind* has sold six million copies, while the cover of the most recent edition of Joel Osteen's (2015) *Your Best Life Now* says eight million copies of this book have been sold. Of note, these and other books have commonly noted moral failure as a cause of depression, and the authors warned, "If you do not pray, you will either be habitually depressed or obsessed with your own ego . . .” and “. . . sometimes depression is caused by our own sin” (Webb et al., 2008, p. 704). Negative emotions, such as anger, ingratitude, or guilt, were another commonly cited cause. One author went as far as to say that “intolerance, agitation, short temperedness mark our behavior. Clinical depression, a mental health problem largely caused by pent-up anger, becomes a real possibility” (Webb et al., 2008, p. 705). Prayer, self-discipline, and willpower were portrayed as reliable ways to keep out depression. One author stated, “It’s even possible to live without negative emotions. God will take them off us like a thick blanket if we ask him to. But we have to pray” (p. 706). Another asserted that “if you are depressed you have to understand that nobody is *making* you depressed . . . . You are choosing to remain in that condition” (p. 706).

Webb and colleagues (2008) note that the representations of depression in these books are gross oversimplifications. There is no acknowledgment of the biopsychosocial complexities found in decades of research on the disorder. These books seem to portray recovery from depression as a quick, if not immediate, process – not one that can last months or even years.

Similar beliefs can be found in some Jewish and Muslim communities as well. When an individual does experience emotional problems, people with these beliefs might conclude that they are not living a good or moral life. What a mental health professional would call a mental disorder is instead interpreted as spiritual failure. An Orthodox Jew experiencing psychological concerns may experience “anxiety due to the feeling that he or she is deficient in his or her level of observance” (Rabinowitz, 2014, p. 243). In a study of Jews in northern Jerusalem, the most common religious explanations for experiencing a mental illness were seeing it as “God’s will” or a result of “sins/bad deeds” (Rosen et al., 2008). One Hasidic (Ultra-Orthodox) Jew in this same study reported the cause of his anxiety was twofold: heredity and the need to repair transgressions. He went on, “Maybe I do not have enough faith; because of this, this is happening” (Rosen et al., 2008, p. 206).

It is easy to see how stigma toward mental illness can be amplified with such beliefs. If a mental illness, such as depression, is caused by a lack of prayer or faith, pent-up anger, or Satan’s influence, then those who are depressed can easily be labeled as lacking in correct religious practice, unfaithful, wantonly angry, and influenced by the demonic. In other words, those who are depressed not only struggle with a mental illness, they also face the burden of religious mental health stigma.

This stigma can also be seen in the process of seeking help for psychological problems. Although most Jews, Christians, and Muslims, even some in more conservative sects, have cited a belief in some biomedical component to mental illness (Mathews, 2008; Trice & Bjorck, 2006), religious beliefs about mental illness also impact psychological help seeking. In a study of Protestant Christians in the southeastern United States, 18.9% of 540 participants agreed that “emotional/mental/relationship problems such as depression, anxiety, intense grief, loneliness, thoughts of self-harm or substance abuse problems are solely religious/spiritual in nature" (Royal & Thompson, 2012, p. 197). Even among those who did not endorse this item, it was common to believe that a person should only go to a mental health professional as a last resort (Royal & Thompson, 2012). Several studies have found that Christians believe that primary treatment should come from the church or individuals associated with the church (e.g., Crosby & Bossley, 2012; McLatchie & Draguns, 1984; Royal & Thompson, 2012). After all, a spiritual problem requires a spiritual solution. The treatment could be through pastoral or church staff counseling or, in rarer cases, through spiritual healing ministries (Huang et al., 2011; Leavey, 2010; Lyles, 1992). Spiritual health ministries may include deliverance rituals such as those discussed previously but may also be activities that involve miraculous healing through prayer in church services or meetings or through multi-session, biblically based programs (Village, 2005).

In contrast to the experience of those in many Christian communities, Reform and Conservative Jews appear to be much more open to mental health treatment, especially individual, outpatient psychotherapy. Miller and colleagues (2014) noted how psychotherapy "is accepted, highly valued, and appreciated" in these communities (p. 274). In contrast, Orthodox Jews' relationship to mental health treatment is more complicated (Rabinowitz, 2014). These individuals may not hesitate to consult with a psychiatrist or may not see taking prescribed medication to alleviate symptoms as problematic. On the other hand, most psychotherapy is perceived to be based on a value system incongruent with their own. For example, many Orthodox Jews perceive these therapies as eschewing personal responsibility in favor of personal satisfaction. Of note, cognitive behavioral therapies that take into consideration the clients' values and practices have been more successful with these groups (Rabinowitz, 2014).

Religious Leaders and Mental Illness

Thirty-nine percent of Americans with a serious personal issue turn to leaders in their religious community in times of need, even when their crisis is directly tied to a mental illness (Taylor et al., 2000). In this way, clergy serve an important role in mental health treatment as frontline mental health workers. In a sample of 235 college students in southeast Texas, men were significantly more likely to seek help from a religious advisor than were women, who were more willing to seek psychological help (Crosby & Bossley, 2012). Those seeking help for a mental health concern from a religious advisor might not get the help they need; one study found that 71% of 98 Protestant church leaders felt inadequately trained to recognize mental illness (Farrell & Goebert, 2008). Another study found that less than half of 179 clergy in New York and Connecticut had any clinical pastoral education (Moran et al., 2005).

Furthermore, even knowledge of available mental health services may be lacking (Jones et al., 2012; Taylor et al., 2000). For example, Farrell and Goebert (2008) gave clergy members two vignettes to read, one describing an individual in a manic state typical of bipolar disorder and the other in a depressive episode typical of major depressive disorder. The clergy were asked to identify symptoms of mental illness and decide whether they would refer these individuals to mental health professionals or provide counsel themselves. Nearly 40% of those who admitted to having inadequate training to recognize mental illness indicated they would counsel the individuals described in these vignettes (Farrell & Goebert, 2008). This discrepancy is disconcerting, especially considering that medication prescribed by a physician is strongly recommended in managing the manic episodes of bipolar disorder and/or to prevent future manic episodes (Butcher et al., 2014). Farrell and Goebert (2008) found that ministers with as little as five hours of mental health training were more likely to be adequately prepared to identify mental illness.

Reasons that religious people are more likely to seek help from religious advisors are varied. One reason is that seeking help from religious advisors carries less stigma than seeking help from mental health professionals (Crosby & Bossley, 2012). Another reason is that religious people may be concerned that a mental health professional would discredit or undermine their faith or that the experience would weaken their faith (e.g., Mayers et al., 2007). For this reason, even when clergy do refer congregants to a mental health professional, they are likely to send them to one known to share their faith (Mayers et al., 2007; McLatchie & Draguns, 1984; Moran et al., 2005). However, a qualitative study in London found that Christian clients who were initially hesitant about seeking secular-based therapy still found it helpful. In fact, most individuals in this study reported that the experience strengthened their faith whether or not there was a match in the spirituality or religious affiliation between therapist and client (Mayers et al., 2007). This indicates that mental health professionals can facilitate treatment in a way that respects and even promotes spiritual or religious well-being, something many religious people may not expect. Still, there is a need to incorporate religion into diversity training for mental health professionals (Crosby & Bossley, 2012). This might be especially salient for counseling religious minorities who may harbor more negative views of counseling and experience greater stigma.

The Intersection of Race and Ethnicity with Religion/Spirituality

Abdullah and Brown (2011) noted that race and ethnicity have major effects on mental health stigma, or, more specifically, differences in cultural values, history, socialization, and cultural understandings of mental illness influence mental health stigma in complex ways that differ among people of African, Latinx, and Asian descent as well as Indigenous groups.[2] Religion, religious

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[2] The diversity among each of these racial and ethnic groups is considerable. For example, there are over 550 federally recognized American Indian tribes in the United States alone. In this chapter, we attempt to provide only an introduction to how religion and mental health stigma interact in each broad racial and ethnic group. Further reading would be essential to do any single group justice.

communities, and religious leaders in many racial and ethnic communities can play an important role in both mental wellness and mental health stigma.

In the United States, racial and ethnic minorities can hold stronger stigmatizing beliefs than do European Americans, though there is a wide range of beliefs (Abdullah & Brown, 2011). People from primarily Black and Latinx Christian churches, particularly more conservative and Pentecostal ones, have tended to endorse more spiritual etiologies and spiritual treatments for mental illness than those from primarily White churches (Cinnirella & Loewenthal,1999; Leavey, 2010; Lyles, 1992; Payne, 2009). Reasons behind this tendency are multifaceted, ranging from lack of access to mental health care, higher levels of religiosity, and concerns about racial or ethnic differences between the clinician and the client (Caplan et al., 2011; Lyles, 1992).

A higher percentage of Protestant African American congregations is conservative and/or Pentecostal compared to White congregations. A study conducted in California found that of 51 African American churches surveyed, 35% were conservative, 33% were Pentecostal, and 22% were nondenominational (another Christian group that tends to be conservative). Only 10% of this sample were mainline Protestant, churches that more frequently endorse the biomedical model of mental illness (Payne 2009). In the study, African American pastors were far more likely to endorse items like “Depression is hopelessness that happens when one does not trust God” and “Depression is due to a lack of faith in God” than were European American pastors. Furthermore, European Americans were six times more likely to agree that “Depression is a biological mood disorder” than were African American pastors (Payne, 2009, p. 361).

In addition, African American clergy – who are particularly important figures in many African American communities – may be wary of mental health services. In one study in New Haven, Connecticut, about half of 99 African American pastors interviewed said they had received specialized training for using pastoral counseling with serious mental health problems. These pastors cited a willingness to exchange referrals with secular mental health professionals in their area but tended to have a lack of information on available services. Even among these pastors, though, about half agreed or strongly agreed that those with severe depression or anxiety could cure themselves if they put their mind to it (Young et al., 2003). Interviews with clergy in another study revealed strong faith in religious coping. One pastor reported, “A person with a strong spiritual balance can almost take more than a person without it because their spiritual balance will help them cope.” Another stated, “I guarantee you, bring me anybody with whatever problem, and it will be gone in six months . . . if they follow the Word” (Lyles, 1992, p. 373). Worthy of note is that African American clergy conduct more pastoral counseling than European American clergy, in part because of limited access to services among their congregations (Young et al., 2003).

Many pastors have also reported feeling uncomfortable referring congregants because they believe a professional would not respect their religious beliefs.

Additionally, pastors have reported concern that a professional (usually assumed to be non-Black) would not be able to relate to Blacks or might be prejudiced against them. In a striking example, one Black woman had seen two White therapists of the same religious background but had not disclosed previous sexual abuse by her parents because she was concerned that the White therapists might believe the stereotype that "black people can't control their sex drives and [she] didn't want to be stereotyped" (Lyles, 1992, p. 370). A study of clergy referral attitudes and behavior in Michigan likewise found that over half of 22 African American clergy were likely or very likely to refer a congregant to a mental health professional of the same ethnicity rather than one of a different ethnicity (VanderWaal et al., 2012). The authors suggested this preference reflected a concern that a mental health professional of a different ethnicity may not comprehend the challenges, cultural traditions, or perspectives of their church members. It seems then that the low utilization of mental health services by African American Christians is influenced both by a tendency toward more conservative or Pentecostal sects of Christianity and concern about the cultural competency of mental health practitioners who are of a different ethnicity.

Religion, in particular Christianity, is also a significant part of Latinx culture. For example, in one study, 90% of 177 Latinx adults in Queens, New York, reported being Christian (Caplan et al., 2011). Furthermore, among this sample, religiosity was significantly correlated with higher endorsement of the perceived stigma of seeking help for depression from friends, coworkers, and family (Caplan et al., 2011). In addition, in the Los Angeles Epidemiologic Catchment Area (ECA) study, only 11% of Mexican Americans who had experienced a mental disorder in the past six months sought any kind of mental health treatment compared to 22% of Whites with mental disorders (U.S. Department of Health and Human Services, 2001). The use of complementary or alternative medicine is commonplace in Latinx communities as well. This includes prayer as well as the use of traditional healing practices such as *curanderismo*, a form of folk medicine with spiritual healing and the maintenance of harmony and balance with nature. Estimates of use of alternative medicine by Mexican and Mexican Americans from range from 50% to 75% (Caplan et al., 2011).

People of Asian descent also have a very low rate of utilization of mental health services (Tan & Dong, 2014). Reasons for this are varied, but many echo concerns faced by other racial and ethnic groups such as lack of access to mental health care including limited providers who are competent to provide culturally appropriate services in addition to being stigmatized for having a mental illness (Tan & Dong, 2014). About 42% of Asian Americans identify as Christian. Which branch of Christianity they assert can depend on their cultural heritage. For example, a majority of those from the Philippines (or whose ancestors originated there) are Catholic, whereas most of those of Korean descent are Protestant (Tan & Dong, 2014). That said, Asian Americans may hold on to both traditional values/belief systems and Christian beliefs at the same time. Some traditional beliefs include the importance of hierarchical family structures, filial piety or the deference and duty one holds toward one's parents, an emphasis on harmony and cohesion in interpersonal relationships, and self-restraint in verbal communication and control over emotions (Abdullah & Brown, 2011; Tan & Dong, 2014). Asian Americans who hold these more traditional beliefs may be more likely to believe that mental illness reflects poorly on the family and can be seen as personal weakness or the result of evil spirits (Abdullah & Brown, 2011). When problems arise, the family is the first line of treatment; seeking help for personal problems from a stranger is unusual (Tan & Dong, 2014). Professional psychological help can be delayed for these reasons. At the same time, the supportive network of family, friends, and community organizations such as churches can act as a resource for Asian American clients (Tan & Dong, 2014).

Research on the referral behavior of Asian American clergy in California indicated low rates of referrals to mental health professionals. In fact, one study found that only 27% of 103 clergy members could name a single provider or mental health agency to use as a referral (Yamada et al., 2012). Clergy in this study were far more likely to refer a congregant to a general health practitioner rather than a mental health professional. Knowledge of mental illnesses and possible treatment options appears to increase the likelihood of a referral, findings that were also found in African American populations (Yamada et al., 2012).

There is little research exploring mental illness or help-seeking stigma in Indigenous groups such as American Indians or Alaska Natives (Abdullah & Brown, 2011; Freitas-Murrell & Swift, 2015), yet such research could help provide greater access to mental health support in these communities. However, the relationship between the Abrahamic religions, particularly Christianity, and Indigenous groups such as American Indians (as with other non-White groups in the United States), is a complex and difficult topic that includes a history of colonialization and oppression (King et al., 2014). In the United States, for example, Christianity was interwoven with government efforts to eradicate American Indian religion, culture, and language (Devens, 2001; Lomawaima & Ostler, 2018) and undermine American Indian approaches to life, such as Indigenous healing practices. Therefore, mental health providers who may represent White Christian culture may still be viewed with suspicion today. Such histories and lived experiences need to be understood in any attempt to understand and improve mental health stigma with the goal of increasing access to mental health.

Implications

Negative beliefs about mental health in religious communities can have significant implications. Negative beliefs can lead to ignorance of the mental health needs and a lack of assistance from the religious community for families who have members with mental illness (Farrell & Goebert, 2008; Leavey et al., 2007; Rogers et al., 2012). In addition, these beliefs can lead to nonadherence to psychiatric treatment, increasing the risk of relapse and hospitalization, and lack of medical treatment for those with severe mental illness (Borras et al., 2007). This lack of consistent care can result in an increase in high-risk symptoms such as suicidal ideation and behavior and psychotic or manic episodes (Borras et al., 2007; Mitchell & Romans, 2003). In rare but significant cases, for example, Christian church members have been discouraged and even forbidden to take psychiatric medication and were told they did not have a mental illness despite having a diagnosis from a mental health professional (Stanford, 2007). Although the stigma of mental illness and help seeking in religious communities is not the only barrier to getting appropriate care, it is considerable. Beliefs can lead directly to avoidance of care. Beliefs can also lead to stereotypes and social judgments that limit people's willingness to seek help.

Future Research Agenda

As our chapter shows, there is some important and insightful research that has already been completed. However, there is so much left unknown and undone. Future research in this area can be fruitfully pursued in many areas, such as explorations of broader religious and spiritual traditions, greater understanding of the intersections of diverse identities (e.g., gender, sexual orientation) and religious faith, and the assessment of interventions that might be done to reduce stigma in religious communities.

One important area for future work is the exploration of the costs and benefits of religious beliefs related to mental illness and help seeking. Establishing that people from different religious groups have religious explanations for mental health symptoms does not, in itself, establish harm or benefit. How those beliefs are enacted in different communities with different individuals and the impact of those behaviors need to be further explored. For example, advising someone who suffers from bipolar disorder to not try a medication regimen and to pray instead may lead to poor outcomes for that person and those close to them. However, encouraging prayer and community/faith healing (e.g., laying on of hands, anointing with oil), for example, for someone struggling with complicated grief or some forms of social anxiety, might prove to be particularly effective without Western-oriented psychological care. Thus, future research might be conducted that explores a range of outcomes (e.g., mental, physical, spiritual) resulting from a wide range of intervention and referral behaviors among various religious communities and people. For example, more research could be conducted that centers on and respects specific religious beliefs (such as the spiritual cause of what Western psychological practice terms major depression) and explores the effects of those beliefs on various outcomes (such as professional treatment seeking, remission/relapse rates, employment, and social support or relationship satisfaction). By partnering with specific religious or cultural groups (such as in participatory, action research models), researchers could address important questions in ways that are culturally congruent and relevant to the religious group. Such research might lead to more answers about what works for which people in what circumstances. Understanding these nuances will help both medical and religious communities reduce stigma and provide the care that is needed for people dealing with mental health concerns.

Another important area for research would be in exploring a wider range of religious and spiritual worldviews. Most of the work done to date is in the Abrahamic religions. However, there is an incredible diversity of beliefs and ideas represented in other religious and spiritual practices throughout the world. Understanding how those beliefs and practices impact people struggling with considerable mental health challenges would provide greater depth and breadth to this topic. Such work could be done with a cross-cultural research lens, understanding similarities and differences between different religious or cultural groups (e.g., how does a spiritual understanding of schizophrenia impact formal and informal treatment adherence among Chinese and Indian Buddhists or among Muslims living in Europe or Africa?).

A third important area for research would be further explorations regarding the intersection between race and ethnicity and religious mental health stigma. We have written in broad brushstrokes in this chapter. Such generalities allow for communicating complex issues in a short amount of space. However, broad strokes also can obfuscate reality by categorizing things together that are as different as they are similar. This is the challenge for research moving forward with regard to religious/spiritual commitments and race/ethnicity. One way to deconstruct unhelpful generalizations is to study the specifics. Understanding the ways that race intersects with religion is crucial to understanding stigma and mental health, especially in countries with histories of colonialism, oppression, and racism. Likewise, an intersectional lens would also include other forms of identity, such as gender, sexual orientation, and class. Future research could be done to understand how stigma is addressed in groups with various identities. Does a person who identifies as a straight, Asian woman and practices Hinduism in the USA need the same support to overcome mental health stigma as a straight, Black man who practices Catholicism in Jamaica? How then might an additional intersection with sexual orientation change that comparison?

Finally, as research in this area continues to grow, it may become important to explore interventions to help promote professional psychological help seeking for those who could benefit from it most. Understanding and respecting religious and spiritual commitments is central to culturally responsive intervention efforts, such as anti-stigma campaigns for the religiously committed. A first step in this process would be to partner with stakeholders in the community, to identify the need (e.g., how troubling the stigma is), and work together to develop a shared goal (e.g., encouraging people to complete a depression screening or educate religious leaders about the benefits of psychoactive medication for schizophrenia). Then, the important step of creating and testing the effectiveness of an intervention could be taken. In addition, research could be done to continue to develop and test culture-specific adaptations of psychotherapy that incorporate the religious/spiritual beliefs of the clients and offer culture-specific formats that might include the client's family, religious leader/community, or other important figures. Such adaptations might not only prove to be more effective in reducing psychological symptoms, but may also help to reduce stigma and make professional psychological care more accessible to a broad range of people.

Conclusion

Religion and spirituality can provide both solace and strain, resources and roadblocks for people dealing with mental health concerns. Stigma of mental illness and of seeking help has been exacerbated by religious beliefs and behaviors in some communities and by the historical animosity psychology held for religious traditions. However, the story of religion and mental health care is not one sided. Religion can also provide considerable support and resources for people going through difficult times, including those struggling with mental illness. By understanding the needs of religious communities, working within their worldviews, and engaging in respectful ways, psychological researchers and clinicians can build bridges that surmount stigma and other barriers and promote the best care for people in need.

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PART IV

Reducing Stigma to Promote Mental Health

18 Interventions to Reduce Mental Illness Stigma and Discrimination at the Person-Level for Individuals and Small Groups

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Introduction

Stigma and discrimination toward people with mental illness are global challenges requiring urgent action. This chapter provides an overview of interventions designed to reduce stigma and discrimination related to mental illness at the person-level for individuals and small groups. Population-based interventions, interventions addressing help-seeking stigma, self-affirmation interventions, and interventions targeted toward individuals with mental illnesses are covered in other chapters of this Handbook.

This chapter will describe the evidence for these person-level interventions, focusing on social-contact and educational interventions and the impact on knowledge, attitudes, and behavior. Recent evidence carried out in particular target groups will be reviewed, including health professionals, police, and students. A global perspective will be presented, although it is recognized that most stigma-related research has taken place in high-income countries (HIC), despite most of the burden of mental illness worldwide being in low- and middle-income countries (LMIC), where approximately 85% of the world's population live. Indeed, the negative impacts of stigma and discrimination can be particularly detrimental in LMIC, where the mental health "treatment gap" (the disparity between the number of people with a mental illness who need care and those who receive care) remains significant (Patel et al., 2016, 2018). A review of research in LMIC will, therefore, be presented before the chapter concludes with recommendations for further research.

Overview of the Literature

Stigma has been defined as "A mark or sign of disgrace usually eliciting negative attitudes to its bearer. If attached to a person with a mental disorder it can lead to negative discrimination. Stigma can be seen as an overarching term that contains three elements: problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behavior (discrimination)" (Thornicroft et al., 2007, p. 1).

The experience of mental illness stigma compounds the challenges already experienced as a result of mental illness (Thornicroft et al., 2007). The consequences of mental illness stigma and resulting discrimination are profound; from the detrimental effects on mental health and increase in suicidality, the reduction of life opportunities and life expectancy, to limiting access to physical healthcare, increased poverty, homelessness, and contact with the criminal justice system (Gronholm et al., 2018). Epidemiological research has consistently shown people with severe mental illness in HIC have higher rates of medical comorbidities and die 15–20 years earlier than the general population (Jones et al., 2008; Wahlbeck et al., 2011). Stigma and discrimination can be considered contributing factors to this premature mortality (Liu et al., 2017).

Common aims of implementing successful interventions to reduce stigma against people with mental illness include increasing knowledge, improving attitudes, and reducing prejudice and acts of discrimination (Thornicroft et al., 2007). Developing an evidence base through research generates insights that enable organizations and structures to implement and invest in the most effective interventions for reducing stigma (Maunder & White, 2019).

The principal strategies for stigma reduction are social contact (e.g., face-to-face contact, or remote interventions such as film, internet, or social media contact) and education (e.g., written materials, lectures, small group workshops; see Corrigan et al., 2012; Gronholm et al., 2017). This chapter will first describe relevant interventions using social-contact strategies before describing interventions using education.

Social Contact

Interventions using social-contact strategies have received significant attention within the field of mental illness anti-stigma research. Knowing someone with mental illness has repeatedly been shown to be associated with less stigmatizing attitudes (Brockington et al., 1993; Pettigrew & Tropp, 2008; Pettigrew et al., 2011). Individuals within the general population who interact with people with mental illness are less likely to be prejudiced (Corrigan et al., 2012). The social psychology theory underpinning social-contact (sometimes called interpersonal contact) interventions is Allport's intergroup contact theory (Allport, 1954), which argues that positive interactions between members of different social groups can reduce prejudice and animosity (Maunder & White, 2019). A meta-analysis of intergroup contact theory, including over 500 studies, found that intergroup contact generally reduces intergroup prejudice and proposed that the mechanism through which social contact reduces prejudice is by reducing anxiety about contact, and increasing empathy and perspective taking (Pettigrew & Tropp, 2008). Interventions that increase social contact, therefore, aim to replicate this phenomenon by using contact as a strategy to reduce stigma and discrimination (Thornicroft et al., 2016).

Social-contact interventions can be delivered in direct or indirect formats. Of increasing importance in the wake of the global COVID-19 pandemic is the use of video, internet, and multimedia interventions (Liu et al., 2020). Direct contact includes face-to-face contact between participants and people with mental illness. Indirect contact can include observing another individual interacting with a person with mental illness, imagined contact, or contact via video, for example, watching a film or interacting through an online chatroom (Maunder & White, 2019). It is important to note that without a structure that generates a positive imagined experience, imagined contact may have a detrimental effect through increasing anxiety rather than increasing empathy and perspective taking (Gronholm et al., 2018).

Interventions using direct and indirect social-contact strategies to reduce stigma have been found to be effective (Clement et al., 2012; Corrigan et al., 2012; Kolodziej & Johnson, 1996; Maunder & White, 2019) and have been reported as the most effective style of intervention in some reviews (Gronholm et al., 2018; Thornicroft et al., 2016). The effectiveness of social contact as an intervention to reduce stigma is enhanced when there is equal status between participants and common goals in the interactions (Thornicroft et al., 2016), and when interactions disconfirm prevailing stereotypes (Corrigan et al., 2012).

However, evidence for the long-term sustainability of the improvements following social-contact interventions is currently lacking (Gronholm et al., 2018; Morgan et al., 2018). A review of 80 studies in high-, middle-, and low-income settings showed that although social-contact interventions are effective, their effectiveness was no greater than other anti-stigma interventions, for example, educational strategies (Mehta et al., 2015). This finding was corroborated in a review by Morgan and colleagues in 2018, which showed that both social-contact interventions and educational interventions show small-medium effects, and neither is superior to the other (Morgan et al., 2018). This review also echoes the finding that there is little evidence about whether positive changes are sustained in the long term or not, due to the lack of longer-term follow-up in most studies.

Some interventions involve both a social-contact and an educational component (Maunder & White, 2019), and the effectiveness of social contact has often been studied in combination with education rather than separately (Gronholm et al., 2018; Holzinger et al., 2008). Therefore, understanding the effectiveness of educational efforts to reduce stigma is foundational to understanding the best ways to achieve the general goal of stigma reduction.

Education

Interventions to reduce mental illness stigma and discrimination based on the principle of education have been widely researched. Interventions using education strategies broadly include written materials, small group work, and lectures for larger groups. As lack of knowledge about mental illness is an underpinning aspect of stigma (Thornicroft et al., 2007), education strategies often target this element of stigma, for example, by utilizing “myth busting” strategies (Gronholm et al., 2017). Education has broadly been shown to be effective in reducing stigmatizing attitudes toward mental illness; however, the duration of these improvements remains unknown, in part due to lack of longer-term follow-up (Corrigan et al., 2012; Thornicroft et al., 2016). This challenge of limited long-term evidence has been noted in relation to most anti-stigma interventions; in a systematic review on the medium- and long-term effectiveness of stigma reduction interventions (focused on studies with over 4-week follow-up periods), most studies (69%) had follow-up periods of only 1–6 months (Mehta et al., 2015).

Written materials include flyers, books, blogs, web pages (Corrigan et al., 2012), and other forms of social media such as Twitter, Facebook, Instagram, and TikTok. Material posted on social media has the potential to be either stigmatizing or anti-stigma. An example of the positive potential of this is the role of Twitter in reducing mental illness stigma and raising awareness, which has been a focus of recent studies (Budenz et al., 2020; Cheng et al., 2018). Audio-visual materials include podcasts, short videos, feature-length films, and virtual reality. The comparative effectiveness of such materials is a subject that requires further investigation and could be a focus of future research. Written materials can be used in focused educational sessions, in wider campaigns, or published for general readership, and the relative low cost and potential wide reach are key benefits of simple educational materials (Corrigan et al., 2012).

Organizations frequently use educational approaches including training workshops to present material with the aim of increasing knowledge and improving attitudes (Gronholm et al., 2018). Training workshops can be internet-based or face-to-face, in small group seminar style or in a less interactive lecture format, and may provide written materials to participants or involve information via lecture, film, or role-play. “Myth busting” is a technique that has been used to replace common myths about mental illness with accurate information (Gronholm et al., 2017). An example of this is replacing the myth that “People with mental illness can’t work” with the fact that “You probably work with someone with mental illness” (Gronholm et al., 2018). Psychoeducation, for example, to improve and increase knowledge about mental health and illness, has also been used (Gronholm et al., 2018).

It is important to note that educational approaches vary widely both in terms of the information they use, the teaching styles, and format, and in their aims. There is significant heterogeneity in research studies evaluating the benefit of educational interventions to reduce mental illness stigma. However, several reviews of the literature, discussed in further detail below, have shown some benefit; educational interventions appear to increase participant knowledge of mental illness and improve attitudes about those with mental illness (Corrigan et al., 2012; Gronholm et al., 2017). Examples of how education has been used in particular target groups and the effectiveness of these particular interventions will be addressed next.

Anti-Stigma Interventions for Specific Target Groups

Much of the research evaluating the effectiveness of interventions using both educational and social-contact strategies to reduce mental illness stigma has been focused on particular target groups. These groups have been described as “power groups” in that they may have influence over the life goals of people with mental illness, and that their behaviors may also have potential to interfere with these life goals. Thus, targeted anti-stigma interventions are of particular value (Corrigan, 2004). These key target groups for anti-stigma interventions include public service workers, such as healthcare professionals and police, and young people at school and university. This section will describe the research findings from studies evaluating anti-stigma interventions focused on these target groups.

Healthcare Staff

Professionals working in healthcare settings have been deemed an important target group for interventions to reduce stigma in light of their high level of contact with people with mental illness (Gronholm et al., 2018) and the impact of stigma on quality of care these professionals provide (de Jacq et al., 2016; Yamaguchi et al., 2013). Perhaps surprisingly, given the known impact of social contact on reducing stigma, research from across the world has shown high levels of stigma toward people with mental illness within health professional groups, including within healthcare students and within mental health professionals (Henderson et al., 2014), as well as in primary healthcare professionals, particularly older and more experienced professionals (Vistorte et al., 2018). Research from 20 countries showed that attitudes of nurses toward people with mental illness were mixed, and overall comparable to the attitudes of the general public rather than being more positive, as might be expected due to increased social contact. The most negative attitudes were reported toward people with schizophrenia.

Intervention studies aimed at improving health professionals’ knowledge, attitudes, and behaviors toward people with mental illness were summarized by Henderson and colleagues in 2014. The authors highlight studies evaluating interventions aimed to reduce stigma toward specific diagnoses such as a training course for general practitioners in substance misuse disorders (see Strang et al., 2007), and more generic interventions using internet-based education. An example of the latter was a study evaluating internet-based education provided for professionals working in a long-term care facility in the United States (see Irvine et al., 2012). Most interventions were educational in nature and showed some improvement in attitudinal outcomes or knowledge, although only a few studies examined whether these improvements were sustained over time (Gronholm et al., 2018; Henderson et al., 2014).

Another review of 18 studies evaluating the effectiveness of anti-stigma interventions for healthcare professionals and students corroborated the findings that educational and social-contact interventions do effectively reduce stigma in these groups; however, it also presented evidence that these positive effects diminish over time (Stubbs, 2014). The review also noted that role-plays were not very effective as an intervention: in two studies comparing medical students exposed to teaching with and without the use of role-play, no difference in outcome was seen. One limitation is that the majority of studies evaluated in this review involved students rather than qualified professionals (Stubbs, 2014).

"Key ingredients" of anti-stigma programs for healthcare professionals have been identified (Knaak et al., 2014), including social contact in the form of personal testimonies, a focus on skills teaching for healthcare professionals around behavior change, myth busting, using a person-centered approach (as opposed to a pathology-first approach) modeled by an enthusiastic facilitator, and emphasizing and demonstrating recovery. These "key ingredients" were identified through the qualitative component of a mixed-methods research study examining the "Opening Minds" anti-stigma initiative in Canada, a systematic effort to reduce mental illness–related stigma established by the Mental Health Commission of Canada (Knaak et al., 2014).

As healthcare professionals are instrumental in providing care for people with mental illness, further research of effective interventions in this group is needed, particularly demonstrating improvements that are sustained over longer periods of time. Further research within professional groups including doctors and nurses of other specialties who frequently provide frontline care to people with mental illness (e.g., in emergency medicine), as well as support workers and allied health professionals working within mental health settings, in both HIC and LMIC, would be of great benefit.

Police

Following the de-institutionalization of mental health services in some countries, a significant increase in contact between police and people with mental illness has been noted. This has contributed to an increased recognition of the importance of adequate training and education for police officers (Hansson & Markstrom, 2014). A Canadian study evaluating a mental health workshop for police officers described a strong police culture of mental illness stigma, with results showing that most officers deem mental illness a sign of personal failure and most would not seek professional help for mental health issues (Stuart, 2017). Two further studies, from the UK and Sweden, evaluating evidence from interventions for police officers are of note. Pinfold and colleagues (2003a) evaluated a training intervention for police officers in the UK involving officers attending two mental health awareness training workshops over a 6-month period including small group work and discussion groups. Pre- and post-intervention questionnaires showed improvement in attitudes toward people with mental illness and views on treatment, but no objective change in officers' perceived knowledge were identified (Pinfold et al., 2003b).

Hansson and Markstrom (2014) conducted a study with Swedish police officers, incorporating an anti-stigma training program into the basic training program for police officer students at Umea University in Sweden. The participant group was compared with a control group of students on the same course in an earlier semester. The intervention included lectures and video presentations including material presented by people with lived experience of mental illness. Statistically significant improvements in overall attitude, mental health literacy, and intentional behaviors were seen in the participant group and these improvements were sustained at 6 months (Hansson & Markstrom, 2014).

The crisis intervention team (CIT) model was developed in 1988 by the Memphis police department to equip police officers with skills and knowledge to use when responding to people with mental illness (Compton et al., 2006). CIT training typically involves undergoing 40 hours of educational training provided by mental health professionals, advocates, and mental health service users. A study of the CIT model in the United States in 2014 evaluated the impact of the 40-hour CIT training and showed improvements in knowledge, attitudes, and skills using outcome measures such as knowledge tests and social distance scales. The improvements were maintained at 22 months compared to police officers who did not undergo the CIT training (Compton et al., 2014).

Despite the promising outcomes of the studies discussed, in light of the significant interaction between police officers and people with mental illness and the high level of stigma, there is a great need for further intervention studies in this area. This could include using a wider range of methods, for example, including social-contact techniques and focusing on a wider range of countries, including LMIC.

Students and Young People

Young people, such as secondary school and university students, have been highlighted as an important target group for mental illness stigma interventions in light of their potential to change the future (Gronholm et al., 2018). Of particular importance are healthcare students, given their future role in providing care for people with mental illness. Several studies have evaluated the impact of mental health training on stigma and prejudice within healthcare students, including nursing and medical students.

Studies in several countries have shown stigmatizing attitudes toward people with mental illness in university students, including medical students. Examples include a survey of university students in Nigeria, which showed social distance toward people with mental illness was higher than expected in a cohort of university students: the authors comment that this "challenges the notion that stigma and negative attitude toward the mentally ill are less severe in Africa than in western cultures" (Adewuya & Makanjuola, 2005). A study surveying medical students in India concluded that undergraduate medical students have a very unfavorable attitude toward people with mental illness as well as toward psychiatry as a specialty (Lingeswaran, 2010). A study of UK medical students that involved surveying 760 students showed a greater level of stigmatizing attitudes toward patients with illnesses considered psychological in origin compared to illnesses with a clear physical cause (e.g., pneumonia). Attitudes toward mental illness were influenced by students' direct and indirect experience of mental illness, for example, whether they had personal experience of mental illness themselves or within their families (Korszun et al., 2012). A study of medical students at the three public universities in Turkey surveying attitudes toward mental illness using vignettes around depression and schizophrenia showed striking levels of stigmatizing attitudes toward people with mental illness among medical students, for example, a high perceived likelihood of dangerousness in people with schizophrenia (Ay et al., 2006). The results of these studies reinforce the notion that stigma toward people with mental illness is a pervasive issue spanning cultures and professions.

Yamaguchi and colleagues reviewed the effects of brief interventions (defined as three or fewer sessions) to reduce mental illness stigma in university and college students (Yamaguchi et al., 2013). Due to the heterogeneity of studies, they classified the interventions into nine categories: social contact, video-based social contact, video-based education, education: lecture, education: text, famous film, education: role-play, and other. The researchers found relatively consistent findings that social contact and video contact are effective for changing attitudes for students other than medical students. Concerningly, this review found little evidence for the effectiveness of reducing mental illness stigma in medical students. The authors suggested this could be due to medical students having greater biological understanding of mental illness and a greater focus on problems caused by mental illness, which may be associated with stronger stigmatization. Few studies evaluated the effects of interventions at long-term follow-up.

Several studies have evaluated the impact of the mental health curriculum in medical school training on stigmatizing attitudes toward people with mental illness. A study of medical students in Nigeria showed an increase in favorable attitudes toward mental illness following exposure to psychiatric training by surveying students before and after they had completed their psychiatry rotation (Ighodaro et al., 2015). A study of Iranian medical students showed favorable attitudes in students at the end of their mental health placement; however, attitudes were not measured beforehand, so no direct comparison was made (Amini et al., 2013).

A study of Turkish medical students showed final-year medical students had more favorable attitudes to people with mental illness compared to second-year students; however, stigmatizing attitudes were still prevalent (Ay et al., 2006). A study of medical students in an Irish university showed a positive attitudinal shift after completing their final-year psychiatry module. Attitudinal questionnaires were completed at the beginning and following completion of the psychiatry module (O' Connor et al., 2013). Conversely, other studies have shown no significant positive influence on attitudes toward mental illness following exposure to psychiatry in training. For example, a study of medical students in north India compared attitudes toward mental illness and psychiatry in students who had not yet completed their psychiatry posting and interns who had completed their clinical posting in psychiatry. Attitudinal questionnaires were used and no significant impact of exposure to the psychiatry curriculum was noted (Gulati et al., 2014). A study of UK medical students found attitudes toward patients with mental illness were actually worse in fifth-year students compared to first-year students, particularly toward patients with unexplained medical symptoms (Korszun et al., 2012).

In light of the concerning level of stigmatizing attitudes toward people with mental illness in healthcare students and the importance of their role as future healthcare professionals, Heim and colleagues (2019) reviewed the evidence on interventions to reduce mental illness stigma among medical and nursing students in LMIC. The studies included in the review showed improvements in attitudes toward people with mental illness in the student groups who participated in the interventions, for example, one study used an intervention that involved a combination of awareness-raising activities, video-based contact intervention, and group discussions, which had a positive attitudinal effect. However, due to large heterogeneity of the interventions considered in terms of intervention content, evaluation design, and outcome measures as well as methodological quality, it was not possible for the reviewers to carry out a meta-analysis or draw conclusions about the most effective interventions. The review did, however, report that some studies showed evidence for positive attitudinal changes with social-contact interventions (Heim et al., 2019).

As well as the specific focus on healthcare students, there is a growing body of evidence evaluating anti-stigma interventions for school-age children. The lack of high-quality studies, the lack of randomized controlled trials, and overall heterogeneous and poor-quality research in this age group, with a lack of long-term follow-up evaluating, has been highlighted (Schachter et al., 2008). This systematic review of school-based interventions for students age 18 or younger recommended the development and implementation of a curriculum focused on developing empathy and social inclusion (Schachter et al., 2008). Since this review, a number of studies in secondary schools have been carried out, which are discussed below.

It has been suggested that interventions using educational strategies are more effective than social-contact-based interventions for young people (Corrigan et al., 2012). This could be due to young people's beliefs about mental illness not being as firmly developed as adults' beliefs, and therefore they are more receptive to being challenged by education (Corrigan et al., 2012). Pinfold and colleagues evaluated the impact of an educational workshop addressing mental illness stigma for UK secondary school students and showed an improvement in attitudes, which was maintained at 6 months (Pinfold et al., 2003b). A study of school students showed that provision of printed anti-stigma materials alone had no impact, contact intervention had a limited impact, and delivery of a classroom-based, taught educational curriculum, including presentation and discussion, had the most beneficial impact on attitudes (Painter et al., 2017).

In Ottawa, Canada, Milin and colleagues carried out a randomized controlled trial including 24 high schools (Milin et al., 2016). A manualized mental health educational resource was integrated into the curriculum taught by teachers, and students completed pre- and post-questionnaires measuring mental health knowledge and attitudes toward mental illness. A significant improvement in both knowledge and attitudes was found in the intervention group in comparison to the control group. Ojio and colleagues (2019) conducted a randomized controlled trial evaluating the effectiveness of watching an educational film focused on the biological basis for mental illness to reduce stigma in high school and university students in Tokyo, Japan, which showed an improvement in students' attitudes.

Although several studies evaluating interventions to reduce stigma toward people with mental illness in students and young people have been carried out, there remains a need for further research in this area, particularly among students in other disciplines beyond healthcare, in more LMIC settings, and more studies of high quality with control groups and large cohorts, followed up for more sustained periods of time.

These reviews and studies illustrate the growing body of evidence regarding the effectiveness of anti-stigma interventions based on educational and social-contact strategies for students and young people (see Table 18.1 for a summary of this research).

Stigma Reduction in Low- and Middle-Income Countries

Evidence for successful interventions to reduce mental illness stigma in LMIC settings is particularly scarce (Clay et al., 2020). As discussed above, the research focused on particular target groups such as healthcare students and professionals in LMIC has such a wide heterogeneity that it is difficult to draw conclusions regarding the most effective interventions. Likewise, more generic interventions to reduce mental illness stigma for individuals and small groups is mixed in quality and low in quantity (Gronholm et al., 2017; Heim et al., 2018; Mehta et al., 2015; Semrau et al., 2015). There is a particular lack of interventional studies addressing mental illness stigma in children and adolescents in LMIC (Hartog et al., 2020).

A review by Semrau and colleagues (2015) concluded that there is insufficient evidence at present to evaluate the most effective interventions in LMIC. Although social-contact interventions have been shown in some reviews to be most effective in HICs, these types of interventions have not yet adequately been studied in LMIC settings. Most research has been carried out in HICs.

Table 18.1 *Summary of studies for anti-stigma interventions for specific target groups*

Reference	Research method	Participants/studies	Intervention	Main finding
Healthcare Staff				
Henderson et al. (2014)	Review			There is some evidence for educational interventions being effective in decreasing stigma for health professionals; however, more high-quality intervention studies needed
Strang et al. (2007)	Quantitative (randomized trial)	$N = 112$ (primary care physicians)	6-month part-time specialist training course in substance misuse	Improvement in knowledge and attitudes seen, yet with intention-to-treat (ITT) analysis no statistically significant benefit
Irvine et al. (2012)	Quantitative Trial 1 – randomized pre-test/post-test. Trial 2 – quasi experimental	Trial 1 – $N = 62$ (nursing aides) Trial 2 – $N = 16$ (licensed health professionals)	Internet-based behavioral skills training and knowledge building	Significant improvements in knowledge, attitudes, self-efficacy, and behavioral intention for Trial 1 and improvements in outcome measures for Trial 2
Stubbs (2014)	Review	18 studies		Interventions involving direct contact, indirect contact, and education were effective in short-term reduction in stigma; role-play did not have randomized controlled trial evidence for effectiveness; and no intervention had long-term benefit

Table 18.1 (*cont.*)

Reference	Research method	Participants/studies	Intervention	Main finding
Knaak et al. (2014)	Mixed methods (qualitative and meta-regression modeling)	$N = 22$ (studies)		Evaluated 22 anti-stigma programs and identified 6 key ingredients, which when all included, led to significantly better outcomes
Police				
Pinfold et al. (2003a)	Mixed methods (qualitative and quantitative)	$N = 109$ (police officers)	Training workshops – 2 × 2 hr sessions over 6 months (delivered by service users, carers, & professionals)	Improvements occurred in attitude scores in participants attending workshops; however, overall stereotype linking mental illness and violence not significantly challenged
Hansson and Markstrom (2014)	Quantitative (controlled trial, nonrandomized)	$N = 120$ (police officer training students)	Education (lectures, including video with service user)	Intervention group had improvements in attitudes, mental health literacy, and intentional behavior, sustained at 6 months
Compton et al. (2014)	Quantitative (intervention and control group)	$N = 586$ (police officers)	CIT training – 40 hours (delivered by service users & professionals)	Crisis intervention team (CIT) training resulted in improvements in knowledge, attitudes, and skills compared to group not receiving CIT training
Students and Young People				
Yamaguchi et al. (2013)	Review	35 studies $N = 4{,}257$		Social contact or video-based social contact most effective in improving attitudes. Lack of evidence for long-term sustained improvement and impact on actual behaviors

Ighodaro et al. (2015)	Quantitative (questionnaires for students at different stages of training)	*N* =354 (medical students and graduate physicians)	Education – exposure to medical school psychiatry rotation	Psychiatric education and clinical experience may result in more progressive attitudes toward people with mental illness
Amini et al. (2013)	Quantitative (questionnaire)	*N* = 168 (medical students)	Education – 4-week psychiatry clerkship	Post-intervention questionnaire showed favorable attitudes toward people with mental illness, but no pre-intervention data collection
Ay et al. (2006)	Quantitative (questionnaire)	*N* = 452 (2nd- and 6th-year medical students)	Education – medical school curriculum	Final-year students had improved attitudes compared to 2nd-year students, but still significant stigmatization of people with mental illness
O' Connor et al. (2013)	Quantitative (questionnaire pre- and post-teaching module)	*N* = 285 (medical students)	Education – teaching modules on attitudes to patients with mental illness (clinical and pre-clinical)	Following the clinical module, a positive attitudinal shift was seen. Students with experience of knowing someone with mental illness also had more tolerant attitudes
Gulati et al. (2014)	Quantitative (cross-sectional)	*N* = 135 (medical students and interns)	Education – medical school psychiatry curriculum	Limited influence of psychiatry curriculum on attitudes toward mental illness and psychiatry
Korszun et al. (2012)	Quantitative (online survey)	*N* = 760 (medical students)	Education – general medical school curriculum, including psychiatry rotation	Personal experience of mental health treatment associated with less stigmatizing attitudes. Overall worse attitudes in more experienced medical students

Table 18.1 (*cont.*)

Reference	Research method	Participants/studies	Intervention	Main finding
Heim et al. (2019)	Systematic review	9 studies		Some studies using social-contact interventions showed positive effects; however, there was low methodological quality in most studies
Schachter et al. (2008)	Systematic review	40 studies		Overall, a focused school curriculum may be beneficial for primary and secondary prevention of stigma; however, limitations included poor-quality studies and inconsistent results
Painter et al. (2017)	Quantitative	$N = 721$ (school students pre-adolescent)	Assigned to one, two, or all of: PowerPoint, classroom discussion–based curriculum or direct contact	Printed material alone had no significant benefit; the best outcomes were for classroom-based curriculum with significantly more positive outcomes than control group
Milin et al. (2016)	Quantitative (randomized controlled trial)	$N = 534$ (high school students)	Normal curriculum or integrated mental health curriculum	Demonstrated effectiveness of mental health literacy of mental health curriculum
Ojio et al. (2019)	Quantitative (individual level randomized controlled trial)	$N = 179$ (high school and university students)	10-minute intervention including biomedical messages or recommended messages	Both groups showed improvement sustained at 1 year but no difference between groups

As in LMIC settings, the experience of stigma and discrimination is uniquely shaped by the context and culture and therefore interventions need to be adapted and specifically designed for the context they are in. Thus, it cannot be assumed that interventions effective in one context will be effective in another, whether considering evidence from HICs as applicable to LMIC, or generalizability of findings between different LMIC settings. Furthermore, the impact of socioeconomic factors such as poverty, access to healthcare, and education inevitably impact the context in which stigma is experienced and must be considered with respect to developing effective and appropriate interventions (Semrau et al., 2015). The feasibility of implementing anti-stigma interventions in LMIC, in terms of funding, political will, and conflicting priorities, also needs to be considered alongside maximizing existing strengths within cultures and contexts (Mascayano et al., 2015).

A review of 80 studies by Mehta and colleagues (2015) evaluated research in high-, middle-, and low-income countries and within this included a focus on the available evidence in LMIC settings specifically. For HIC, the review concluded that although there is evidence for the effectiveness of anti-stigma interventions for improving knowledge and attitudes, social-contact interventions were not more effective than interventions without social-contact components. For LMIC, 11 studies were included, none of which assessed behavioral outcomes. Knowledge and attitude measures were most commonly used as outcome measures, and reductions in stigmatizing attitudes were seen in some studies. However, the results in this review were recommended to be interpreted with caution due to most studies measuring outcomes immediately after the intervention. The authors also highlight that as only limited details were available regarding how these interventions were designed and implemented, their findings are considered to have high risk of bias and thus the results need to be considered in view of this limitation.

Heim and colleagues carried out systematic reviews of interventions to reduce mental health-related stigma in healthcare students (discussed above) and among primary healthcare professionals in LMIC settings (Heim et al., 2018, 2019). Among healthcare students, all reported studies included improvements in at least one outcome measure, although no studies included behavioral outcomes. Studies with social-contact interventions demonstrated attitudinal change. Among primary care professionals, the most frequently used interventions included lecture-based education. Little evidence was found for the effectiveness of brief interventions (ranging from 1 hour to 1 day); however, longer training interventions (e.g., studied interventions ranged from 4 days to 6 weeks) did produce statistically significant changes. However, across both reviews it was concluded that due to the large heterogeneity in the methodological approaches used and mixed quality, it was not possible to complete a meta-analysis and not possible to draw conclusions about the most effective interventions.

Despite the ongoing need for more high-quality intervention studies, there have recently been a number of studies carried out in LMIC. A study within the "RESHAPE" project (Reducing Stigma among Healthcare Providers to

Improve Mental Health Services) is a pilot study in Nepal using social contact with mental health service users in training for non-specialist primary healthcare workers (Kohrt et al., 2018). The "RESHAPE" project also includes a proof-of-concept study for a social-contact intervention using the "what matters most" framework for primary health providers in Nepal. "What matters most" is an anthropological theory, conceptualizing stigma as a "moral phenomenon in which threats to personal and group identity within a particular local world lead to stigmatizing behaviors," allowing for the consideration of culture-specific threats and impacts posed by stigma in a given context. Improvements in attitudes were described during qualitative interviews and seen in attitudinal outcome measures (Kohrt et al., 2020). Reducing stigma among healthcare providers is of particular relevance in LMIC settings, given the global push to integrate mental health services into primary care settings where professionals have less mental health training.

Maulik and colleagues (2019) report on the results of an anti-stigma intervention in rural India, consisting of task sharing, a campaign and support for primary health workers using technology, with follow-up over a 2-year period. The authors discussed the importance of developing culturally relevant methods for effective anti-stigma campaigns considering the context, in this case rural India. Most knowledge, attitude, and behavior scores showed improvements over three time points across the 2-year period. Scores on the "Barriers to Access to Care Evaluation" questions improved in subsequent visits to a statistically significant extent for participants, regardless of gender and education level. This is the first study of its kind from a community-based LMIC setting reporting the longitudinal impact of an anti-stigma intervention.

Future Research and Recommendations

This chapter has reviewed the growing body of evidence for interventions to reduce mental illness stigma at the individual and small group levels. Although there have been some encouraging developments with recent high-quality studies focused on particular target groups that include LMIC settings, there remains an urgent need for scaling up high-quality intervention studies (Thornicroft et al., 2016). There is evidence that interventions using both educational and social-contact strategies do improve stigmatizing attitudes; however, the evidence for the maintenance of these improvements in the long term remains lacking (Gronholm et al., 2017). There remains a need for interventions to be carefully considered in terms of their cultural relevance and consideration of the context in which they are implemented.

A limitation of the studies in this field is that the methodological approaches used are so heterogeneous that it has rarely been feasible to synthesize findings, via, for example, meta-analyses (Thornicroft et al., 2016). Furthermore, most research to date that has shown improvements following interventions to reduce stigma has shown changes in attitudinal and knowledge measures only, whereas behavioral outcomes have rarely been evaluated (Thornicroft et al., 2016). However, changing discriminatory behavior is at the heart of interventions to reduce mental illness stigma, as the actual experience of discrimination is a dimension of stigma that has direct tangible impacts on people who are stigmatized, and indeed many people describe the discriminatory consequences of mental health stigma as worse than those of the condition itself (Lancet, 2016; Thornicroft et al., 2016). Therefore, it is essential for research evaluating behavioral outcomes to be developed and implemented.

Particular areas in need of further research include a focus on high-quality, randomized designs for interventions that are tailored to specific target groups, and also tailored to specific contexts and cultures (Gronholm et al., 2018). Within these studies, using validated and appropriate outcome measures with appropriate controls and reporting the study procedures in full are important, as well as using large sample sizes and procedures to increase representativeness (Gronholm et al., 2018).

Although studies involving service users demonstrate the significant impact of self-stigma (the process by which a person with mental illness internalizes and applies the societal stigma relating to mental illness to themselves; Rose et al., 2011), there are very few studies involving service users evaluating the impact of anti-stigma interventions, which is a significant omission. People who have direct personal experience of stigma and discrimination relating to mental illness are well placed to lead change, and involving service users and their families in research is a recognized strategy for improving care and reducing stigma (Rai et al., 2018). Finally, as discussed above, the lack of research in LMIC is a notable gap that urgently needs to be met in light of the significant treatment gap for the burden of mental disorders in LMIC.

Conclusion

This chapter has described the interventions designed to reduce the stigma of mental illness at the person-level for individuals and small groups. The current evidence for anti-stigma interventions using social-contact and educational strategies has been presented. We have highlighted the need for further high-quality research evaluating the long-term sustainability of interventions aiming to reduce stigma and discrimination relating to mental illness and the urgent need for further research in LMIC settings.

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19 Population-Based Interventions to Reduce the Stigma of Mental Illness

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In September 2013, two UK supermarkets and Amazon advertised a "mental patient" Halloween costume, a white boiler suit with red splashes sold together with an axe. Thousands of people used Twitter to show their disapproval; the topic "went viral" with tweets passed rapidly and across social networks. The story was the lead item on UK national news the next day and the mainstream media sourced their information from Twitter. The retailers removed the costumes from sale, apologized, and one made a donation to England's "Time to Change" anti-stigma campaign.

During the protest, a #mentalpatient hashtag was created by people with lived experience. They used this searchable string 6,694 times in 24 hours to post photographs of themselves ("selfies") alongside texts such as "this is what a real mental patient looks like." This is an example of protest strategy (Betton et al., 2015), which was initiated by individuals on Twitter and was taken up by the campaigning organizations to amplify the dissemination of the anti-stigmatizing message. This incident also reflects the multi-level nature of stigma, which operates on intrapersonal, interpersonal, community, population, organizational, and structural levels (Rao et al, 2019). In this case, a social media platform afforded a form of community action against stigmatizing organizational behavior, amplified by mental health charities and the mainstream media. While the event certainly led to actions by several corporations, the extent to which such incidents reduce self-stigma among people with lived experience or influence wider public attitudes has yet to be measured. The sharing of such photographs by thousands of people may create a sense of solidarity among them, while at the same time providing a virtual form of intergroup contact with people without experience of a mental illness. Further, when many people use a common hashtag, it may be harder to ignore or minimize their experience as an exception.

This event also reflects the need for population-level approaches to stigma reduction to address it at multiple levels to affect cultural change. In this chapter, we present some considerations for such efforts in terms of methods and content; and describe some recent population-level anti-stigma programs, with results of evaluation where available. This chapter is based on recent original articles, systematic reviews cited in the relevant sections, as well as previous narrative reviews (Clement et al., 2010; Rüsch et al., 2011; Thornicroft et al., 2016).

Population-Level Intervention: Principles and Design Considerations

Stigma is defined as "an attribute that is deeply discrediting that reduces someone from a whole and usual person to a tainted, discounted one" (Goffman, 1974). The process of stigmatization is near universal, and many personal, social, or cultural factors can become the source of stigmatization. For example, individuals or groups can apply stigma to those who live a certain way, hold certain cultural beliefs, or make lifestyle choices, or to people affected with specific health conditions, such as some infectious disorders or mental health problems. Therefore, the mental illness stigma is defined as the complex interactions of negative beliefs, attitudes, and behaviors toward people with mental disorders. The mental illness stigma operates through loss of economic and social opportunity due to discrimination and withdrawal from the seeking of such opportunities as a response to the anticipation of discrimination (Corrigan & Shapiro, 2010). Its combined effects are severe: poor access to mental (Rüsch et al., 2014) and physical healthcare (Liu et al., 2017); reduced life expectancy (Henderson & Thornicroft, 2009); exclusion from higher education (Lee et al., 2009) and employment (Social Exclusion Unit, 2004); increased risk of contact with criminal justice systems; victimization (Maniglio, 2009); and poverty (Shefer et al., 2016). For many people, these consequences have been described as worse than the experience of the mental illness itself (Evans-Lacko et al., 2012a; Lasalvia et al., 2013) .

According to the National Institute of Mental Health England (Dye et al., 2005), a population-level intervention to reduce mental health stigma should include the following principles in order to be effective: inclusion of service users and carers in the design, delivery monitoring, and periodic assessment of the efficacy of the campaign. National campaigns should be supported by local grass-roots initiatives; focus on behavior change; target clear, specific messages toward identifiable audiences; and include long-term planning and funding. Considerations in the design of population-level programs include whether it will focus on stigma in relation to mental illness/health in general, a specific mental health condition, or all forms of disability including mental health disabilities. Interventions may be based, implicitly or explicitly, on diverse conceptualizations of stigma or mental health problems, and may use different theories to underpin the design of the interventions.

Mass media interventions are one of the most commonly used types of population-based interventions (Sartorius & Schulze, 2005). National programs aiming to reduce mental health-related stigma and containing mass media components are taking place in a number of countries. Local and regional interventions are also widespread (www.time-to-change.org.uk/about-us/what-we-do/our-global-work/global-anti-stigma-alliance). Mass media interventions can be scaled up with relative ease to the population level and hence, if effective, are a feasible intervention for large-scale change. Even if mass media interventions were to produce only a small magnitude of change, this may translate into important impacts at the population level (Noar, 2006).

Other types of interventions, such as direct social contact (Couture & Penn, 2003), have also occasionally been used on a large scale (Corrigan & Gelb, 2006; Evans-Lacko et al., 2012b). For example, "In Our Voice," a 90-minute standardized contact program developed by consumers of mental health services, significantly improved participants' stigma as regards knowledge, attitudes and social distance (Corrigan & Gelb, 2006). However, a direct social-contact strategy at the population level is unusual as it presents greater implementation challenges than mass media approaches. One challenge relates to the difficulties in involving sufficient numbers of people with lived experience as "active" participants in the initiative, as many may be understandably reluctant due to fear of further social exclusion.

Many factors can influence the effectiveness of population-based interventions, including: the theoretical basis; the degree of targeting; campaign intensity; the media channel (Noar, 2006); the type of mass media element included (Link & Phelan, 2001) and the particular messages conveyed (Clement et al., 2010); and the duration of the campaign (Friend & Levy, 2002). In particular, over the course of the last two decades the basis for population-level anti-stigma programs has largely shifted from one focused on education to the direct application of theories of behavior change used in social marketing; intergroup contact to reduce interpersonal stigma, and campaigning to reduce structural discrimination. Campaigning has been undertaken by organizations in the forms of lobbying, and by both organizations and individuals in the form of protest.

The use of mass media for challenging stigma can be defined as a social marketing strategy (Donovan & Henley, 2010). Social marketing is based on different models of communication and persuasion and uses various behavior change theories such as the theory of reasoned action (Hill et al., 1977); the health belief model (Rosenstock, 1990); the transtheoretical (stages of change) model (Prochaska & DiClemente, 1986); and the elaboration likelihood model (Donovan & Henley, 2010; Noar, 2006). Symbolic communication and modeling are also processes thought to be important in mass media interventions (Bandura, 2001). The mass media operates by potentially influencing not only individuals but also communities and policy maker (Andersen, 2007). Social marketing strategies are increasingly used to address social change. In particular, the goals of these strategies are to change attitude and behavior, which is different from improving the level of education or awareness on the topic of mental disorders. The method uses a systematic match between the message, the audience, and the delivery tool, making it possible to evaluate the effectiveness of the campaign.

Social marketing theory (Donovan & Henley, 2010) states the importance of including a clear call to action, suggesting that awareness raising about stigma alone is not enough to lead to behavioral change. It is also recognized that changes in attitudes may not necessarily translate into changes in behavior (Marcus et al., 1998). In theory, a social marketing campaign can promote the message that it is unlawful to discriminate on the basis of mental health and it could be able to change behavior (discrimination) outcomes without necessarily changing attitudes (prejudice). Furthermore, mass media may change perceptions of social norms, with the change in social norms leading to behavior changes, leaving individual attitudes untouched (Wakefield et al., 2010). Subtle factors in communication can influence social behavior without necessarily being mediated by conscious choice (Bargh & Gollwitzer, 1994), and so mass media may affect behavior directly. In practice, mental health–related stigma programs to our knowledge have rarely taken this approach, preferring to combine calls to action with methods such as indirect contact.

Application of Intergroup Contact to Population-Level Approaches

Mass media interventions usually include some form of personal narratives from people who have experienced mental health problems, such as celebrities or members of the public. These may reduce stigma because they are an indirect form of social/ interpersonal contact with people with mental health problems, and this form of contact has been theorized, and demonstrated, to reduce stigma (Corrigan et al., 2012; Couture & Penn, 2003). Such narratives may also reduce stigma by increasing awareness of the variation among members of out-groups and in-groups, increasing social identity complexity and increasing tolerance (Schmid et al., 2009). Alternatively, narratives may act as “mediated associations” in which an individual feels empathy toward the suffering of another without the other’s physical presence, elicited through language (stories, film dialogue) or pictorial representation (e.g., photographs), which is then translated into a commitment to social justice (Kumagai, 2008).

Protest is another approach for countering discriminatory behavior. Corrigan has compared protest and other approaches including indirect contact (one form of mass media intervention). Protest-based interventions are less commonly studied than contact-based interventions, and unlike indirect contact do not seem to significantly reduce discriminatory intentions (Corrigan et al., 2012). However, protest has been found to be an effective strategy when targeting organizations (rather than individuals), for example as a response to negative stereotypes in public statements, media reports, or advertisements. An example of protest strategy from the UK occurred via Twitter in September 2013, as we described in the introduction (Betton et al., 2015). This represents a good example of a protest initiated by individuals that was then taken up by the campaigning organizations to amplify the dissemination of the anti-stigmatizing message.

Importance of Messaging in Population-Level Approaches

All mass-media anti-stigma programs will contain – explicitly or implicitly – messages about what mental health problems are and what a world without discrimination against people with mental health problems would look like (Littlewood, 2001). These must be carefully chosen since messages may not only be ineffectual but counterproductive (Lauber, 2008). In general, messages for social marketing are honed through market research, such as focus groups, of the potential target audiences. Moreover, the broad type of message chosen should be informed by evidence. Unfortunately, there is little research evidence to inform decisions about this key aspect of anti-stigma initiatives, as little work has been done to compare the effectiveness of different types of interventions. A consensus study undertaken in 2008 presented delegates at an international anti-stigma conference with a review of the existing evidence between rounds of voting on each type of message found to have been used by campaigns to that date (Clement et al., 2010). The results of the consensus exercise were high regarding the inclusion of both recovery-oriented and "see the person" message types; and reasonable regarding messages about social inclusion/human rights and the high prevalence of mental disorders. Qualitative analysis of the discussion among the delegates identified four themes: (1) benefits of messages countering the "otherness" of people with mental ill health; (2) problematic nature of messages referring to etiology; (3) message impact being dependent on the particular audience; and (4) need for specific packages of messages.

Since this study, a substantial contribution to this field has been made by work by Schomerus and colleagues (2013) on the effectiveness of information about the continuum model of mental illness. According to the continuum model, mental disorders and well-being lie on a spectrum, from a few mild symptoms to many severe symptoms. Highlighting the continuous distribution of mental disorders has been proposed as an innovative and potentially useful anti-stigma strategy. The replacement of the qualitative difference between those with and those without mental disorders with a more quantitative difference on a symptom continuum is in line with current models of the stigma process. In fact, highlighting the normality of the distribution of mental distress can help to reduce separation between people with mental disorders and the general population.

Schomerus and colleagues (2016) have tested this theory using a randomized controlled trial (RCT) and found that attitudes toward a person with mental disorder can be improved by providing information on a mental health–mental illness continuum, as compared to either information based on a dichotomous model or no information. The use of the Continuum Model for challenging stigma attached to specific conditions, such as Attention Deficit/Hyperactivity Disorder, also confirmed the potential importance of this type of message for reducing stigma toward children and young people (Speerforck et al., 2019).

Therefore, when planning an anti-stigma program is essential to clearly define the type of message(s) to be conveyed, considering the positive, neutral, or negative effects such messages can have. In particular, a promising approach is represented by the Continuum Model, which highlights the fact that mental health and mental disorders lie on a continuum, with a threshold to be identify for diagnose a mental disorder.

Targeting: Demographic Segmentation within Population-Based Interventions

Population-based interventions may also vary on the basis of the target of the group (e.g., age, socioeconomic status, and/or gender). Children and young people are a popular choice for anti-stigma programs, including Opening Minds in Canada, Time to Change in England and Wales, and Each Mind Matters in California. There are several reasons for this choice. First, many mental health problems develop during childhood or adolescence, including around half of disorders identified during adulthood (Kessler et al., 2007; McGorry et al., 2011), so children may be vulnerable to the impact of stigma at this point in ways that may affect the trajectory of their illness and of their lives in general. Second, there is evidence that mental illness stereotypes are learned as early as 7–11 years old, suggesting that anti-stigma work is needed at this age (Müller et al., 2016). Third, there is evidence that young people's attitudes can be particularly negative (Bradbury, 2020), though they have improved at least in England (Henderson et al., 2020). The mass media may be a contributor to young people's stigma. In particular, it has been found that portrayals of mental illness in children's films, TV programs, and video games provided children with pervasive depictions of people with psychiatric disorders as unattractive, villainous, and dangerous, and were frequently coupled with the use of offensive slang and negative labels (Ferrari et al., 2019). This was seen to facilitate rejection of peers with mental health problems, and also to encourage insensitivity and a lack of empathy from young children in relation to mental illness (Evans-Lacko et al., 2012a).

Segmentation reflects the different consumption of media by different groups, and the need to target social marketing in ways to which people can easily relate. Campaigns may not have the budget to reach all groups and, therefore, have to consider which they are able to influence without widening existing differences in stigma by group membership. This may result in a compromise based on the need to show initial impact. For example, in England there is evidence for a socioeconomic gradient in stigma, such that lower socioeconomic groups have more negative attitudes and greater desire for social distance with respect to people with mental illness compared to people from higher socioeconomic groups (Henderson et al., 2020). After the initiation of the Time to Change social marketing campaign in the UK, there seemed to be a population attitude shift in a positive way toward those with mental health problems. Time to Change then moved its marketing campaign to target to lower- to middle-income groups and to men in 2017, since there were still persistent socioeconomic and gender differences in stigma-related knowledge, attitudes, and desire for social distance.

While population segmentation is common in relation to age, gender, and socioeconomic status, there is also a need to reach other demographic groups with these population campaigns. First, social marketing must be inclusive of demographic diversity to have an impact on stigma on people in minority groups. Second, campaigns must benefit people experiencing intersectional stigma on the basis of mental health problems and characteristics such as ethnicity, sexuality, or gender identity. Finally, an anti-stigma intervention may be received differently by minority groups (Glasgow Anti-Stigma Partnership, 2007), thus acting as a moderator of the effectiveness of the intervention.

Media Channels: Mass and Social Media

Mass media are channels of communication intended to reach large numbers of people, which are not dependent on person-to-person contact (Bala et al., 2008; Brinn et al., 2010). There are many different forms of mass media: print (e.g., newspapers, magazines, billboards, pamphlets, flyers, coasters used for drinks in bars and restaurants); radio; television; cinema; mobile phones (e.g., mobile device applications); and internet (e.g., websites, blogs, podcasts, viral messaging, social networking sites) (Donovan & Henley, 2010). Traditional media allow businesses to target a broad audience through billboards, print advertising, television commercials, and more. In comparison, new media (called digital media) allow companies to target a narrow audience through social media, paid online ads, and search results. Traditional media include television, radio, and print advertisements; direct mail advertisements; billboards and off-site signs; cold calling/door-to-door sales; and banner ads. Price-wise, traditional media tend to cost more than new media due to their broad targeting and advertising channels. Digital media include methods of communication which mostly involve the internet, such as search engine optimization, pay-per-click advertising, content/email marketing, and social media.

Many of these methods were launched several years ago, but have only recently gained prominence. These new digital marketing methods – such as social media marketing, voice search optimization, video marketing, increasing website traffic – are constantly changing in order to address the attitudes of consumers. The biggest advantage of social media is related to the possibility of having one-to-one and unfiltered conversations with each potential “customer.” For example, through direct instant message on Facebook or Instagram is possible to answer questions, respond to feedback, and address concerns or forestall possible issues quickly. Therefore, it creates a new way of communication in which it is possible to personalize the interaction with users.

Evaluation and Use of Evidence

The effectiveness of population-level interventions is rarely amenable to evaluation using the gold standard of RCTs. More commonly used evaluation methods and approaches are quasi-experimental designs treating such interventions as natural experiments, with before-and-after data obtained from archival analysis of official statistics or repeated surveys, and comparisons with populations that have not been exposed to the intervention, where possible (Petersen et al., 2016). Within the constraints created by the large scale of population-based interventions, there are basic design criteria that should be met. First, at least one baseline measure should be taken of the chosen outcomes. This may sound obvious, but sometimes evaluation is planned too late for this to be possible. Second, the choice of measures should reflect the intervention logic model or theory of change and its content. For example, if the program is focused on behavior change, this is what should be measured rather than, for example, knowledge. If specific diagnoses are the focus, then these should be covered by the measures instead of using measures of stigma in relation to mental illness generally. Based on these aspects, existing standardized measures developed for general population use should be chosen. Brevity of measures should be prioritized as much as possible, especially where more than one measure is to be used to cover more than one aspect of stigma.

Not all national or regional anti-stigma programs undergo evaluation as described above. When the overall budget is too low to accommodate the costs of evaluation, this is understandable, although the lower cost of online surveys compared to telephone or face-to-face data collection means that more programs should be able to undertake this. Regardless of the capacity of a program to undertake evaluation, use of the existing evidence from smaller-scale research and from other population-level programs is always possible, especially given the availability of open access publications. As described above, available evidence from smaller-scale research includes that from the application of intergroup contact theory (Schmid et al., 2009) and other methods to reduce stigma and studies of types of anti-stigma messages. In terms of the medium, there is also work on the specific use of mass media to reduce stigma. A systematic review in 2013 (Clement et al., 2013) concluded that mass media interventions delivered by regular or electronic mail, by audio or video recordings, or via the internet are effective at reducing prejudice (based on 22 RCTs), but there was no evidence for effects on discrimination, based on five trials which measured it.

Although the same theoretical approaches may be applied in different countries for national population-based campaigns, everything else must be tailored to the setting. Because well-resourced, long-term programs with evidence of effectiveness have been running in many high-income countries (HIC) in the absence of equivalent programs in low- or middle-income countries (LMICs), attention is increasingly turning to stigma reduction in LMIC settings. In LMICs where mental health care coverage is low and hence inaccessible to many people, it is hoped that increasing the provision of treatment will reduce stigma, for example through generation of greater therapeutic optimism. However, similar to HICs, stigma in low-resource settings is an obstacle to accessing services, particularly with respect to more severe disorders (Andrade et al., 2014).

This suggests that other anti-stigma interventions should be considered, include other population-level approaches. The Time to Change global program, which ran from 2018 to 2020, used social marketing in Ghana, Kenya, Uganda, and Nigeria, though this was narrowly targeted to adults in urban areas (Potts & Henderson, 2021). It should be noted that the widespread use of smartphones and social media may enable delivery of social marketing campaigns at lower cost than when restricted to traditional media, and that this applies across many LMIC as well as HIC.

Regarding what can be learned from programs, below we summarize those national or regional programs known to us, including the available evaluation evidence. Reflecting the lack of long-term programs in LMICs, data on medium- and long-term effects of interventions to reduce public stigma in LMICs are limited (Thornicroft et al., 2016).

Examples of Population-Based Anti-Stigma Interventions Worldwide

The following are national anti-stigma programs that include population-based and mass media interventions (Figure 19.1).

Australia: Beyondblue. The main aims of the Beyondblue campaign are increased community awareness and reduced stigma, through both mass media and internet-based interventions and targeted community, school, and workplace-based education and information strategies; greater consumer and carer participation and confrontation of social, structural, and legislative barriers; testing of depression prevention and early intervention programs; primary

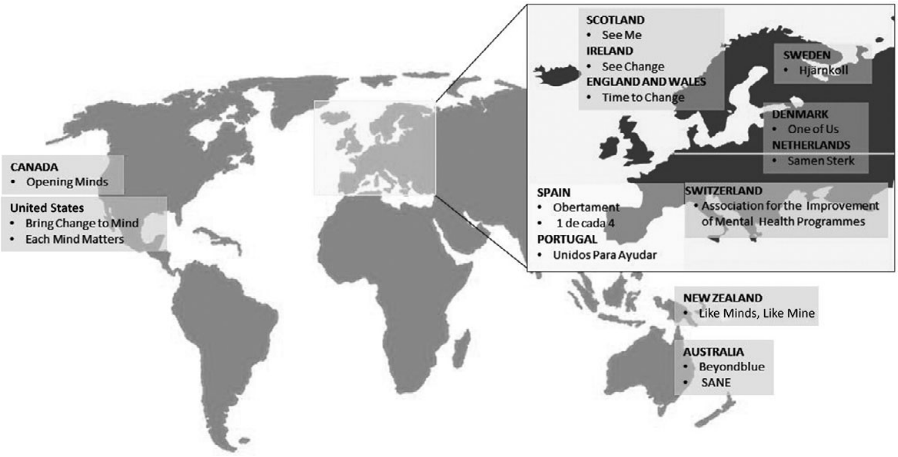

Figure 19.1 *Anti-stigma movements around the world.*

care workforce training linked with financial and structural reform (www.beyondblue.org.au/about-us/about-our-work/discrimination-in-insurance); and support for research to guide health service reform (Hickie, 2004). One of the most important and original campaigns targets the insurance providers: since 2002, Beyondblue and Mental Health Australia (MHA) have been working to improve access to insurance, influence the industry to make changes to their policies and practices, and bring greater fairness to the insurance market for the mentally ill. In addition, the program includes a website that offers a wealth of information, including downloadable resource packs, online programs, informational videos, and more. This campaign is very popular with younger people: a good proportion of Australian young people are aware of Ybblue (the youth program of Beyondblue), and the awareness is associated with better mental health literacy, a better recognition of depression, and greater exposure to depression in self or family and friends (Morgan & Jorm, 2007).

Australia: SANE. SANE works collaboratively with the media, community groups, governments, and institutions (i.e., the police force, legal services), serving adults aged 18 years and older. SANE conducts various activities, for example, Stigma Watch, an initiative comprising response to community concerns about stigmatizing language used in the media and the production of training materials and guidelines for media professionals. They organize public awareness campaigns, which include components such as conversation starters, improving understanding of complex mental illnesses, and eliminating self-stigma associated with these illnesses. They also host online help through the program’s website (www.sane.org/), which is moderated 24/7 by mental health professionals. SANE is primarily focused on reducing the stigma surrounding complex or poorly understood mental illnesses and on policy development and advocacy, ensuring that the needs of people affected by complex mental illnesses are reflected in public policy and the health and social service systems.

Canada: Opening Minds. The Opening Minds (OM) program began in 2009 and represents the largest systematic activity promoted for challenging stigma related to mental illnesses in Canada. The program aims to change attitudes and behaviors with four different targets: young people, the workplace, healthcare providers, and mass media. Opening Minds aims to benefit all people with lived experience of a mental illness. The goal is for these individuals to never experience stigma at home, school, or work; to receive timely and equitable care from healthcare providers; and to receive useful support and correct information regarding how to seek help and how to reach recovery.

The two-part HEADSTRONG program is tailored to high school students. The first part includes the organization of small group meetings of students to discuss mental health, history of recovery from mental disorders, stigma-busting activities, and design of action plans to use when they return to school and of creative activities to improve awareness at the school level. The effectiveness of the high school programs has been proved (Chen et al., 2018), despite the heterogeneity across the programs in the way they were delivered. It seems that the contact-based education focusing on mental illnesses may be an important component of diversity training for young children, ideally before mental illness stereotypes begin to become firmly established (Koller & Stuart, 2016).

Particular attention was paid to healthcare providers. Observing the different OM programs, Knaak and Patten (2016) developed a theoretical model articulating a four-stage process for designing and delivering successful anti-stigma programming for health professionals. In particular, the model targets the roots of healthcare provider stigma, which include pessimism about recovery/feeling like what they do doesn't matter, seeing the illness ahead of the person, lack of skills/confidence, lack of awareness of own prejudices, through four steps. These steps include planning and preparation, building a program using key ingredients, "Make the Connection" (program-delivery strategies), and working toward culture change.

Denmark: One of Us. In Demark "En Af Os" (One of Us) is a population-based anti-stigma program sponsored by both government and non-government organizations. The final aim is to improve life for all citizens in Denmark by promoting social inclusion and fighting mental illness–related discrimination. It has five specific target groups: youth, workplace (labor market), service users and their relatives, healthcare staff, and the media. According to the target, the association organizes different activities: more structured as specific packages of material for professional health caregivers to social-contact activities (talks led by a program ambassador).

England and Wales: Time to Change. Time to Change (TTC) is an anti-stigma program established in October 2007 in England and in Wales in 2011. TTC primarily targets the general population via large-scale, mass media social marketing. The main innovative aspect of the TTC program is related to its long-term approach, use of evidence-based methods, significant investment in rigorous evaluation, use of social media both to amplify its message and empower people to tackle stigma, and involvement of people with lived experience at every level of both program delivery and evaluation.

The program in England has so far comprised three phases. Phase 1 (2007–2011) consisted of several interventions, including a social marketing campaign, programs for specific target groups (i.e., medical students, teachers, and employers), local anti-discrimination initiatives, programs for people with mental health problems to promote social contact, social-contact events organized by a range of stakeholders, and the use of social media such as Twitter and Facebook. The initial focus of the social marketing campaign was on education-based "myth busting," followed by a focus on reducing prejudice and changing behaviors. Additionally, Time to Change involved local initiatives and work with target groups such as medical students and employers.

At the end of phase 1 there were significant improvements in intended behavior and a positive trend in attitudes toward mental illness (Evans-Lacko et al., 2012b). Phase 2 (2011–2015) has built on the experience and evidence from phase 1 to deliver an even more evidence-based program. TTC phase 2 targeted four main focus areas: the workplace; the youth; the media; and the general community. By the end of phase 2 there were improvements in population-level stigma related knowledge, attitudes, and intended behavior (Henderson, Robinson et al., 2016) and a reduction in experiences of discrimination reported by mental health service users, overall and in many specific life areas (Corker et al., 2016; Sampogna et al., 2017a, 2017b, 2020). The life areas that did not show change tended to be those in which discrimination is often structural, such as welfare benefits, housing, and healthcare. In phase 3, the target audience for the social marketing campaign was changed from middle-income to low- to middle-income adults (aged 25–45 for all phases). After 10 years of the social marketing campaign, the improvements in stigma-related knowledge, attitudes, and intended behavior equate to around 10% of the population improving in this way (Henderson et al., 2020). In 2020, the Royal Society of Public Health voted TTC as one of the top 20 public health programs of the first 20 years of the twenty-first century (www.rsph.org.uk/about-us/news/top-20-public-health-achievements-of-the-21st-century.html) .

Ireland: See Change. See Change is Ireland's organization dedicated to ending the stigma of mental illness. The aim is to reduce stigma and discrimination about mental health problems and to promote the same rights for everyone according to the principles of Equality, Inclusivity, Empowerment, Openness, and Dignity. To achieve these objectives, the organization works through national, regional, and community-based campaigns using ambassadors who can directly relate their own experiences. See Change pays particular attention to the workplace, identifying it as a key setting for a social change. One of its main campaigns is the Green Ribbon: wearing a green ribbon during a particular month of the year means caring about mental health and pushes people to talk about stigma and discrimination.

Netherlands: Samen Sterk. In the Netherlands, the population-based anti-stigma program Samen Sterk Zonder Stigma (Together Strong Against Stigma) aims to eliminate the prejudice and discrimination associated with mental illnesses. It focuses on the following target groups: mental health professionals, the workplace, the media, the community, and young people. Several activities have been promoted for each group, such as the meeting with ambassadors, the development of non-stigmatizing reporting guidelines for media professionals, and the development of a shorter version of CORAL (Conceal Or ReveAL), a decision aid for employees with respect to disclosing a mental illness (Henderson et al., 2013).

New Zealand: Like Minds, Like Mine. One of the longest-running, population-based anti-stigma programs is "Like Minds, Like Mine," which was established in New Zealand in 1997. The program aims to fight prejudice and discrimination related to mental illnesses by targeting the workplace and community settings. It emphasizes the removal of barriers to social inclusion for the most excluded groups, including people with severe mental illnesses, Indigenous populations (Maori and Pacific people), and people under the age of 25 years. The main target groups include the media, the workplace, and the community. Activities have included guidelines for responsible media reporting, public awareness campaigns, and a wealth of online resources for minimizing stigma in any environment, accessible through the program's website.

Portugal: Unidos Para Ayudar. Unidos Para Ayudar (UPA) is a Portuguese anti-stigma campaign. It was developed within the project Encontrarse, founded by the Private Institution of Social Solidarity, a public utility non-profit, which works with people with severe mental illness. UPA promotes events such as musical concerts through an interactive website. It pays particular attention to younger people: UPA Kids is dedicated to children, and it seeks to expand and intensify work with the younger population through the development and implementation of projects that promote children's mental health.

Scotland: See Me. Scotland's National Program to stop mental health stigma is called "See Me." It was founded by the Scottish Government and Comic Relief and managed by the Scottish Association of Mental Health and the Mental Health Foundation. The program proposes different campaigns to mobilize people to work together to put an end to mental health stigma, change negative behaviors toward people with mental illness, and respect their human rights. The social-contact theory is the core of the program. The campaign involves people at home, at school, at work, or in local communities. The basis of this program is to foster the ability to be more comfortable talking about mental health. A good example is the campaign "Walk a Mile," in which people spend time together talking about mental health while "walking a mile in each other's shoes." See Me also collaborates with Time to Change for the annual Time to Talk Day. In 2003, two years after the start of the See Me campaign, there was a demonstrated improvement in attitudes toward certain conditions, such as depression, phobias, and schizophrenia (Mehta et al., 2009).

Spain: Obertament. Obertament (Open Mind) was funded in 2010 in Catalonia and aims to improve the lives of individuals living with mental illnesses. Like Opening Minds, the primary target groups are media, youth, healthcare, and workplace. Activities include the establishment of a Media Observatory, which includes media guidelines for reporting on mental health–related topics and educational workshops for journalists; the development of online toolkits; activism training for the general population, which has helped to create a powerful network of anti-stigma champions throughout Catalonia; and the What's Up! project, which aims to raise awareness about stigma and increase mental health literacy among school-aged youth.

Spain: 1 de cada 4. "1 de cada 4" (1 in 4) is a cross-sector anti-stigma strategy coordinated by the Awareness Group, which is a part of the Comprehensive Mental Health Plan of Andalusia. It started in 2007 as part of a broad approach that includes the improvement of social and mental health services based on recovery and human rights. The aim of this project is to fight stigma, discrimination, and violation of human rights that are often experienced by people with mental illness. It also supports service users and their relatives in their recovery journey. The campaigns are aimed at the general population, especially at professionals from several sectors (media, health, social service, and policy and other security forces) and to people with mental health conditions and their relatives. Activities include short documentary films, a *Media Reporting Guide*, and various training courses and workshops.

Sweden: Hjärnkoll. Hjärnkoll is the Swedish government–sponsored program to reduce stigma and discrimination and increase quality in the psychiatric care and social services for people with psychosocial health conditions. The program, which is based on social-contact theory, supports approximately 300 ambassadors who have experienced mental illness directly or indirectly through family or friends (Henderson, Stuart et al., 2016). According to the Center for Evidence-based Psychosocial Intervention (CEPI), which evaluated the effect of the first two years of the campaign, this led to significant and positive changes in attitudes, mental health literacy, and intended future behavior among the Swedish people (Hansson et al. 2016). In addition, one particular focus of the campaign is police officers. Through the Hjärnkoll project, a specific program was developed to address mental illness stigma among police officers. This program included an introductory lecture on attitudes toward people with mental illness, including a video presentation made by the national anti-stigma program and focusing on mental disorders; two lectures by people with lived experience of mental disorders; and six videos by people with lived experience of mental disorders. Evaluation of this police-focused program showed that it led to a significant change among officers in attitudes toward people with mental illness, more positive interactions and an improvement in mental health literacy (Hansson & Markström, 2014).

Switzerland. The Association for the Improvement of Mental Health Programs was founded in 2004. Its aim is to raise the importance of mental health through seminars, talks, interactive means of consultation, studies, and other theoretical and practical work. This association also supports innovative initiatives in the field of mental health in the least-developed countries.

United States: Bring Change to Mind. Bring Change to Mind is a non-profit organization founded in 2009 by Glenn Close after discovering her sister's bipolar disorder and her nephew's schizoaffective disorder. Bring Change to Mind grew out of an unyielding determination to put an end to discrimination surrounding mental health. The organization develops multimedia campaigns to encourage cultural conversation around mental health, curates storytelling movements, supports a constructive dialogue about mental health through Public Service Announcements, and develops youth programs. In 2015 the Bring Change to Mind launched its peer-to-peer high school program and for the school year 2020–2021 managed to involve 320 schools and 9,500 students. The association does not target just young people, but people of all ages and involves them through its interactive website, videos, and participation in TV programs.

California, United States: Each Mind Matters. Each Mind Matters is a mental health movement in California, dedicated to strengthening the power of community and raising mental health awareness through conversation.

The user-friendly website includes sections targeted at all age groups. There is also a section for military veterans and the mental health challenges they may face while transitioning to civilian life. It has been evaluated by the Rand Corporation, which has found a reduction in desire for social distance and an increased awareness of stigma since the program began (www.eachmindmatters.org/rand-study-results/).

Time to Change Global. Time to Change Global is an anti-stigma program designed to reduce stigma and discrimination toward people with mental health problems in low- and middle-income countries. It began in 2018 and involved five countries: Ghana, Nigeria, Kenya, Uganda, and India. The program is a partnership between UK mental health charities Mind and Rethink Mental Illness, international disability and development organization CBM, and five country-level partners. In Ghana, since March 2019, a local partner supports a group of people with personal experience of mental health problems, that they called Champions, to plan and run events to engage the public, change perceptions, and get more people talking openly about mental health. The same activities have been organized in India, Nigeria, Uganda, and Kenya: groups with experience of mental illness, supported by different local sponsors, organize events, including organizing community tea parties, inviting local dancers and actors to perform, to change attitudes and reduce stigma in rural villages and towns in Doddaballapur, Abuja, Kampala, and Nairobi. Social media campaigns have also been created. In September 2019, in Ghana, the media campaign #ItCouldBeYou was launched for people between the ages of 18 and 34. The advertisements featuring the voices and stories of some Champions reached 630,000 people in Accra via radio, Facebook, and other social media. In January 2020, Nigeria's Champions joined the same campaign. In Nairobi, the #SpeakUp social marketing campaign was developed, aimed at people aged 18–34. It has reached 1.6 million people across Facebook and Instagram.

Data were collected by market research agencies before and after the campaigns in Accra and Nairobi to investigate pre-post differences in stigma-related outcome measures: mental health–related knowledge, attitudes, and desire for social distance (Potts & Henderson, 2021). Other covariates were included in regression models to control for differences in participant demographics. A significant positive change in a stigma-related outcome was found at each site. Desire for social distance from people with mental health problems in Accra was lower after the launch of the campaign. This increase in intended contact in the absence of other changes is consistent with the early results for Time to Change England. The estimate for the magnitude of this change is the same as Time to Change England for the general population between 2009 and 2019 (Henderson et al, 2020), a very promising result for a short-term public mental health campaign. In Nairobi, the stigma-related knowledge score was higher in the post-campaign sample. The different results observed between sites may be due to campaign as well as population differences.

Future Research Recommendations

Although at the international level several countries are active in the delivery of population-based interventions, there is a need for improving the evaluation of the effects of these programs, their sustainability, their transferability to other settings (such as low-income countries), or their overall cost-effectiveness. Validated theories of change that would identify the active ingredients in a program have not been widely addressed. Therefore, the clear definition of principles and procedures underlying anti-stigma programs that can be meaningfully tested using rigorous methods remains an important public health priority. Future research in the field of population-based anti-stigma intervention should include higher-quality research designs and evaluation of those interventions that are implemented. Basic and applied researchers working in the fields of social psychology, social psychiatry, and sociology can build a knowledge base together. In particular, RCTs can be conducted involving small groups of participants, which can provide important information for implementing larger, population-based programs. Those in the field can influence the future of the research and practice by sharing experiences, needs, and limitations of implementation on the larger levels.

Evaluation should also incorporate economic analyses when appropriate. Furthermore, a periodic assessment of experiences of discrimination at a population level should be carried out to identify the existing gaps and to tailor the interventions. Finally, an assessment of sustainability should be included. A consistent limitation in the identified studies is that there is rarely adequate funding to support sufficiently long-term anti-stigma interventions and hence their evaluation. Finally, partnerships and networks including all stakeholders in mental health should be promoted in order to develop new population-based interventions that are well received by the general population.

Conclusion

Although the story of challenging and overcoming stigma is not yet completed, some headway has been made thus far. In particular, population-based anti-stigma interventions represent relevant and effective strategies for overcoming stigma attached to mental disorders. However, these interventions are time-consuming, require targeting a whole population, and should be conducted with the active involvement of users and carers in order to increase their efficacy. Available studies have confirmed that effective anti-stigma programs can be implemented, but all efforts implemented so far need further initiatives in the coming years. We should learn from the past in order to shape our future and develop even more effective interventions. Table 19.1 summarizes global intervention efforts discussed in this chapter.

Table 19.1 *Summary of global anti-stigma intervention efforts*

Name of campaign	Year	State(s)	Level of approach	Key features
Beyondblue	2005	Australia	Community and Governmental	Youth program
SANE	1986	Australia	Community, Organizational and Governmental	24/7 assistance
Opening Minds	2009	Canada	Interpersonal and Community	Youth program
Each Mind Matters	2004	California, United States	Community	Veterans program
One of Us	2015	Denmark	Community and Organizational	Specific program for healthcare professional
Time to Change	2007	England and Wales	Community	Structural and large program
Time to Change Global	2018	Ghana, Nigeria, Kenya, Uganda, and India	Community	Social-contact theory
See Change	2010	Ireland	Community	Workplace intervention
Samen Sterk	2011	Netherlands	Community and Organizational	Project CORAL
Like Minds, Like Mine	1997	New Zealand	Community	Guideline for responsible media reporting
Unidos Para Ayudar	2007	Portugal	Community	Youth program
See Me	2001	Scotland	Community	Social-contact theory
Obertament	2010	Spain	Interpersonal and Community	Media Observatory Youth program
1 de cada 4	2007	Spain	Interpersonal and Organizational	Media Reporting Guide
Hjärnkoll	2007	Sweden	Community	Social-contact theory
Association for the Improvement of Mental Health Programs	2004	Switzerland	Community, Organizational and Governmental	Initiative for lead development countries.
Bring Change to Mind	2009	United States	Community and Organizational	Youth program

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20 Interventions to Reduce Help-Seeking Stigma for Mental Health Conditions

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According to the Global Burden of Disease Study, in 2019 mental health conditions affected around 12% of people worldwide (Murray et al., 2020). While a variety of treatments and services are effective for reducing mental health problems and associated impairment, several barriers impede access to care and support (Kohn et al., 2004). These barriers are important for understanding the initial help-seeking process, and they can also continue to obstruct care and support throughout the help-seeking process. This chapter describes what we know about the help-seeking process for mental health conditions, the key role of help-seeking stigma as an impediment in this process, and what we can do to facilitate help seeking and thus improve access to care and support.

What Is Help-Seeking?

Help-seeking is a process involving different phases to access care and support (Pescosolido & Boyer, 2010; Pescosolido et al., 1998; Schomerus et al., 2019). Early help seeking happens when individuals recognize mental health problems and perceive a need for help. A decision or plan can then be made to seek care or support. Finally, help seeking involves the process of receiving help and/or taking actions that are deemed appropriate for the individual's mental health problems. Stigma can present a key barrier to seeking care and support for mental health problems – even in very early stages whereby, for example, stigma can inhibit early recognition of problems (Clement et al., 2015; Gronholm et al., 2017; Savage et al., 2015; Yang et al., 2015).

Most research recognizes that help seeking should be viewed as a dynamic social process, rather than a linear series of steps. Pescosolido's network episode model (NEM) builds on earlier help-seeking and healthcare utilization theories, such as the sociobehavioral model (Andersen, 1968) and health belief model (Becker, 1974; Rosenstock et al., 1988), by recognizing the timing and context in which care or support are provided and suggesting that four interrelated components are important for the help-seeking process: the illness career (the process by which an individual enters into the treatment system), the social support system (the social network surrounding the individual including peers, family, community groups, etc.), the treatment system (the health and social support available to the individual), and the social context (a priori set of community support) (Pescosolido & Boyer, 2010; Pescosolido et al., 1998).

In consideration of the individual's wider social context, help-seeking can also be categorized into formal help (e.g., from healthcare providers and treatment) and informal help (e.g., support from family, friends, peers, community leaders and self-help). Formal and informal types of support are often used together (Brown et al., 2014) and may interact with one another in terms of the care an individual receives. For instance, peers or family members could encourage individuals to seek treatment from professional services or they could make referrals on the individual's behalf. On the other hand, healthcare providers could also refer individuals to receive more social support (e.g., via peer support).

General Barriers to Help-seeking

A range of both individual and contextual barriers can influence an individuals' probability of receiving help, and these can be present at various stages throughout the help-seeking process. We have plotted potential facilitators and barriers of help-seeking in Figure 20.1. The figure emphasizes the interconnectedness between potential barriers and facilitators at both the individual and societal levels. Lower recognition of one's mental health problems, for example, is a common barrier that is strongly associated with help-seeking and is commonly associated with stigma of mental health problems (Mojtabai et al., 2016). Self-identification as having a mental illness is also a crucial component that leads to actual help-seeking (Schomerus et al., 2019). Experience with professional services, including interactions with healthcare providers, access, costs, availability, and quality of treatment, can act both as facilitators or barriers to the help-seeking process (Lamb et al., 2012). Negative past experiences, lack of success with previous treatment, anticipated stigma from one's social network, and the fear of losing self-sufficiency can hinder the help-seeking process as well (Savage et al., 2015). Therefore, tackling these barriers is a crucial part of promoting the help-seeking process (see Figure 20.1).

Stigma is a major barrier to help-seeking (Clement et al., 2015). Public stigma, internalized and/or self-stigma, and structural stigma can all impede help-seeking. Public stigma reflects population misconceptions and negative beliefs and can lead to the devaluation of people with mental health conditions. It can also manifest more specifically in relation to beliefs about help-seeking and treatment (Michaels et al., 2017), whereby, for example, it is seen as a weakness to seek treatment for a mental health problem. Public stigma in relation to help-seeking can influence the level of resources available (e.g., lower levels of financing for mental health services) and the acceptability of seeking help from family, friends, work colleagues, and even healthcare professionals and, hence, reduce the availability of support systems (Yang et al., 2015). On the other hand, supportive cultures with low levels of public stigma toward

Figure 20.1 *The help-seeking process and influencing factors*
NOTE: The circles represent components in the help-seeking process (help-seeking knowledge, attitudes, intentions, behavior) as interconnected and influencing each other. Social support system (Gulliver et al., 2010), mental health literacy (Gulliver et al., 2010), self-identification (Stolzenburg et al., 2017), self-experience perception (Savage et al., 2015), impairment or ability (Tomczyk et al., 2020), socioeconomic status (Hunt & Eisenberg, 2010), area of residence (Cheesmond et al., 2019), social milieu (Speerforck & Schomerus, 2020), culture (Clement et al., 2015), and referral (Pescosolido et al., 1998) all act as barriers or facilitators for the help-seeking process. The outer circle has internalized stigma, structural stigma, and public stigma (Schomerus et al., 2009), which all have an interactive relationship with the barriers and facilitators of help seeking.

people with mental illness have the potential to facilitate more openness, support, and help-seeking behavior, including increased participation in treatment (Evans-Lacko et al., 2012; Lewer et al., 2015).

Internalized stigma (also called self-stigma) is the endorsement of negative stereotypes about oneself that leads to self-prejudice and self-discrimination (Corrigan & Rao, 2012) and hindrances to help seeking. For instance, people who are experiencing substance use could be aware of the negative public attitudes toward people with substance use problems (e.g., being "dangerous" and "erratic"), and start applying those negative public attitudes to oneself (e.g., "I am dangerous and erratic"). It can impede recognition of one's own mental health problems to avoid self-labeling (Stolzenburg et al., 2017) and is associated with reduced impairment, self-efficacy, and hope (Schomerus et al., 2011), and higher re-hospitalization rates (Rüsch et al., 2009).

Finally, structural stigma can hinder help seeking by impeding access to care, by discriminating against people with mental health conditions when public resources are allocated to services (Schomerus et al., 2006), or by deterring help seeking because of structural consequences of getting a psychiatric diagnosis, for example, when seeking insurance or applying for certain jobs. Hence, stigma is closely linked to several help-seeking barriers, and many interventions that address help seeking also impact on some aspects of stigma, often without explicitly mentioning it (Yang et al., 2015).

Types of Interventions to Reduce Help-Seeking Stigma

The multiple types and stages associated with the help-seeking process necessitate many forms of help-seeking interventions. The aims of these interventions range from improving attitudes or intentions toward help-seeking to increased utilization of care and support. Many help-seeking interventions target factors that may exacerbate help-seeking stigma, including low mental health literacy, and these are the focus of this chapter. Although there is some research on how help-seeking intentions are related with actual help-seeking (Schomerus et al., 2019), attitudes, intentions, and behaviors are not always perfectly aligned; this is called the intention-behavior gap. This gap exists because every stage of help seeking comes with its own set of barriers.

The types of help-seeking interventions available can address stigma directly or indirectly, and they can focus on various stages of the help-seeking process. Table 20.1 describes a variety of available interventions based on four different systematic reviews (Aguirre Velasco et al., 2020; Gulliver et al., 2012; Kauer et al., 2014; Xu et al., 2018). Interventions can be delivered at an individual level (targeting each person individually), the network level (targeting the social network of the individual such as schools or peer groups), or at a broader societal level (social marketing, mass media). Additionally, they can focus on structural stigma, for example, by altering government or institutional policies. Help-seeking interventions may also apply multiple strategies, such as using both psychoeducation and resource/information sharing together.

Assessing Help-Seeking Interventions

Because of the complexity of the help-seeking process and variety of goals of interventions, the assessment of help-seeking also differs according to each study. For example, interventions that are trying to increase actual help-seeking behavior would be different from those that focus on attitudes and intentions about help seeking or having a mental health problem.

Table 20.1 *Types of help-seeking interventions*

Target of intervention	Type of intervention	How does it help address help-seeking/ stigma related to help seeking?	Example from literature
People with mental health problems	Psychoeducation	Provides information to improve mental health literacy, recognition of mental health problems, coping strategies, and how to seek help; having a better understanding of mental health problems often reduces stigma toward mental health problems	MH-Guru is an online psychoeducation workplace induction program focusing on mental health literacy surrounding depression and anxiety. It is accompanied by vignettes and videos about depression and anxiety to decrease stigma toward common mental health problems (Griffiths et al., 2016)
	Help-seeking resources/ information sharing	Directs persons with mental health problems to further information, mental health services, or resources that may be useful; often used in conjunction with psychoeducation and facilitates access to health services	Link is a help-seeking service navigation website that recommends suitable service options (Sanci et al., 2019)
	Peer support	Trains peers to promote help-seeking and social connectedness via contact with people with lived experiences of mental health problems	AboutFace is a web-based video gallery of veterans sharing their experiences of post-traumatic stress disorder (PTSD) and how treatment has improved their lives (Hamblen et al., 2018)
	Personalized feedback	Gives individual feedback on the person's mental health problems as well as offering suggestions of what type of treatment could be pursued	Every Mind Matters is an online platform that provides interpretations of one's own mental health and personalized action plans for individuals struggling with mental health problems
	Psychotherapy, e.g., cognitive behavioral therapy (CBT)	Uses cognitive behavioral techniques to promote formal and informal help-seeking; addresses self-stigma as an example of dysfunctional cognition	Brief CBT interventions for veterans with PTSD modify beliefs and perceived need of treatment (Stecker et al., 2014)

Table 20.1 (*cont.*)

Target of intervention	Type of intervention	How does it help address help-seeking/ stigma related to help seeking?	Example from literature
Social network of people with mental health problems	Mental Health First Aid	Training to help other people with mental health problems. Reduces public stigma by increasing confidence in how to help people with mental health problems	Mental Health First Aid is provided in a workplace setting to help people in mental health crises or early stages of depression, anxiety, and psychotic disorders as well as to provide information on where to seek help (Kitchener & Jorm, 2004)
	School program	Targets schools to improve mental health literacy (MHL), train students as gatekeepers and peer supporters, and provide help-seeking avenues, often via contact with a person with lived experiences of mental health problems	"HeadStrong" is an educational intervention that deals with MHL, stigma help seeking, psychological distress, and suicidal ideation (Perry et al., 2014)
	Social marketing and mass media program	Reduces the desire for social distance and negative emotional reactions like fear or anger toward people with mental health problems with aims to improve understanding and pro-social behavior	A key aim of the social marketing component of Time to Change was to reduce stigma-related behavior toward people with mental health problems (Evans-Lacko et al., 2014)
Government and institutional bodies	Policies to increase mental health parity	Calls for structural changes that reduce stigma or facilitate help seeking	Combatting stigma and subsequently enhancing help-seeking behavior for suicide by regulating portrayals of suicide in the mass media (Niederkrotenthaler et al., 2014)

It is also possible to measure precursors to the help-seeking process, including self-identification of having a mental illness. This indicates a certain degree of heterogeneity in outcomes within the literature of help-seeking interventions.

Evidence for Effectiveness of Help-Seeking Interventions

A number of studies, including meta-analyses, have demonstrated small to moderate effect sizes for increasing help seeking. A systematic review by Gulliver and colleagues identified six randomized controlled trials (RCTs) in relation to help-seeking interventions for depression, anxiety, and general psychological distress (Gulliver et al., 2012). Most of the interventions had some type of mental health literacy content and de-stigmatization information and/or provided information about help-seeking resources. Trials measuring help-seeking attitudes, willingness, or beliefs found small but significant improvements, but those investigating behavior saw small effect sizes.

A systematic review done by Xu and colleagues found that approximately one-third of the interventions used psychoeducational, social contact, and cognitive behavioral strategies to tackle mental health stigma that obstructs help seeking (Xu et al., 2018). Twenty-five studies looking at help-seeking interventions led to sustained improvements over 1–6 months for formal help-seeking behaviors. However, this effect only pertained to those at risk of having a mental health problem; there were no improvements in formal help seeking with interventions targeting the general population. No studies have shown an effect on help seeking for interventions targeting informal help seeking. Interventions targeting the social support group of those with mental health problems did not show evidence of increased formal help seeking. The authors explained that this might be because people in the general population may consider the intervention only for future mental health problems; therefore, studies would need to have a longer follow-up time to see an effect.

According to a systematic review done by Aguirre Velasco and colleagues, help-seeking interventions focusing on adolescents consisted of psychoeducation in classroom settings, outreach interventions, peer training, and online/ digital interventions, and many targeted help-seeking intentions by addressing stigma, mental health literacy, and attitudes toward mental health services. The review identified three studies that showed improvements in help-seeking intentions and actual help seeking as well as reductions in self-stigma against help seeking (Aguirre Velasco et al., 2020).

Evidence for Interventions Increasing Help-Seeking by Addressing Help-Seeking Stigma

Although many of the studies target help-seeking by tackling mental illness stigma one way or another, few interventions and studies specifically focused on help-seeking stigma as a primary intervention aim and/or outcome. These help-seeking interventions are also heterogeneous in terms of target population, intervention format, and therefore outcomes. This variety, however, results in a diverse evidence base of ways to address help-seeking stigma.

In a study by Cornish and colleagues (2019), 319 current and former military personnel in the intervention group viewed an online video and brochure tackling stigma against mental health problems and promoting help seeking. The control group viewed a control video and brochure. While there were reductions in self-stigma toward help-seeking and increases in help-seeking compared to the control group, follow-up analyses suggested that those with high self-stigma and distress spent the least amount of time engaging with the intervention material. This could suggest that while help-seeking resources are important tools for reducing help-seeking stigma, those who may need the intervention most may be the least likely to engage with the material (Cornish et al., 2019).

In the intervention study done by Nickerson and colleagues, 103 refugee men with post-traumatic stress disorder (PTSD) symptoms were either given an 11-module online stigma reduction intervention called "Tell Your Story" or put in a waitlist control group. At 1-month follow-up, participants in the intervention group showed an increase in help-seeking behavior compared to those in the control group. Both groups, however, showed increased self-stigma related to help-seeking compared to baseline, but the intervention group showed a smaller increase compared to the control group. This may indicate that the intervention has a protective effect against exacerbation of self-stigma toward help seeking. On the other hand, waitlist control groups showed greater increases in help-seeking intentions at follow-up compared to the intervention group, which may be a consequence of distress that those in the waitlist control experienced (Nickerson et al., 2020).

Another study specifically investigating help-seeking stigma used cognitive bias modification with 32 undergraduates with a mental health condition who had not received mental health treatment in the past year. Their study showed a statistically significant reduction in self-stigma of help seeking and perceived public stigma of mental illness for participants in both intervention arm and control arm at 2-month follow-up, and 25% of the sample-initiated treatment for their mental health problem. While the results correspond with previous literature in terms of the efficacy of both psychoeducation and techniques related to cognitive bias in promoting help seeking overall, the results of the study itself remains inconclusive whether cognitive bias modification would be more efficacious than a waitlist or inactive control groups. However, the authors highlighted the importance in terms of actual behavioral change brought forth by an anti-stigma intervention (Stanley et al., 2018).

New Emerging Help-Seeking Interventions

Digital help-seeking interventions have received increasing attention due to their potential for wide reach, accessibility, and low cost. Moreover, being able to access these interventions often within the privacy of one's own home could be an important way to reduce stigma-related barriers associated with accessing in person care and the necessary disclosure often involved in that process. Furthermore, many health services have been physically inaccessible during the COVID-19 pandemic and have been transitioning to remote services (Druss, 2020), and these are likely to grow in the future. Finally, given that mental health care is a scarce resource and thus is often associated with long waitlists, digitalizing help-seeking interventions could improve accessibility and lead to opportunities for digital support, especially in hard-to-reach places (e.g., rural areas that lack adequate health and social care facilities within an accessible vicinity).

Kauer and colleagues (2014) conducted a systematic review of online help-seeking interventions for young people. Three RCTs showed no significant changes in help-seeking behavior. In contrast, four quasi-experimental and cross-sectional studies showed significant but small effect sizes for increased help-seeking behavior. This indicates that more progress is needed to better understand how to facilitate help seeking among young people using digital interventions. However, the results also indicated that young people were generally satisfied with the online help-seeking interventions, with accessibility and availability (Bradley et al., 2012; Burns et al., 2010; Collin et al., 2011; Davis-McCabe & Winthrop, 2010; Horgan & Sweeney, 2010), as well as anonymity (Bradley et al., 2012; Burns et al., 2010; Horgan & Sweeney, 2010; Kummervold et al., 2002), as these traits were highlighted as some of the most common benefits of online interventions. While the review by Kauer and colleagues delineates the potential efficacy and limitations of digital interventions for help seeking, it only looked at studies up to 2013, and there have been further developments in these types of interventions. An updated review focused on digital interventions targeting all age groups is needed.

Research on online help-seeking interventions conducted after 2013 continues to focus on young people's ability to seek help. Many of these help-seeking interventions are embedded in wider, multicomponent interventions targeting specific problems. These interventions range from providing adolescent mothers with resources for taking care of their mental health as well as parenting information (Chu et al., 2019), giving teens advice on coping with bullying, weight issues, and relationship difficulties alongside mental health resources (Sanci et al., 2019), to tackling alcohol issues (Tuliao et al., 2019). Such multicomponent interventions not only aim to target help seeking of the users, but also to practically tackle the root of the person's mental health problems.

Among interventions targeting adults, there has been research on online help-seeking interventions tailored for the workplace. For instance, Griffiths and colleagues (2016) conducted a study on an online psychoeducation training that aims to increase anxiety/depression literacy, provide advice about how to support coworkers or employees experiencing depression or anxiety, and combat stigma by including video vignettes as a proxy form of contact. This study showed strong evidence of greater improvements in anxiety/depression literacy as well as improvements in the respondents' own attitudes related to depression and anxiety for participants in the intervention vs. control group. Similarly, Billings et al. (2008) tested whether audio-narrated interventions with information and graphics on how to manage stress and mood would increase positive help-seeking attitudes in adults recruited from major tech industries. The intervention also included cognitive behavioral techniques such as goal setting, problem solving, and relaxation. The study showed strong evidence of a more positive attitude toward help seeking in the intervention group compared to waitlist controls.

More complex interventions include ones done by the SimCoach program, where a virtual human offers assistance with mental health problems, including PTSD and depression, via a chat interface (Meeker et al., 2015). The RCT found that those in the intervention group who used the chat interface for screening and receiving resources reported greater intention to seek help from the sources provided compared to those in the content-matched control group who received the same resources via text. This highlights how an interactive component of online interventions could offer support that is more effective for patients seeking help.

Future Implications

A strength of current help-seeking interventions is that they deal with barriers such as stigma and lower awareness/mental health literacy in attempts to increase self-recognition, improve help-seeking attitudes and intentions, and ultimately promote help-seeking behaviors when needed. There are nevertheless several research and practice implications to consider for moving the field forward. Current help-seeking interventions tend to focus on psychoeducation or linking people with mental health problems to informational resources. However, there is certainly a need for these interventions to expand their targets to the social context of the individual. This may involve interventions that engage the informal network of the person seeking help or those that build informal networks consisting of people who share similar mental health–related experiences, which endorses information sharing.

The literature on help-seeking stigma predominantly targets young people and students, but interventions shown to be efficacious with young people may not always yield the same effects in an older population or hard-to-reach social groups. Additionally, as most of the research has been conducted in high-income countries, there needs to be more research in low- to middle-income countries (Xu et al., 2018). This is important considering the different contexts around access and cultural conceptualizations of help-seeking stigma. Therefore, future studies could be done to investigate how the help-seeking process varies in different social groups and how to best tailor interventions to fit the help-seeking pattern for that specific group (Brown et al., 2014).

While accessibility and cost-effectiveness have often been highlighted for these help-seeking interventions, there has yet to be evaluations of whether these interventions have wide reach or high engagement/retention. This is something to further consider, especially in the realm of new emerging digital help-seeking interventions, in light of the COVID-19 pandemic and growing technological possibilities. Alongside digitizing psychoeducation and sharing help-seeking information, we could strive to do more complex interventions such as online peer support as digital platforms allow for a wider outreach in terms of social networks.

Finally, systematic reviews highlight a high risk of bias in many of the help-seeking intervention studies (Xu et al., 2018). There is certainly a need for higher quality studies with more rigorous research to establish the efficacy of these interventions, including more representative samples and more rigorous randomization procedures. For example, studies looking at interventions toward help seeking would have a larger sample size for sufficiently powered analyses, assign participants into groups via random sequence generation, ensure the use of validated measures that consider different types of help seeking and stigma and include evidence of psychometric properties, and conduct longer-term follow-ups. More research that focuses on improving and assessing the impact of interventions on actual behavior rather than focusing on intentions or attitudes only, in addition to applying multiple tools and resources, including both in person and digital formats, will strengthen future research and our understanding of help seeking.

Conclusion

Interventions that target help seeking and stigma are as multifaceted as the help-seeking process. Different aspects of stigma pose barriers that are addressed in these interventions and are closely intertwined with other barriers. The most researched help-seeking interventions focus on ease of access and cost-effectiveness by using a combination of strategies including psychoeducation modules, information and/or resource-sharing, and contact (usually indirect, e.g., via video or through vignettes) with people who have had lived experience of mental health problems. Current evidence indicates small-to-moderate effect sizes for improving help-seeking attitudes, including reducing help-seeking stigma. As would be expected, research that evaluated actual behavior showed smaller effect sizes compared to attitudes or intentions but demonstrated some significant improvements in help seeking. The rise of digital interventions also shows increased potential for accessibility at a lower cost, although there needs to be more comprehensive research evaluation of these interventions. Furthermore, research should reflect the complexities of the help-seeking process by considering the role and influence of the social network and social context of the individual with mental health problems in both the intervention and the evaluation.

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21 Self-Affirmation Interventions to Reduce Mental Health Stigma

Andrew J. Seidman

Stigma is currently defined in the *Oxford English Dictionary* as a "mark of disgrace" that signifies a person as *different and lesser* than others (Simpson & Weiner, 1998); it indicates the presence of an "attribute that is deeply discrediting," one that communicates its bearer is a "less desirable kind" (Goffman et al., 1963, p. 3). Historically, applications of stigma included physical harm to leave visually discernible bodily marks and signs, but now commonly manifests as stereotypes, prejudices, and discrimination (Corrigan, 2004; Hinshaw & Cicchetti, 2000). Its reach and effects reflect the extent to which the specific attribute is stigmatized; at high levels of unacceptability, the stigmatizing characteristic can come to define a person as "thoroughly bad, or dangerous, or weak" by minimizing other social identities and reducing a "whole and usual person to a tainted, discounted one" (Goffman et al., 1963, p. 3).

Mental health stigma – a worldwide phenomenon and enduring public health crisis, officially declared so by the U.S. Surgeon General over two decades ago in 1999 – is a primary reason why, on average, although 1 in 5 (over 50 million) American adults suffer with a diagnosable mental health condition per year, less than 50% seek professional psychological help (National Institute of Mental Health, 2021; U.S. Department of Health and Human Services, 1999). Mental health stigma is typically conceptualized at two levels: (1) *public stigma*, which consists of societal-level negative stereotypes, prejudices, and discrimination toward mental illness and mental health care, including perceptions of incompetence, danger, and an overall sense of undesirableness; and (2) *self-stigma*, which reflects the internalization of these negative attitudes and subsequent loss of self-integrity (Bathje & Pryor, 2011; Corrigan, 2004; Vogel et al., 2006). There are also unique public and self-stigmas associated with being "*mentally ill*" (by receiving a diagnosis) or a "*help seeker*" (by participating in care Tucker et al., 2013; Vogel et al., 2006).

To elude stigma and *stereotype threat*, or being negatively associated with derogatory mental health labels and judgments, people routinely avoid psychological care (e.g., Link et al., 1989; Steele & Aronson, 1995; Thornicroft et al., 2016; Vogel et al., 2006). Across populations, statistical modeling has consistently shown the self-stigma of seeking help to fully mediate the relationship between public stigma and *attitudes* toward psychotherapy (Vogel et al., 2006, 2013, 2017). In other words, although public stigma naturally precedes self-stigma, it is the extent to which one agrees with and internalizes these negative stereotypes that accounts for differences in attitudes. Similarly, help-seeking attitudes fully mediate the relationship between self-stigma and *intentions* to seek psychological help, a construct critical to planning and initiating behavior (Ajzen, 1991; Vogel et al., 2006, 2013, 2017).

Mental Health Stigma and Therapy Avoidance

Nearly 70 years ago, Clausen and Yarrow (1955) summarized public attitudes toward mental health care in a way that sounds familiar still today: suggesting a person seek professional psychological help in "contemporary America is a fairly common way of saying that one feels irritated, exasperated, and generally unsympathetic toward another person" (p. 30). Although stigma levels vary across individuals, demographic factors (e.g., sex, age, race/ethnicity), and sociocultural contexts (e.g., family, community, workplace), there are clear and robust penalties for having a mental illness and seeking psychological help across providers, settings, and forms of treatment, including self-esteem loss, social rejection, loss of career opportunities, and even impaired medical care (see Hinshaw & Cicchetti, 2000; Vogel et al., 2007; Thornicroft et al., 2016 for reviews). Moreover, stigma extends to family and larger social networks, tainting persons by association (Phelan et al., 1983; Topkaya et al., 2015). People are understandably motivated to avoid stigmatization, but this effort is not without long-term consequence: on average, a person experiencing clinically significant distress waits at least 10 years after symptom onset before seeking psychological help (Wang et al., 2004).

Until recently, efforts to address stigma were surprisingly rare; now, stigma is a growing facet of public dialogue and a common target of interventions (Clement et al., 2015; Corrigan, 2004; Thornicroft et al., 2016). In turn, information about mental health, symptom prevalence, and treatment is increasingly available. Providing this information as an intervention to encourage help seeking or change stigma through psychoeducation can take many forms, including public health campaigns, online or in-person screenings (e.g., National Depression Screening Day), professional referrals, and encouragement from peers and loved ones. However, stigma is commonly activated in situations in which mental health is made salient. Although psychoeducation is shared to encourage reflection on distress, functioning, and benefits of seeking professional help, it can instead elicit a *rebound* or *boomerang effect*, inadvertently activating mental health stereotypes and further discouraging help seeking (Corrigan & Penn, 1999; Hovland et al., 1953; Lienemann & Siegel, 2016).

Self-Stigma and Maintaining Competency

Self-stigma levels reflect the extent to which public stigma is internalized, thereby providing an index of individual shame-proneness to societal stereotypes of mental health (Corrigan, 2004; Vogel et al., 2006). Not surprisingly, self-stigma is related to worse attitudes toward psychotherapy, lower outcome expectations, and reduced intentions and willingness to seek help (Vogel et al., 2007, 2017). Further, self-stigma deters the initiation and maintenance of help-seeking behavior, including requesting psychoeducation and both scheduling and attending sessions (Kessler et al., 2001; Lannin et al., 2015; Seidman, Wade et al., 2019).

Feared consequences of mental health stigma are not restricted to initiating therapy; they also deter treatment attendance and engagement. According to Corrigan and colleagues (2014), the decrease in global perceptions of self-integrity and self-efficacy "commensurate with self-stigma harms participation in care" (p. 44). Among a nationwide sample of adults with mental illness, the primary reason for not initiating or dropping out of treatment early was self-reliance, or the desire to "solve the problem on my own" (Kessler et al., 2001, p. 995), a finding that has been replicated in another large epidemiological study (Mojtabai et al., 2011).

Lower "doses" of the requisite processes (i.e., common factors) for successful psychological treatment can be partly attributed to self-stigma's presence in the therapy room, which has been implicated in the use of client self-defensive behaviors, including concealment and nondisclosure (Baumann & Hill, 2015; Wampold & Imel, 2015). Clients with increased self-stigma are less engaged in treatment (Kendra et al., 2014), which impedes development of the therapist–client working alliance, or professional helping relationship (Bordin, 1979; Owen et al., 2013). An impaired alliance is not only experienced by clients; therapists of clients with higher stigma perceive their alliances as more tenuous (Nakash et al., 2014). Stigma's negative relationship with the working alliance is especially concerning, as differences in alliance ratings account for as much as 8% of variance in treatment outcome (Horvath et al., 2011). Indeed, through its dampening effect on working alliance development, increased self-stigma predicts worse therapy outcomes (Owen et al., 2013).

Professional psychological treatment is effective for a variety of mental health concerns across diverse populations (Wampold & Imel, 2015). In addition to alleviating symptoms, psychological services promote healthy functioning and can prevent symptom onset, suggesting an even larger population that could derive benefit than only individuals with a mental health disorder. Increasing rates of distress, especially in the wake of COVID-19, have signaled the alarm for researchers, clinicians, public health experts, and mental health advocates: there is a clear need for improved public literacy about mental health and its care, as well as increased access to and use of professional help (National

Institute of Mental Health, 2021; Pfefferbaum & North, 2020). I believe self-affirmation offers special promise in advancing toward this goal.

Self-Affirmation

According to self-affirmation theory (Steele, 1988, p. 262), all people have a *self-system*, or internal narrative through which we constantly explain and justify ourselves to "ourselves, and the world at large" – a behavior motivated by the human need to maintain a global sense of self-integrity and positive self-perceptions (e.g., as competent, good, stable, and in control). The need to maintain self-integrity is critical to understanding self-affirmation. In their review of the literature examining this motivation, Cohen and Sherman (2014) summarize three key points. First, self-affirmation is directed toward maintaining global positive self-perceptions versus those localized to a specific domain (e.g., being a good person vs. a good student). Second, the motivation is to feel competent in several areas of life to feel "good enough." Third, the self-system is not motivated to shower oneself with praise, but, instead, to establish and maintain self-integrity by encouraging people to act in meaningful ways consistent with personal values.

The human need to maintain a global sense of self-integrity is so strong that the *self* has been described as "totalitarian" (Greenwald, 1980). In order to maintain positive self-perceptions, the self-system constantly monitors the environment for threatening information that could induce *cognitive dissonance*, a form of psychological discomfort and self-integrity threat elicited by inconsistencies between self-perceptions, thoughts, and behaviors (Festinger, 1957). In response to threat, people commonly engage in *psychological reactance*, a repertoire of defensive fear-based responses including information denial, rejection, and avoidance (Hovland et al., 1953; Steindl et al., 2015). Its reflexive automaticity and universality have implicated reactance as part of a larger biobehavioral system of self-defense (Carver & White, 1994; Gray, 1982).

When a sense of global self-integrity is threatened and cognitive dissonance levels rise, people employ self-image restoration processes to reestablish positive self-perceptions. Historically, self-integrity was hypothesized to be maintained via one of two pathways: rationalization (e.g., cognitive reappraisal of behavior) or actual behavioral change (Festinger, 1957). According to Steele (1988, p. 262), people can restore self-integrity through a third, alternative pathway: self-affirmation, which captures an "extra degree of psychological resilience not captured by [Festinger's] dissonance theory."

By reflecting on prized personal values across life domains (e.g., family and friend relationships, career, volunteering, hobbies), a person *self-affirms*, or gains access to multiple sources of self-worth, which activates a sense of self-integrity. Through this process, self-affirmation *decouples* oneself from threat, or contextualizes dissonance-inducing information within a larger sense-of-self (Sherman, 2013). Self-affirmation ameliorates the need for self-defense, thereby reducing subsequent reactance. In turn, self-affirmation promotes an “open mind,” increasing availability and access to the self’s resources, and promoting non-defensive information processing and engagement (see Cohen & Sherman, 2014; Correll et al., 2004; Steele, 1988; van Koningsbruggen et al., 2018 for reviews).

Brain, Body, and Mind: The Psychological, Neurological, Physiological, and Cognitive Underpinnings of Self-Affirmation

A sense of self-integrity is composed of favorable self-perceptions, and experimental inductions of self-affirmation have demonstrated its utility to increase numerous indices of a positive self-image and subjective well-being, including self-esteem, self-compassion, a feeling that one’s needs in life are being met, and meaning in life (Armitage & Rowe, 2011; Lindsay & Creswell, 2014; Nelson et al., 2014). Self-affirmation promotes feelings of social belongingness and improves perceptions of relationship security, domains especially jeopardized by mental health stigma (Crocker et al., 2008; Shnabel et al., 2013; Stinson et al., 2011). Beyond promoting self-integrity, self-affirmation also activates relevant emotions, including greater positive affect (e.g., feeling happy, inspired, content) while also dampening distress (less irritable, upset) and self-defensive emotions (e.g., scared, hostile; Lannin et al., 2017; Nelson et al., 2014). Additionally, self-affirmation influences perceptions of anticipated regret of failing to meet future health goals, which is positively associated with health-promoting attitudes and behaviors (Barkoukis et al., 2020; Sandberg & Conner, 2008; van Koningsbruggen et al., 2016).

Self-reported negative affect and defensive emotions represent just one experiential component of the psychological response to threat, which is accompanied by a robust repertoire of activity at neurological, physiological, and cognitive levels (Cacioppo et al., 2000). Psychological threat activates the *behavioral-inhibition system* (BIS; Gray, 1976), a biologically modulated environmental- and self-monitoring process attuned to rejection and punishment cues; when activated, the BIS orchestrates a series of biological responses to regulate basic motivational “approach vs. avoid” decisions (Carver & White, 1994). It is well known that psychological threat increases activation of brain structures and regions responsible for encoding and processing negative emotional stimuli, including the amygdala as well as specific cortical and striatal areas (for a review, see Yarkoni et al., 2011). In response to threat, neural processes communicate with bodily functions associated with the sympathetic (i.e., arousal) nervous system to coordinate complex psychophysiological responses, including increases in blood pressure and heart rate, as well as the excretion of the stress hormones cortisol and epinephrine (Blascovich & Tomaka, 1996; Creswell et al., 2005; Mendes et al., 2001; Sherman et al., 2009).

Psychological threat has immediate, negative effects on cognitive resources associated with executive functioning, including attention control, working memory, and self-regulation (Beilock et al., 2007; Schmader et al., 2008; Steele & Aronson, 1995). Threat perceptions "hijack executive resources" by increasing activity in brain regions associated with fear processing (Johns et al. 2008, p. 691). Executive functioning is impaired by basic and powerful defensive processes potentiated by threat that activate the startle-eyeblink response (Crowell et al., 2015), increase pupil dilation (Vanderhasselt et al., 2015), and reduce volitional regulation of eye gaze (Cisler & Koster, 2010). In turn, psychological threat interferes with normal attention processes and reduces cognitive performance on tests of problem-solving capacity (Creswell et al., 2013), and attention-shifting (Harris et al., 2007; Kessels et al., 2016); it worsens reaction time (Johns et al., 2008; Legault et al., 2012).

Although psychological threat impairs neural, physiological, and cognitive functioning, as well as self-reported affect and attitudes, self-affirmation appears to buffer its negative effects, suggesting that health-risk information may not have an immutable path toward inducing threat and a rebound effect (see Sweeney & Moyer, 2020; van Koningsbruggen et al., 2018 for reviews). Novel experiments using neuroimaging have demonstrated that self-affirmation increases activation in brain regions associated with self-processing, favorable evaluation, and positive autobiographical memories (Cascio et al., 2016; Dutcher et al., 2016; Falk et al., 2015; Speer et al., 2014). Moreover, there appears to be a positive dose-response relationship, in that increased activity in the ventral striatum and ventromedial prefrontal cortex during self-affirmation, two regions robustly associated with favorable self-processing, predicts more healthy behavior change (Cascio et al., 2016; Falk et al., 2015). Self-affirmation also buffers physiological reactance by reducing the startle-eyeblink response (Crowell et al., 2015) and excretion of cortisol and norepinephrine (Creswell et al., 2005; Sherman et al., 2009) while also promoting healthy heart functioning as indexed by the parasympathetic (i.e., at rest) nervous system activity, including lower heart rate (Tang & Schmeichel, 2015) and increased respiratory sinus arrythmia (Chen et al., 2020). Self-affirmation also promotes volitional use of cognitive resources (e.g., selective attention) and the ability to tolerate threatening stimuli as indexed by electroencephalographic (EEG) monitoring (Finley et al., 2018; Gu et al., 2019; Legault et al., 2012). Promisingly, self-affirmation increases perceived salience of health-risk information while simultaneously preserving attentional focus, an effect especially pronounced among high-risk individuals (Harris et al., 2007, 2017) .

Cross-Cultural Considerations

The *self* exists at the core of self-affirmation, an intervention that inherently facilitates self-enhancement (Steele, 1988). Although most inductions of self-affirmation use personal values relevant across diverse populations (e.g., kindness, curiosity; McQueen & Klein, 2006; Peterson & Seligman, 2004; Schwartz et al., 2012), there is significant diversity in cultural norms regarding self-enhancement. Among Western and White populations, "what importantly defines a person are internal and private attributes, abilities, beliefs, and characteristics that makes one unique, special, and different from others" (Cross et al., 2003, p. 934). Among Eastern and non-White cultural groups, historically underrepresented in the psychology literature, there is traditionally larger emphasis on interdependence and relationship functioning, although there are many variations in the degree to which these values are endorsed across and within groups (Markus & Kitayama, 1991). Therefore, self-affirmation may be less successful among individuals who are less inclined to engage in self-enhancement processes due to sociocultural norms.

Diversity in cultural norms and values can moderate self-affirmation strategy and success (e.g., Heine & Lehman, 1997). In a series of studies, Hoshino-Browne and colleagues (2005) demonstrated how European Canadian students displayed more dissonance (i.e., rationalized more) when making a decision for themselves as opposed to a friend, which should be more threatening to an independent sense of self; the inverse was true for Asian Canadians. Further affirming an interdependent aspect of the self (i.e., values shared by self and family), but not independent (i.e., personal-only), reduced this dissonance for Asian Canadians. Recent findings of cross-cultural differences in self-affirmation further demonstrate the need for culturally informed interventions (e.g., Cai et al., 2013; Covarrubias et al., 2016).

Self-Affirmation: Initial Applications

The Self-System, Health Information, and Personal Threat

The self-system is especially sensitive to health-risk feedback, or information that highlights illness susceptibility and a need for professional care (Steele, 1988). Tailored health-risk information, by design, is intended to maximize personal salience in order to enhance receptivity, but it also increases awareness of personal distress and relevant stereotypes. In turn, this information or feedback can induce mental health stereotype threat, including fears of being associated with stigmatizing labels (e.g., "crazy") that threaten fundamental perceptions of self-competence and social belongingness (Corrigan, 2004; Link et al., 1989; Vogel et al., 2006).

Reactance, Mental Illness, and Help Seeking

Due to stigma, interventions can have boomerang and rebound effects by *increasing* activation of mental health stereotypes and *decreasing* help-seeking openness (Corrigan & Penn, 1999; Lienemann & Siegel, 2016). For example, distressed college students instructed to read a psychoeducational brochure and contemplate personal reasons to seek therapy (or not) reported higher self-stigma and were less willing to receive personalized results from a distress screening tool than their noncontemplative peers (Lannin, Ludwikowski, et al., 2019). These unanticipated effects are especially pronounced among at-risk groups; in one study, reactance to public service announcements about depression risk (i.e., print, video) increased alongside depression severity, which mediated the relationship between depression symptoms and negative help-seeking attitudes and intentions (Lienemann & Siegel, 2016). In other words, as information salience increases, so does threat and reactance; those most likely to benefit from psychological help are also those most likely to derogate and reject it (Clement et al., 2015; Corrigan & Penn, 1999).

Ultimately, the short-term impulse to maintain self-integrity supersedes the long-term benefit of seriously considering individual health risks and quality of life (Cohen & Sherman, 2014; Correll et al., 2004). Viewed together, these findings provide a rationale for the mixed efficacy of interventions to reduce stigma and increase help seeking (e.g., Clement et al., 2015; Thornicroft et al., 2016). Given the prevalence of stigma, persons who may benefit from mental health care are likely to wrestle with a fundamental dilemma: How can I be competent, self-reliant, and in control, while *also* seeking professional psychological help?

How Self-Affirmation Might Overcome Reactance

Historically, self-integrity was hypothesized to be maintained through two pathways: rationalization or behavioral change (Festinger, 1957). Over 30 years later, Steele (1988) offered a third, alternative pathway: self-affirming via reflection on personal values. Values provide a means of understanding and interacting with oneself and the world, reminding people of their goals and “desirable end states,” thereby implicating the self-system and self-affirmation (Rokeach, 1973; Schwartz & Bilsky, 1987, p. 551). Although self-affirmation interventions usually ask participants to reflect on a “top” value (McQueen & Klein, 2006), values are “adjacent” to one another and interrelated (e.g., compassion and benevolence; dominance and maintaining face; Schwartz et al., 2012). Therefore, self-affirming by reflecting on personal values provides the self-system with access to multiple domains of self-integrity and “a more expansive view of the self and its resources” (Cohen & Sherman, 2014, p. 333; Steele, 1988).

Self-affirming prior to threat induction via health-risk feedback has an inoculating effect (Critcher et al., 2010). By enhancing a person’s sense of self-integrity before they engage with information that poses psychological threat, self-affirmation reduces neurological, physiological, cognitive, and self-report emotional and attitudinal reactance. Self-affirmation also promotes decoupling, a psychological process that weakens the association between threatening stimuli and personal identity (Critcher & Dunning, 2015; Sherman et al., 2013).

Reduced mobilization of self-defensive resources helps create psychological distance, an important factor in how people represent and construe information and situations in daily life (Trope & Liberman, 2010; Wakslak & Trope, 2009). Psychological distancing and decoupling provide space to assess the broad, goal-relevant implications of behavioral choices, or a *high-level construal*; conversely, a low-level construal is characterized by the "here and now," accentuating secondary but immediate features (e.g., concrete logistics; Trope & Liberman, 2010). In health settings, a low-level construal interferes with health behavior due to the human tendency to value future rewards less as they become more distant in time (i.e., temporal discounting; Ainslie, 1975). Conversely, a high level motivates reflection on personal goals and outcomes and is associated with increased ratings of salience of health-risk information, message acceptance, negative attitudes toward succumbing to short-term urges over long-term progress, and actual behavioral change (Belding et al., 2015; Fujita & Carnevale, 2012).

With increased psychological distance, people can develop broader and more goal-defined conceptualizations of personal behavior, prioritizing desirable long-term outcomes over immediate urges (Trope & Liberman, 2010). Promisingly, self-affirmation induced numerous indices of a high-level construal across a novel series of studies, suggesting its promise in transcending immediate self-image concerns and promoting value-driven decision making (Schmeichel & Vohs, 2009; Wakslak & Trope, 2009). Further, even one-time interventions can initiate a "downstream" effect and promote *spontaneous self-affirmation* in daily life response to psychological threat (e.g., not preceded by an intervention; Brady et al., 2016).

Self-Affirmation Intervention Types

A self-affirmation intervention is a brief, self-directed, and scalable task that can be implemented, via pen and paper, computer, or mobile device, prior to health-risk exposure in order to prophylactically reduce reactance (McQueen & Klein, 2006). In most studies, participants randomized to complete a self-affirmation task begin by rank-ordering a diverse list of personal values and character strengths (e.g., achievement, curiosity, power, kindness) in order of personal importance (e.g., 1 = *most*; 4 = *least*; McQueen & Klein, 2006; Peterson & Seligman, 2004; Schwartz et al., 2012). In some designs, participants rank-order multiple scales, deciding between several top-rated values before identifying a final top choice; others include a write-in component to ensure an important value is not omitted. Afterward, participants often complete a brief writing task that promotes further self-reflection by describing times in which they acted consistently with their top value, when it made them feel good about themselves, or when it provided a sense of personal meaning (Cohen et al., 2000; McQueen & Klein, 2006).

Participants not randomized to self-affirmation either complete a task designed to minimize its likelihood or are spontaneously exposed to health-risk information, which can be considered the "standard of care" to the extent it captures a real-life scenario (Lannin et al., 2013, p. 264). Non-self-affirming tasks ask participants to reflect on their least important value or one they think others deem especially important (Napper et al., 2009; van Koningsbruggen et al., 2016). In nonrelated tasks designed to constrain any value elicitation, participants have ranked jellybean flavors (Lannin et al., 2013) and alphabetized last names (Lannin, Vogel, et al., 2019).

Self-Affirmation: Mental Health Applications

Self-affirming by reflecting on personal values and how they manifest in daily life reminds people of various domains of self-integrity and facilitates a broader sense-of-self (Steele, 1988). Comprehensive meta-analyses and reviews have demonstrated the benefits of using self-affirmation to reduce reactance across neural, physiological, cognitive, and self-report levels, as well as promote positive health-related emotions, attitudes, and behaviors (see Sweeney & Moyer, 2020; van Koningsbruggen et al., 2018). Consequently, self-affirmation researchers are increasingly beginning to test its effects on mental health domains, including reducing stigma, encouraging help seeking, and improving psychotherapy experiences.

Reducing Stigma Associated with Seeking Psychological Help

In the first study to apply self-affirmation to psychological help seeking, Lannin and colleagues (2013) recruited 84 distressed undergraduate students (defined via clinical cut-off score) to a lab-based "memory study." Participants randomly assigned to complete a self-affirmation intervention ranked 13 personal values and wrote about experiences in which they used their top value to guide meaningful behavior. Immediately afterward, participants were exposed to psychoeducation, which consisted of a brochure describing counseling and its benefits (Levine et al., 1983). Compared to their nonaffirmed peers, self-affirmed participants reported lower levels of self-stigma associated with seeking help. In a second study, using an Amazon Mechanical Turk (MTurk) sample of 186 community adults who endorsed a current mental health concern but were not in therapy, self-affirming (vs. not) prior to psychoeducation was associated with reduced emotional reactance, including feeling less upset, hostile, irritable, and scared (Lannin et al., 2017).

Stigma appears especially salient in the early stages of psychological help seeking (Corrigan et al., 2014; Mojtabai et al., 2011). However, there are only two known studies testing self-affirmation's utility in this situation. Among 124 undergraduate students who attended an individual intake appointment to assess eligibility for counseling (participants were granted research credit), self-affirming (vs. not) before reading a psychoeducational brochure at the beginning of the intake had a direct effect on reducing self-stigma (Seidman, Lanin et al., 2019). When administered before a one-time, 75-minute group counseling session (N = 138 students in 26 groups), self-affirmed participants reported lower post-session perceptions of public stigma associated with seeking help (Seidman et al., 2022) .

Encouraging Psychological Help Seeking

Beyond reducing stigma, self-affirmation also promotes positive attitudes and anticipated beneficial outcomes associated with participating in mental health care. Through its ameliorative effects on self-stigma, self-affirmation has a positive, indirect effect on willingness to seek psychotherapy (Lannin et al., 2013). Among a sample of distressed adults not in therapy, self-affirming was associated with a higher level of intentions to seek counseling (Lannin et al., 2017). Among 74 student veterans, a population particularly likely to avoid mental health services (Rudd et al., 2011), self-affirmation immediately increased and sustained intentions to seek psychological help over the following week, suggesting its utility in creating a "window" of help-seeking openness (Seidman et al., 2018).

As self-affirmation can buffer reactance to psychoeducation, researchers are increasingly testing ways to enhance participant engagement with this information. In a recent study, Lannin, Ludwikowski, and colleagues (2019) recruited a sample of predominantly Black undergraduate students ($N = 126$) from a Historically Black College/University (HBCU) to complete a self-affirmation intervention (vs. not) prior to viewing psychoeducation. Participants were further randomized to "contemplate" this information by generating and rank-ordering three reasons they would consider (and avoid) counseling. After, they completed a brief screening for distress. Results revealed that self-affirmed participants who also engaged in contemplation were six times more likely to request personalized screening results than their peers who contemplated but did not self-affirm. Further, these participants were most likely to request additional psychoeducation.

In a similar study, Lannin, Vogel, and colleagues (2019) randomized undergraduate students ($N = 384$) to complete a self-affirmation intervention (vs. not) before randomizing exposure to different types of psychoeducation. In the "reassuring" condition, participants read a psychoeducational brochure describing counseling as a way to cope with normal developmental stressors (Levine et al., 1983); in the "nonreassuring" brochure, participants read about the benefits of counseling, as well as information about mental health prevalence, risks, and outcomes. The "reassuring" brochure was rated overall as less threatening, and self-affirmed participants rated both sources of psychoeducation as less threatening than their nonaffirmed peers. However, there was no synergistic effect of self-affirmation and reassuring information.

Self-Affirmation, Mechanisms of Change, and Help Seeking

Eliciting self-affirmation by reflecting on personal values offers clear benefit when applied to seeking psychological help. However, there are only two known studies testing its mechanisms of change in this context. One study found no support for positive emotion induction or negative emotion reduction as mediators of its effects (Lannin et al., 2013). Another study found that self-affirmation had an indirect effect on improved expectations for self-disclosing in therapy via reductions in self-stigma (Seidman, Lannin et al., 2019). Intervention design and efficacy will be greatly enhanced by a more informed understanding of *how* self-affirmation reduces reactance to psychoeducation and encourages psychological help seeking.

Given self-affirmation's effect across numerous levels of psychological experience, including neurological, physiological, cognitive, and self-report domains (e.g., affect, attitudes, behavioral intentions), future research could enhance psychoeducation receptivity and help promote help-seeking behavior by integrating biobehavioral methodologies to derive comprehensive explanatory models of change, including potential mediators, moderators, and boundary conditions that constrain its utility.

For example, neuroimaging research has demonstrated that self-affirming self-transcendent values (e.g., importance of relationships) vs. nontranscendent (e.g., independence, money) are associated with less activity in threat-modulated brain regions (i.e., amygdala, anterior insula) during processing of self-relevant and threatening health information (Kang et al., 2017; Schwartz et al., 2012). At the self-report level, prioritizing self-transcendent values is associated with less self-stigma and more openness to interact with persons with mental illness (Lannin, Ludwikowski et al., 2020; Lannin, Parris, et al., 2020; Lannin, Tucker, et al. 2019; Norman et al., 2008). Viewed together, these findings suggest the promise of "restricting" affirmations to self-transcendent values as a novel means toward reducing stigma and increasing help seeking.

Psychological distance and a high-level construal (i.e., the "big picture") elicited by self-affirmation might be especially useful in understanding its effects (Critcher & Dunning, 2015; Trope & Liberman, 2010; Wakslak & Trope, 2009). By promoting a high construal level of seeking psychological help, self-affirmation may accentuate its features that correspond with personal values and goals (e.g., as a means toward improving well-being and relationship functioning; De Smet et al., 2020) and minimize characteristics associated with a low-level construal (e.g., scheduling, treatment logistics). Indeed, potential clients report more positive attitudes toward descriptions of therapy that emphasize its global features, including the importance of feeling heard, understood, and respected, as opposed to more incidental, concrete features such as the specific application of a psychological treatment (Swan et al., 2016).

Conclusion

Self-affirmation provides a comprehensive theoretical framework to understand the human need to maintain a global sense of self-integrity and how it interferes with health-risk communication, as well as a practical intervention component to ameliorate this effect. As applied to mental health, self-affirmation also offers researchers, clinicians, public health professionals, and mental health activists, a brief, practical, self-directed, and customizable intervention to increase psychoeducation receptivity and encourage psychological help seeking.

Due to the brevity, efficacy, and scalability of self-affirmation interventions, there has been a call for their integration into programs targeting public health and societal-level problems (Ehret & Sherman, 2014; Walton & Wilson, 2018). In fact, remotely administered self-affirmation interventions have been used to buffer against increases in anxiety during the COVID-19 pandemic (Li et al., 2020). Further, researchers are now able to test the real-time benefits of inducing self-affirmation in daily life using ecological momentary assessment, a highly feasible method of ambulatory data collection (e.g., Runyan & Steinke, 2015; Taber et al., 2019).

The shame and fear associated with mental health stigma remain a clear barrier to using professional psychological help. However, studies of self-affirmation indicate self-stigma, negative attitudes, and behavioral aversion toward mental health care are not immutable. That a self-affirmation, a brief, standardized, self-directed, and cross-culturally valid values-based intervention completable at nearly any time, induces a sense of self-integrity strong enough to ameliorate reactance and encourage psychological help seeking is exceptionally promising. It is my hope that researchers, clinicians, policy makers, and activists are encouraged by the potential of self-affirmation to reach diverse groups of individuals faster and with fewer resources than traditional interventions, and feel further inspired to continue refining its theory and application in the pursuit of a common goal: reducing the scourge of mental health stigma, encouraging psychological help seeking, and promoting a healthier, happier, and more just society.

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22 Mindfulness and Self-Compassion Interventions to Address Mental Health Stigma

Patrick J. Heath

Goffman (1963) described stigma as a “mark of shame” caused by an attribute that is viewed unfavorably by others. For example, an individual may view a “stigmatized” individual as lesser than or tainted, or discount them as unworthy of attention. While this term was originally used in the context of physical characteristics, the concept has been applied to social attributes as well. Specifically, social stigma describes an aspect of someone’s social identity that may be viewed as a weakness or failing by others in society (Goffman, 1963). As detailed throughout this book, mental illness and the act of seeking therapy have commonly been viewed by society as indicators of a weakness or failure, and have thus been stigmatized (e.g., Corrigan, 2004; Komiya et al., 2000).

Mental health stigma is a term that broadly describes the stigmas associated with having a mental illness or seeking psychological services. These stigmas revolve around an anticipated fear that having a mental illness or seeking out psychological help will result in being stereotyped, discriminated against, or shamed, or will lead to a loss of self-worth (Corrigan, 2004; Vogel et al., 2006). For example, individuals considering seeking help have reported fearing that they might be viewed by others as cowardly, unstable, or pitiful (Hammer & Vogel, 2017). While these stereotypes describe feared public perceptions, these beliefs can be internalized, leading an individual to direct these types of negative stereotypes toward themselves (Corrigan et al., 2006; Vogel et al., 2006). This self-directed stigma is referred to as *self-sigma*, while the perceived public beliefs are referred to as *public stigma*. Research shows that both the public and self-stigmas associated with having a mental illness and seeking psychological help are linked to more negative outcomes including a reduced likelihood of seeking psychological treatment (Corrigan, 2004, Vogel et al., 2006), though self-stigma associated with seeking help is believed to be the more proximal predictor of an individual’s eventual decision to seek services (e.g., Garriott et al., 2017; Lannin et al., 2015, 2016; Vogel et al., 2017).

Mindfulness is a construct that has received growing attention since its emergence as a form of psychological intervention in the 1980s (e.g., Kabat-Zinn, 1982). Several definitions of the construct have been proposed. For example, Kabat-Zinn (1994) suggested that mindfulness could be described as “paying attention in a particular way: on purpose, in the present moment, and non-judgmentally” (p. 4). Shapiro and colleagues (2006) provided an alternate conceptualization, speaking of mindfulness in the form of three axioms, or building blocks: intention, attention, and attitude. According to Shapiro et al. (2006), these three axioms interact with one another to create a state of mindfulness. Beyond these basic building blocks, others have debated whether mindfulness is a state- or trait-like construct. State mindfulness refers to mindfulness that an individual engages in at a *specific* point in time, whereas trait mindfulness (sometimes referred to as dispositional mindfulness) describes an individual's *general* tendency to be mindful (Brown & Ryan, 2003). It is believed that an individual can increase their trait levels of mindfulness by repeatedly, and intentionally, engaging in mindfulness states (Carmody & Baer, 2008). Although definitions and conceptualization of mindfulness have been debated, it is generally believed that mindfulness involves a conscious focus on the present moment, and a nonjudgmental stance toward one's positive and negative experiences (Bishop et al., 2004; Kabat-Zinn, 2003).

Self-compassion is a construct that originated in Buddhist philosophy and describes a caring and compassionate approach to oneself, especially in the face of perceived failure, inadequacy, or suffering (Neff, 2003a). According to theory, self-compassion is composed of three core components: self-kindness, common humanity, and mindfulness (Neff, 2003a). Self-kindness describes taking a positive stance toward oneself; common humanity describes the ability to recognize failure, inadequacy, or suffering as part of a larger human experience (e.g., "I am not alone in this experience"); and mindfulness describes focusing on the present moment (Neff, 2003a), which is largely based on the mindfulness theory previously discussed.

There are clear overlaps between mindfulness and self-compassion, in both theory and practice. While a thorough review of the similarities and differences between these two constructs is beyond the scope of this chapter, it is important to note that they are not mutually exclusive. For example, mindfulness theories suggest that approaching oneself nonjudgmentally and with openness is a core component of mindful practice (Bränström & Duncan, 2014). This might suggest that self-compassion is a built-in component of mindfulness. Alternatively, Neff's (2003a) self-compassion theory posits that mindfulness is a subcomponent of self-compassion. Despite the overlap, research linking these constructs to stigma has typically focused on only one at a time, and thus, literature on the two constructs will be reviewed separately in the coming pages. As will be discussed in more detail at the end of this chapter, additional research is needed incorporating both constructs into a comprehensive model of mindfulness, self-compassion, and stigma.

Mindfulness and Mental Health Stigma

On the surface, it may not be immediately apparent as to why, and how, mindfulness is connected to mental health stigma. How might a present focused awareness be related to negative, stereotypic, beliefs about mental illness and seeking psychological help? One might even think an increased focus on moment-to-moment thoughts could result in rumination on stigmatized aspects of mental health and help seeking. However, a closer look at the definition of mindfulness illuminates important points of connection with mental health stigma and shows how it may be an effective strategy to reduce stigma.

Mindfulness' focus on recognizing thoughts may provide individuals an opportunity to directly question stigmatizing beliefs. For example, previous research suggests that many individuals hold implicit biases against those with a mental illness, including the belief that those with a mental illness are more likely to be dangerous (FitzGerald & Hurst, 2017). These implicit biases may lead to immediate and unconscious reactions to the idea of having a mental illness or seeking out psychological help. Fortunately, mindfulness is an effective strategy to reduce the impact of implicit biases. Mindfulness meditation exercises have been shown to reduce implicit bias toward a number of groups, including racial and ethnic minorities (Kang et al., 2014) and individuals from different age categories (Lueke & Gibson, 2014), and predicts more positive attitudes toward individuals from commonly stigmatized or stereotyped groups, such as those who are homeless (Parks et al., 2014). Additionally, mindfulness-based activities are linked to reduced distress experienced by individuals experiencing stigma because of body weight (Lillis et al., 2009) and sexual orientation (Yadavaia & Hayes, 2012). Given these findings, mindfulness might also serve as an important strategy to combat implicitly held stigmatizing beliefs against mental health or help seeking, since it should bring implicit beliefs to light, allowing an individual to interrogate potentially stigmatizing thoughts and beliefs (Arch & Craske, 2006).

Mindfulness' focus on a nonjudgmental approach to the self is more obviously connected to stigma. Specifically, a nonjudgmental stance toward one's experience directly contradicts the negative evaluations that serve as a driving factor of mental health stigma. As previously noted, stigma is commonly conceptualized as a "mark of shame" (Goffman, 1963), and thus, mindfulness should help reduce the shame associated with perceiving oneself as having a stigmatized identity. In line with this, engaging in mindfulness practice has been associated with lower levels of shame for those experiencing post-traumatic stress symptoms (Goldsmith et al., 2014), and dispositional mindfulness is inversely related to shame for individuals struggling to cope with compulsive sexual behaviors and substance use concerns (Brem et al., 2017). Moreover, mindfulness interventions have been connected to lower levels of shame and guilt and increased self-acceptance (Goldsmith et al., 2014).

Other research has more explicitly linked mindfulness to mental health stigma. For example, in a sample of parents of children diagnosed with autism spectrum disorder, Chan and Lam (2017) found that higher trait mindfulness was linked to lower courtesy stigma, or the perceived stigmatization parents had because of their association with an individual from a commonly stigmatized group. In another study of military veterans, higher levels of mindfulness predicted lower levels of psychological help-seeking self-stigma (Barr et al., 2019). Given that military personnel are believed to be particularly at risk of the effects of mental health stigma (Acosta et al., 2014; Hoge et al., 2004), these findings are particularly important.

Other research has found that mindfulness may be useful for reducing the impact of stigma on subsequent distress. One study surveyed 605 community adults and found that higher levels of trait mindfulness moderated the effect of experienced discrimination on symptoms of depression, in that those with higher levels of mindfulness reported a weaker link between discrimination and depression (Brown-Ianuzzi et al., 2014). Another study found that mindfulness moderated the relationship between experiences of racism and anxiety levels in a sample of 57 African Americans (Graham et al., 2013). Finally, mindfulness was found to moderate the relationship between sexuality-related discrimination and both distress and self-esteem in a sample of 369 gay men (Lyons, 2016).

Synthesizing the extant literature on mindfulness and stigma, Chan and colleagues (2018) proposed a “mindfulness model of stigma resistance.” In the model, mindfulness was hypothesized to predict lower levels of stigma through the mediating effects of self-compassion and psychological flexibility, which is the ability to accept the presence of one’s thoughts and emotions while choosing to behave according to one’s values (Hayes et al., 2006). According to the model, mindfulness increases self-compassion and psychological flexibility, which results in increased resistance to stigmatized beliefs about mental illness (i.e., negative stereotypes). This model was an important development given that it provided a structure through which researchers and clinicians could understand the effects of mindfulness on mental health stigma. Although initial correlational data showed support for this model (Chan et al., 2018), longitudinal and experimental research is needed to support the causality of these factors.

In line with the Chan et al. (2018) study, much of the research examining the link between mindfulness and mental health stigma has used correlational designs, limiting the ability to draw causal conclusions. However, a small number of studies have directly targeted mental health stigma with mindfulness interventions. One study conducted by Masuda and colleagues (2007) examined the potential for a mindfulness-based intervention to reduce mental health stigma. Specifically, the authors assessed the difference between an acceptance and commitment therapy (ACT) intervention and an education intervention on stigma beliefs. Individuals in both groups received information on stigmatizing language and the prevalence of mental illness; however, those in the ACT group also engaged in nonjudgmental awareness activities. Results indicated that individuals who completed the ACT intervention reported lower mental health stigma broadly, while those in the education only group reported lower stigma only if they began the intervention with higher levels of psychological flexibility.

In another ACT based study, Luoma et al. (2008) utilized a 6-hour, ACT intervention designed to increase mindfulness, psychological acceptance, cognitive defusion (i.e., separating oneself from one's maladaptive thoughts), and value clarification. Importantly, the authors targeted their intervention toward decreasing stigma associated with past substance use. The findings indicated that the intervention resulted in lower levels of internalized stigma (i.e., self-stigma) and shame after completing the intervention. However, the intervention did not reduce the participants' public stigma perceptions. This is an important distinction because it suggests that the effectiveness of mindfulness interventions in reducing mental health stigma does not require an individual to change their perceptions of what society deems stigmatizing, which might be a difficult task given the prevalence of stigmatizing messages both in the United States and throughout the world (Yanos et al., 2020)

Self-Compassion and Mental Health Stigma

Self-compassion is conceptualized as a compassionate stance toward oneself in the face of perceived failure or inadequacy (Neff, 2003a). Almost by definition, self-compassion is antithetical to mental health stigma. While the incongruence between mindfulness and stigma has been previously discussed, the other two subcomponents of self-compassion (self-kindness and common humanity) are also incongruent with stigma. Self-kindness directly contradicts the critical nature of stigmatizing beliefs, and common humanity acts against the isolating effect of feeling stigmatized. To illustrate this, an individual experiencing mental health stigma might report feeling ashamed or "lesser than" because of experiencing a mental illness or feeling the need to seek psychological services. However, a self-compassionate individual would view their experience as a normal aspect of the human condition and respond with self-kindness rather than self-criticism.

Early research identified a link between self-compassion and variables theoretically related to stigma. For example, Neff (2003a) noted that self-compassion should encourage more adaptive coping skills given that an individual practicing self-compassion is able to see themselves as not alone in their experience, and research subsequently identified a link between self-compassion and an increased likelihood of engaging in health-related behaviors (Dickstein et al., 2010; Sirois et al., 2015). Self-compassion has also been linked to reduced defensiveness (Gilbert, 2005), a reduced likelihood of blaming oneself for an illness (Terry & Leary, 2011), and lower levels of self-criticism (Neff, 2003b), and is a protective factor against negative external evaluations (Leary et al., 2007). Previous self-compassion interventions have also been found to reduce shame-proneness (Johnson & O'Brien, 2013), as well as symptoms of depression, anxiety, and stress (MacBeth & Gumley, 2012). Taken together, these findings suggest that self-compassion may be salient in the context of mental health stigma.

Additional support for the link between self-compassion and mental health stigma comes from studies identifying a relationship between self-compassion and other forms of discrimination. For example, Liao and colleagues (2015) found that self-compassion partially mediated the link between perceived discrimination and psychological distress in a sample of 265 sexual minorities. Specifically, discrimination-linked expectations of rejection linked to perceived discrimination predicted lower self-compassion, which was inversely related with distress. Another study found that self-compassion moderated the effect of racial discrimination on symptoms of depression in a sample of 205 Asian American college students (Liu et al., 2020). Specifically, Liu et al. (2020) found that elevated levels of self-compassion helped reduce the relationship between discrimination and depression. Self-compassion also mediated the effect of perceived discrimination on depression for sexual and gender minority youth (Vigna et al., 2018), mediated the effect of stigma experiences on depression for overweight or obese individuals (Hilbert et al., 2015), and moderated the link between stigma and reduced life satisfaction for those living with HIV (Yang & Mak, 2017). Overall, the mediation results suggest that experiencing discrimination may lead to lower levels of self-compassion, resulting in heightened distress. Meanwhile, the moderation results suggest that increasing self-compassion through intervention could help mitigate the negative impact of discrimination on mental health.

More recent research has directly tested the link between self-compassion and mental health stigma. Specifically, several studies have found an inverse relationship between self-compassion and help-seeking stigma (e.g., Booth et al., 2019; Heath et al., 2017, 2018; Wasylkiw & Clairo, 2018). In one of these studies, self-compassion not only predicted lower levels of help-seeking stigma, but also moderated the relationship between public and self-stigma such that individuals with higher levels of self-compassion demonstrated a weaker relationship between public and self-stigma (Heath et al., 2018). This suggests that self-compassion has the potential not only to reduce stigma beliefs but it could also serve as a potential intervention point to help reduce the internalization of public stigma into self-stigma. Interestingly, no known research has examined self-compassion within the context of mental illness stigma, though it is likely that self-compassion would be inversely related to that construct as well.

Building on the extant literature, Wong et al. (2019) proposed a theoretical framework of how self-compassion might buffer the effects of stigma on negative outcomes. According to the model, self-compassion leads to cognitive, emotional, and social processes, which, in turn, should moderate the effect of public stigma on self-stigma as well as the effect of public stigma on negative outcomes. According to the model, self-compassion should increase one's ability to self-affirm and find benefits in the face of challenges, process and regulate emotions, and develop social support networks while engaging in self-forgiveness. In support of this model, research has shown that self-affirmation interventions are able to reduce mental health stigma levels (Lannin et al., 2013) and that dispositional self-forgiveness is correlated with lower levels of help-seeking stigma (Carpenter et al., 2020); however, future research is needed to directly test the model. Specifically, studies examining whether the effects of self-compassion interventions on mental health stigma are indeed caused by the cognitive, emotional, and social processes suggested by Wong and colleagues (2019) would be beneficial.

Studies that include a cognitive (e.g., self-affirmation), emotional (e.g., emotion regulation skills), and social (e.g., forgiveness) outcome as part of their intervention, in addition to pre- and post-intervention levels of stigma, would shed light on the processes through which self-compassion might reduce stigma and its effects on related mental health outcomes.

Interestingly, much of the research examining self-compassion and mental health stigma has utilized all-male samples. These findings hold particular importance since men are believed to be more susceptible to mental health stigma given the incongruence between socialized masculine gender role norms, mental illness, and help-seeking behaviors (Vogel et al., 2011). Specifically, men who adhere to masculine norms like being emotionally controlled or more self-reliant are also more likely to view having a mental illness or seeking psychological help as a weakness or failure (Vogel & Heath, 2016). Both Heath and colleagues (2017) and Booth and colleagues (2019) demonstrated that self-compassion moderated the link between these masculine gender norms (e.g., self-reliance, emotional control) and help-seeking stigma. While men's adherence to masculine gender norms generally predicted higher levels of stigma, this effect was lessened for men who reported higher levels of self-compassion (Booth et al., 2019; Heath et al., 2017). Given that other interventions targeting stigma reduction in men have demonstrated mixed effects (e.g., Hammer & Vogel, 2010), it is possible that self-compassion could be a key factor in reducing stigma for this at-risk group.

One important limitation in the extant literature linking self-compassion to mental health stigma is that these studies have utilized cross-sectional and correlational designs. There are currently no known studies specifically focused on self-compassion interventions for reducing mental health stigma. That said, several of the reviewed studies have found that self-compassion moderates the link between stigma and theoretically relevant variables, which hold relevance for intervention research (Frazier et al., 2004). As such, this evidence supports the development and assessment of self-compassion interventions for the purpose of reducing mental health stigma. The intervention studies reviewed earlier in this chapter (e.g., Luoma et al., 2008; Masuda et al., 2007) serve as important models on this front. While both studies utilized ACT interventions (which are often considered mindfulness based), ACT also focuses heavily on self-compassion concepts (Neff & Tirch, 2013), and research typically finds that self-compassion levels increase over the course of ACT treatment (e.g., Yadavaia et al., 2014). As such, the Luoma et al. (2008) and Masuda et al. (2007) studies provide initial evidence that self-compassion interventions could reduce mental health stigma.

Future Research

The extant literature justifies further research on the links between mindfulness, self-compassion, and mental health stigma. Three areas that might benefit from additional attention in the research literature are detailed in this section, including further explicating theoretical models linking mindfulness, self-compassion, and mental health stigma; the development of novel mindfulness and self-compassion-based stigma interventions; and the assessment of different modes of intervention.

Theory

While theoretical models have been proposed for the connections between mental health stigma and mindfulness (Chan et al., 2018) and self-compassion (Wong et al., 2019), additional research is needed to fully spell out the theoretical connections between these constructs. For example, though Chan and colleagues (2018) showed that self-compassion and psychological flexibility mediated the relationship between mindfulness and stigma, there are likely additional mediating factors that could be examined. Constructs like self-confidence, life satisfaction, self-regulation, and distress are linked to both mindfulness and self-compassion (e.g., Leyland et al., 2019; MacBeth & Gumley, 2012; Mesmer-Magnus et al., 2017) but have yet to be tested as mediating factors in the link to self-stigma.

Another possibility is to merge the models proposed by Wong and colleagues (2019) and Chan and colleagues (2018) to create a more comprehensive model of mindfulness, self-compassion, and stigma. Given the established theoretical and empirical link between mindfulness and self-compassion, this type of model might be a more accurate representation of the interrelationships between these constructs and stigma and would allow researchers to identify the unique effects of each of these processes on stigma. Figure 22.1 illustrates a proposed synthesis of these models. Of note, mindfulness and self-compassion are considered distinct, yet related, constructs that both impact the cognitive, emotional, and social processes highlighted by Wong et al. (2019). In turn, these processes are theorized to moderate any, or all, of the links between public stigma, self-stigma, and related outcomes (e.g., help-seeking attitudes, intentions, or behavior, or distress associated with experiencing stigma). Future research is needed to test this proposed model and compare it to the models proposed by Chan et al. (2018) and Wong et al. (2019).

Novel Interventions

Increased attention to the development and testing of theoretical models linking mindfulness, self-compassion, and mental health stigma will provide researchers and clinicians additional targets for intervention. Many current mindfulness and self-compassion interventions are tailored toward reducing distress (e.g., depression, anxiety) and have primarily been used in therapy settings. For example, two of the stigma-reducing interventions highlighted in this chapter (Luoma et al., 2008; Masuda et al., 2007) utilized adapted ACT interventions, a therapeutic approach traditionally used to treat mental health concerns.

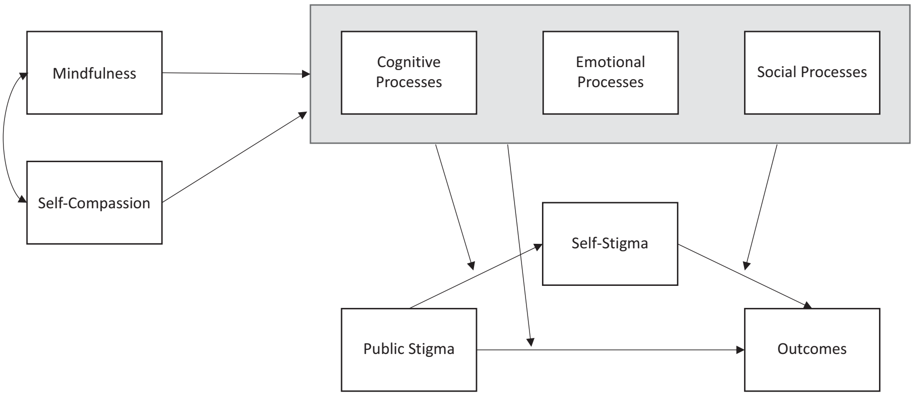

Figure 22.1 *Proposed theoretical model between mindfulness, self-compassion, and mental health stigma.*
Note: This is a proposed theoretical model integrating the models put forth by Chan et al. (2018) and Wong et al. (2019)

Though effective, the Luoma et al. (2008) and Masuda et al. (2007) interventions were time intensive and may not be applicable to larger-scale use. Other mindfulness and self-compassion interventions aimed at distress reduction have ranged from daily exercises completed over the course of a week (Shapira & Mongrain, 2010), weekly meetings attended over a 3-week span (Smeets et al., 2014), and weekly, 2-hour-long meetings attended over 8 consecutive weeks (Neff & Germer, 2013). A summary of these interventions is displayed in Table 22.1. While these interventions show effectiveness at reducing distress, they may not be feasible as stigma interventions with people who are reluctant to engage in mental health service use. Specifically, stigma interventions likely require shorter, more targeted activities, given that those who stigmatize mental health and help seeking are likely to resist engaging in a lengthy activity designed to reduce their stigmatized beliefs (Lannin et al., 2013).

As such, it may be beneficial to develop and evaluate brief mindfulness and self-compassion interventions that may be more palatable to individuals who are reluctant to seek out a longer-term treatment. For example, one study found that a brief self-compassion writing exercise (e.g., write a paragraph "expressing understanding, kindness, and concern to yourself the way you might express concern to a friend who had undergone the experience"), resulted in reduced shame proneness and depressive symptoms both immediately and 2 weeks post-intervention (Johnson & O'Brien, 2013). Though this study asked participants to write three separate paragraphs over the course of a week, it is much less time intensive than previously developed interventions. Testing the impact of brief mindfulness or self-compassion writing exercises on mental health stigma could be a useful next step.

In addition to developing novel mindfulness and self-compassion interventions, future researchers might also consider pairing mindfulness or self-compassion activities with interventions that target similar constructs. For

Table 22.1 *A summary of reviewed interventions*

Study	Intervention target	Intervention details	Timing
Johnson and O'Brien (2013)	Self-compassion	Three written self-compassion-based paragraphs	One 15-minute session
Luoma et al. (2008)	Mindfulness/ Self-compassion	Didactic and experiential ACT group therapy	Three 2-hour sessions
Masuda et al. (2007)	Mindfulness/ Self-compassion	Didactic ACT workshop	One 2.5-hour session
Neff and Germer (2013)	Mindfulness/ Self-compassion	Mindful self-compassion intervention	Eight 2-hour sessions
Shapira and Mongrain (2010)	Self-compassion	Online, daily, self-compassion exercises	Seven 15-minute sessions
Smeets et al. (2014)	Self-compassion	Didactic and experiential group meetings, individual homework	Two 1.5-hour sessions, one 45-minute session

Note: This is summary information of mindfulness and self-compassion intervention studies discussed in this chapter and is not a comprehensive list of all mindfulness and self-compassion interventions. ACT = acceptance and commitment therapy.

example, given the proposal that self-forgiveness could mediate the link between self-compassion and stigma (Wong et al., 2019), future research might examine the use of both a self-compassion and a self-forgiveness activity to reduce stigma. Given the conceptual similarity between self-compassion and self-forgiveness, it is likely that these two types of interventions would affect the same underlying mechanisms of change and could result in an even more pronounced reduction in stigma. For example, as Carpenter and colleagues (2020) detailed, self-forgiveness allows individuals to avoid prolonged, self-critical reactions in the face of failure, which should decrease the likelihood of stigmatizing oneself for experiencing mental health concerns or for seeking psychological help. Given that both self-compassion and self-forgiveness are associated with an "approach-and-repair" psychological response style (e.g., Carpenter et al., 2020; Zhang & Chen, 2016), they may serve as valuable partners in stigma reduction interventions. Given the variety of mediating variables proposed by Wong and colleagues (2019), a few pairings might exist that could result in more potent stigma interventions (e.g., pairing mindfulness or self-compassion with a self-affirmation activity).

Finally, researchers and clinicians might also seek out novel and effective strategies to market these interventions. Previous work has documented "rebound effects" where individuals who have their stigmatizing beliefs directly challenged actually begin to report stronger stigma beliefs (Corrigan, 2004). In addition, of the many difficulties associated with implementing large-scale stigma interventions, perhaps the most challenging is gaining participant buy-in in the first place. Specifically, those who stigmatize mental health and psychological help seeking are not likely to voluntarily sign up for interventions designed to change their beliefs. As such, it may be helpful to market stigma reducing interventions in other ways. Highlighting these brief interventions as useful self-help strategies for stress, anxiety, or depression reduction may be one way to circumvent resistance to activities designed to increase the likelihood of seeking out mental health services.

Modes of Delivery

Identifying the best strategy for implementing stigma reduction interventions has been a challenge. As previously noted, obtaining participant buy-in for stigma reducing activities can be difficult given the impact stigma has on willingness to engage in treatment broadly. As such, it may be important for future stigma reduction efforts, especially those incorporating mindfulness and self-compassion activities, to utilize novel and innovative strategies for reaching those who stigmatize mental health and help seeking. One possibility is to move mindfulness and self-compassion interventions online, given that internet use has been linked to feelings of anonymity and empowerment (e.g., Valaitis, 2005). Online intervention may be especially beneficial for individuals at high risk of mental health stigma, like men (Vogel & Heath, 2016) or individuals in the military (Dickstein et al., 2010), given that engaging in stigma reduction activities may be more accessible in the privacy of one's own residence (Webb et al., 2008). The need for online intervention has been made even more clear by the recent COVID-19 pandemic, which has led to an increased demand for telemental health services (Whaibeh et al., 2020).

Some research supports the provision of stigma interventions online. For example, one study found that individuals who read anti-stigma psychoeducational materials online demonstrate increased retention relative to other formats (Finkelstein et al., 2008). In another study, participants who engaged in simulated conversations with virtual student avatars, reported lower levels of help-seeking stigma relative to a control group (Kirschner et al., 2020). Similar types of interventions could be developed using mindfulness and self-compassion-based strategies. For example, studies could look at the effectiveness of readings about mindfulness or self-compassion, or have participants engage in writing exercises where they are asked to apply these concepts to their own lives.

The use of other media-based interventions (e.g., video or audio) could be helpful as well. Previous video-based interventions have shown some effectiveness in reducing mental health stigma (e.g., Brown et al., 2010; Corrigan et al., 2007; Demyan & Anderson, 2012; Winkler et al., 2017), with most focused on increasing contact between participants and individuals with mental health concerns through videos. Audio interventions have also received some attention in the literature with mixed results (Clement et al., 2013), though one study found that listening to a podcast that included normalizing information about mental health significantly decreased negative appraisals of mental health concerns (French et al., 2011). Given that there are already many videos and audio files focused on mindfulness and self-compassion topics accessible through various online video or audio streaming platforms, these types of activities hold great potential for stigma reduction. Future research is needed to directly test the effectiveness of these types of activities (e.g., meditations, guided instructional videos) within the context of mental health stigma.

Conclusion

Overall, a growing body of literature has shown a link between mindfulness, self-compassion, and mental health stigma. Though much of this research has been correlational in nature, early evidence suggests that mindfulness and self-compassion-based interventions may be helpful in reducing mental health stigma and mitigating its impact on related outcomes. While these initial findings are promising, future research is needed to further explicate theoretical links between the constructs, develop and test novel intervention approaches, and identify the ideal mode of intervention delivery. Increased attention to these areas will help researchers and clinicians realize the full potential of mindfulness and self-compassion as mental health stigma interventions.

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23 What Is Left to Be Done

Key Points, Future Directions, and New Innovations

Nathaniel G. Wade & David L. Vogel

As can be seen from the work presented in this Handbook, mental health stigma, unfortunately, is still very much a part of our human experience. People who experience mental illness and those who seek treatment are often stigmatized and there is still very much a need for the research represented in this Handbook, and for policy change, intervention, and greater movement toward social justice that can be informed by it. Editing this Handbook has been an educational journey for us. Despite our own work in this area, we have learned so much about stigma and the excellent work that has been done to understand and ameliorate the effects of this human tendency to oppress those who are different. We wanted to start this final chapter with a summary of three key points the chapters highlight about the current research in this field.

Expansion of Theories to Explain Stigma

As the opening chapters of the Handbook illustrate, theories to understand and explain stigma and its effects have been expanding. There are new theories that advance our understanding of the different types of stigma related to mental health, the impact that stigma can have, and how stigma can be resisted and overcome. As Sheehan and colleagues (Chapter 2) illustrate these various theories work in concert to provide a deeper and fuller picture of what stigma is and how it might develop. The theories complement one another rather than stand in direct contrast to each other.

One approach to stigma that can be seen as a thread throughout the entire Handbook is the need to appreciate the different forms that stigma can take. Although authors might disagree on the specific way stigma is defined, most agree that there are different forms of stigma related to mental health and these distinct forms are important for our understanding and intervention. This might be most clearly presented by Brenner and colleagues (Chapter 3) in their clear exposition of the difference between public and self-stigmas. As they say, stigma can be understood more clearly when we consider “the source of stigma (the public or the self) and the target of stigma (mental illness or help-seeking)” (p. 3). This simple instruction provides great clarity and depth to our understanding of the different ways that mental health stigma manifests, guiding how we might conceptualize and intervene to reduce stigma. In fact, without such a categorization it becomes almost impossible to make sense of the research presented throughout the Handbook. In addition, this theoretical and conceptual work aids future researchers in this area by providing clearer road maps that can both locate specific work and show the ways that work is connected to and distinct from other work.

The Intersectionality of Stigma

Another crucial area of development that has been showcased in this Handbook is the importance of understanding how stigmas intersect at important identity "crossroads." Mental illness and professional help seeking are attributed as marks of disgrace by most societies throughout the world. People who struggle with a mental health concern and people who seek out mental health services are often seen by people, even themselves, as less than or as inferior. We know that this view leads to all manner of ill outcomes (e.g., joblessness, isolation/loneliness, worse healthcare, and even suicide; Mak et al., 2007; Mejia-Lancheros et al., 2021). Yet for many people their mental illness is not their only stigmatized identity. When people hold other identities stigmatized by society (e.g., LGBTQ; racial/ethnic minorities), the discriminatory and self-stigmatizing effects are potentially compounded. What it means to be someone with Major Depressive Disorder, for example, might be quite different if you are a White, heterosexual woman than if you are a Black, gay man.

The chapters on intersectionality and stigma among minoritized groups teach us that power matters and that power is attached to some identities and not others. In general, we know that having a mental illness or seeking psychological help can reduce one's power in social settings. However, if one is already in a position with less power, or experiences considerable oppression based on other aspects of their identity, then the stigma associated with mental illness and help seeking could add another considerable burden. Thus, stigma cannot be understood in isolation. There is not a uniform impact across all people and all social contexts. This foundational insight is a crucial reminder of the need for a contextual approach that seeks to understand the realities of individuals within specific situations. The work done by the authors of those chapters is a central contribution to the work on stigma and mental health that needs to continue moving forward.

The Effectiveness of Interventions to Reduce Stigma

The last set of findings that we want to highlight is the effectiveness of interventions to reduce stigma. Several chapters highlight ways that researchers, interventionists, and public leaders have tried to address the public and personal health costs of stigma. Interventions have been described at various levels: national, community, and personal. Different models have been described, from more traditional anti-stigma campaigns relying on contact (interacting with someone who has a mental illness) and education (teaching people about the realities of mental illness) to newer individual-focused approaches, such as self-affirmation and self-compassion.

Despite this variation, research on the effectiveness of these interventions tells a more unified story. When seeking to reduce stigma there are clearly ways to effectively intervene. At the public level, interventions have been successfully applied to reduce stigma among a population. One of the most successful programs at this level is the Time to Change program in the UK. Through a sustained, long-term effort using social marketing campaigns, social media interventions, and education among a broad audience as well as targeted audiences (e.g., medical students), the Time to Change program significantly improved attitudes toward mental illness, increased accurate knowledge about mental illness, and decreased the discrimination experienced by those who use mental health services among people in England.

Similar effectiveness has been shown in research on interventions that target specific people or communities. Parry and colleagues (Chapter 18) review various studies that address the effectiveness of interventions focused on specific groups, such as healthcare staff and the police. In general, interventions that provide participants with social contact with people who have a mental illness and education about mental illness seem to improve attitudes toward those with mental illness. Although the longer-term effects of these interventions and the impact such interventions have on people's actual behaviors are not well studied, the research provides considerable support for the worth of such endeavors and indicates further research is warranted.

Of course, not everything works to reduce stigma in every group and even when interventions do "work" they tend to be rather modest in their effect. Stigma is a powerful force that is not easily dismantled. Based on the work reviewed in the chapters of this Handbook, we are optimistic about the changes that have been made and the progress in creating effective interventions. However, we remain cautious about the magnitude of the effects and realistic about the need for more work in this area.

What Is Left to Be Done

One of the most important contributions of a work like this Handbook is the identification of areas for future research. To be sure, the exploration of work that has already been conducted, an organization of current findings and what they mean, and the further development of theory in this area is a crucial contribution of the current volume. However, in their work to do this, the authors have also implicitly and explicitly outlined some of the most pressing areas for future work. What follows is a summary of three key area in which we feel future research could be most effectively leveraged to take our understanding to the next important level toward the reduction, even elimination, of stigma as it relates to mental health.

Intersectionality

As noted above, understanding that a person's identities intersect to create, maintain, and buffer against stigma and mental health is a crucial insight of this Handbook that has not received enough research attention prior to this work. As a result, there is much left to be done in this area. For example, one question that could be addressed is the effects of compounded stigma, in which a person holds multiple identities that are stigmatized by society (e.g., a trans individual with a mental illness). Minority Stress Theory predicts and explains why people who have less power in a society tend to have worse mental health outcomes (Meyer, 2003, 2015). How might different minority statuses relate to stigma more directly? In what situations and under what conditions are such stigmas additive, multiplicative, or even exponential? As discussed in Chapter 10, Andrysiak and colleagues note that most research has assumed additive effects, yet this may be too simplistic to fully understand the full effects of stigma. With this broader view, there is a need to more fully consider how can stigma that is compounded from different sources be managed, how can it be stopped, and what is needed for the person and their community?

Another area of exploration that is needed is in understanding what identity factors might be associated with resilience and strength, what buffers stigma, and what exacerbates it? In other words, could experiences of addressing and managing stigma associated with one identity protect from the effects of stigma with other identities? And what might theory predict for stigma and what might be done to reduce that effect? There is much from divergent scholarly areas that could be converged to further explicate the role different identities play in the development and maintenance of stigma.

Interventions

One of the main applications of stigma research is creating and applying interventions to help reduce stigma as a barrier to health. Despite what we know, there is much that is still to be learned. Although there is some initial work on the cost-effectiveness of large-scale, population-based interventions, much more work could be done in this area. Understanding the resources that are needed to reduce stigma for individuals, families, communities, and societies would be valuable information for researchers, policy makers, and other stakeholders. What is the level of financial, personnel, and knowledge investment that is needed to affect change at these various levels? What can be done to make interventions more cost-effective?

In addition, more research needs to be done to understand at what level of intervention are stigma reduction campaigns most effective. Some work has been done to show effectiveness at the population level. These interventions are based on the idea that stigma is a process that is created and maintained by a group of people (e.g., a society) who endorse, believe, and act on stigma;

in other words, to really change stigma you need to change a community's beliefs and behaviors (i.e., their prejudice and discrimination). Such interventions are complex, expensive, and time consuming, but they address the issue at a very broad level that could have very wide-ranging impact. Other interventions have focused more on the individual and sought to provide tools that a person could use to buffer the effects of societal stigma. We (e.g., Cornish et al., 2019; Seidman et al., 2018) have taken this approach in our intervention work based on our findings that self-stigma mediates the relationship between public stigma of help seeking and people's attitudes toward and intentions to seek psychotherapy (Vogel et al., 2007). Given the mediation, if we can change the individual's self-stigma we believe we can help them buffer the effects of public stigma and make help seeking more likely regardless of population-level stigma. Interventions to reduce self-stigma among people who could benefit from psychotherapy do seem to be effective (Chapters 20 and 21, this volume). Thus, the question is raised about whether psychological help seeking might be increased without more expensive, population-based interventions. Furthermore, research might be done to see whether changing a target population's self-stigma might then work to reduce public stigma more broadly.

Of course, population-based and individualized interventions are not directly opposing approaches; both can be pursued as complementary ways to intervene. However, it would be useful for future research to examine which level of intervention is effective in which situations and toward what outcomes. Also, how can we make such interventions work together, perhaps synergistically, to move the needle further on stigma reduction?

Finally, research on interventions could be conducted to help understand who is affected, when, and under what conditions. These more specific analyses are needed to tailor different approaches for different people, different settings, and different goals. Multiple research methods and projects conducted in different settings, locales, and by various different researchers are needed. This suggestion might dovetail well with the work that is needed on intersectionality. Understanding ways to intervene to reduce stigma that are culturally affirming and psychologically effective would be an excellent way to further understand not only intervention efficacy but also the ways different identities and cultural values of those who are suffering can be affirmed and how such affirmation might aid in the reduction of stigma.

Innovative Areas of Study

Finally, as we were reading through all of these excellent chapters by our expert colleagues, we were struck with the exciting opportunities that lie ahead for research in this area. We look forward to new creative and innovative studies that take the stigma research into uncharted areas. We need insightful studies that take unique perspectives on the field, challenge some of our well-worn ideas, and push the limits of our knowledge. What questions are we failing to ask? What explanations have we not pursued or even considered? What areas have simply not received any attention at all?

Some initial ideas that we have for new and/or innovative research in stigma would include developmental aspects of stigma, indigenously-based cross-cultural understandings of stigma, and theoretical developments that more systematically integrate mental illness and help-seeking stigma. Developmental approaches to stigma could provide rich new insights into the development and maintenance of stigma. How and when do children first understand stigmatizing attitudes toward those with mental illness and how is that taught/learned? How does the experience of stigma change over the lifespan for people dealing with mental illness? Are there consistent factors that moderate that change over time (e.g., age, whether or to what degree one recovers from the mental illness)?

The stigma field would also benefit from research that employs multiple cultural lenses to understanding how people deal with the attitudes and behaviors of people toward those who have a mental illness or seek formal help for a mental health concern. What we envision are studies led by researchers from cultures and perspectives who hold or understand intimately the worldview of the culture under investigation. Expanding conceptions of mental illness, psychological help seeking, and stigma to encompass the full range of complex human experiences is needed. How do different cultures view mental health concerns and the help-seeking process? How does that impact the stigma experienced in that culture? What does that mean for the course of the mental illness, how people recover or not, and how they maintain their position in society or not?

Regarding further theoretical developments, one main area for development could be an integration of work on the stigma of mental illness and psychological help seeking. Most of the work in these two areas have come from different researchers and their respective disciplines. Work to integrate the knowledge and insights from these two areas could deepen our understanding of stigma and help to bridge the field. We hope that in some small ways this Handbook has been able to do that by offering explanations of those different approaches and reviews from the various perspectives (e.g., Chapters 2 and 3). However, more systematic work needs to be done that explicitly bridges the theory and practice in these two areas.

Conclusion

The need for stigma research continues. This volume shows us the breadth and depth of the work that has been conducted to date. It also shows us the areas that are in need of further understanding. Although research alone cannot solve the many problems that stem from stigma and the oppression it creates, research can provide a foundation from which change can occur. Research is most effective when paired with the power to do something different. The knowledge we create and the realities we discover can be used to reduce the burdens for people weighed down by stigma and to create communities in which all people have the opportunity to pursue their potential. This takes a collective will toward equity and inclusion that leverages not only the knowledge gained through research but the collective resources and priority to overcome our tendency to stigmatize others and to see the humanity in everyone.

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