Structures and Types of Stigma

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Stigma is a complex phenomenon described by the intersection of structures and types. In this chapter, we describe components of these structures, which largely derive from social psychological research, and types, which reflect mechanisms of stigma and mental illness. This includes a discussion of stigma as experienced by family members and more implicit forms of stigma. These constructs sometimes vary by mental illness so this chapter summarizes research in this area as well (Box 3.1).

Information Box 3.1: A Brief Overview on Stigma

- Stigma is comprised of three social-cognitive structures: stereotypes, prejudices, and discrimination.
- Three common stereotypes of mental illness are dangerousness, incompetence, and permanence, which can often result in discriminatory behaviors against the individual.
- Mental illness stigma includes the following types: public stigma, self-stigma, label avoidance, structural stigma, and courtesy stigma.
- The stigma of mental illness varies depending on diagnosis, symptoms, visibility, and multiple group membership.

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Social Psychological Structures

In his seminal work, sociologist Erving Goffman (1963) described stigma as comprised of (a) tribal identities (race, ethnicity), (b) abominations of body (physical abnormalities), and (c) blemishes of individual character (e.g., mental illness, addiction). Since Goffman's era, social psychology has contributed to the understanding of stigma on ethnicity, gender, sexual orientation, and health conditions through the application of the social-cognitive model. This model is useful in explaining the process of stigma development for people with mental illness in particular. According to the social-cognitive model (Table 3.1), stereotypes, prejudice, and discrimination are components of stigma formation. Stereotypes are public attitudes (e.g., "Most people think women are bad drivers"), prejudice is the emotional reaction resulting from agreement with public attitudes ("Yes, women *are* clueless when it comes to driving- and I'm nervous to ride with them"), and discrimination is the behavior that results from stereotypes and prejudices (e.g., female drivers are not hired at the same rate as males). For stigma to occur, the public must first identify difference and then label the difference between themselves and the stigmatized group (Link and Phelan 2001). In some stigmatized groups, such as blacks and females, group membership is readily apparent. In the case of mental illness, social cues such as eccentric appearance, the presence of symptoms, or overt labeling ("I know that guy; he's bipolar") provide the foundation from which the cognitive-behavioral process unfolds. When a person is identified as a member, or potential member, of a stigmatized group, stereotypes associated with that group are activated, and the person is labeled as a group member. Stigma occurs when the cultural environment dictates that label as negative and when there is a distinction between the stigmatized and the stigmatizer ("She's a woman and won't be able to handle

Table 3.1 A matrix for understanding stigma

	Public stigma	Self-stigma	Label avoidance	Structural stigma
Stereotype (cognitive)	People with mental illness are violent	People with mental illness are incompetent	People with mental illness are "psycho"	People with mental illness are lazy
Prejudice (affective)	Landlord feels scared of Bob because he has a mental illness	I am a person with mental illness and therefore incompetent. Who would want to date me?	I have a mental illness and am ashamed to be seen as "psycho"	I feel disgusted by Joann; if she really wanted a job, she could try harder
Discrimination (behavior)	Landlord won't rent apartment to Bob	I think "why try" and stop looking for a relationship	I don't tell my boss I need time off to see a therapist for fear I will lose my job	Funding cuts for employment programs in mental health

this truck like us men") (Link and Phelan 2001). This results in the loss of status and opportunity for the stigmatized group in the form of discrimination.

Stereotypes and Prejudice

Although stereotypes may facilitate information-processing speed and provide social information (Bodenhausen and Richeson 2010), stereotypes are often not based in fact and change over time within a particular culture (Angermeyer et al. 2014b). For example, many in the USA are familiar with the stereotype that women are bad drivers. Statistically, however, females are less likely than males to be involved in vehicle accidents and engage in less risky driving practices (Insurance Institute for Highway Safety 2013; Li et al. 1998). At one time, Irish-Americans were viewed as lazy, unintelligent, and alcoholic and were discriminated against in housing and employment. Today, Irish-Americans are seen in a much more favorable public light. Likewise, stereotypes about mental illness are overgeneralization about the group that vary by cultural context (Pescosolido et al. 2008).

Whereas stereotypes are thoughts based on public opinion, prejudice occurs when people endorse the stereotype and experience negative affective reactions to the stigmatized person. We may be aware that people generally believe women are bad drivers but may disagree with that stereotype and therefore do not stigmatize. However, if we endorse the stereotype of women as bad drivers, when we get in the car with a woman, we may feel scared or annoyed. Similarly, if we agree with the stereotype that people with depression are lazy, we may blame them for their illness, get angry, and deny them our social support. Prejudice thus links the stereotype with the discriminatory behavior. To fully provide a basis for understanding stigma, we will examine mental illness specific stereotypes and prejudice in the categories of dangerousness, incompetence, and permanence (see Fig. 3.1).

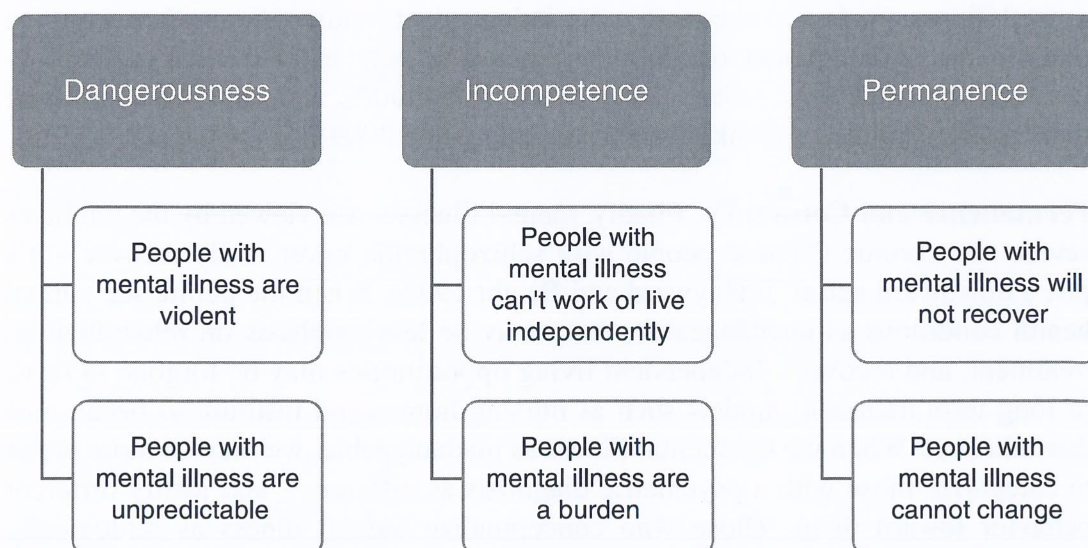

Fig. 3.1 Common stereotypes of mental illness

Dangerousness Among the most prominent and problematic stereotypes applied specifically to people with mental illness are those of dangerousness or unpredictability ("Those people with schizophrenia can become violent at any moment and go on a shooting rampage") (Broussard et al. 2012; Link et al. 1999; Haywood and Bright 1997). When landlords endorse the stereotype of a person with schizophrenia as dangerous, they may be afraid to have such a person as a tenant and may deny their rental applications. Research shows that the stereotype of people with mental illness as dangerous impacts how willing the public is to have people with serious mental illness as friends, neighbors, and colleagues (Angermeyer and Matschinger 2005). Exaggerated media portrayals of people with mental illness are implicated in the development and exacerbation of this stereotype (Vahabzadeh et al. 2011; Haller et al. 2006; Stout et al. 2004; Michalak et al. 2011). When someone with schizophrenia commits a violent crime, news organizations may selectively report the event, focusing on the mental health diagnosis of the person over the crime itself (Angermeyer and Schulze 2001). This strengthens the connection between schizophrenia and violence in the mind of the public and further promotes the stereotype of dangerousness. The public views people with mental illness as much more dangerous than the research suggests they actually are; other factors such as age, gender, and ethnicity are in fact stronger predictors of violence than mental illness status (Corrigan et al. 2004). Additionally, those with mental illness are more likely to be victims of violent crime than perpetrators of violence (Choe et al. 2008).

Incompetence Another commonly endorsed stereotype of mental illness is that of incompetence ("That bipolar guy should not be making his own decisions! He doesn't know what he's doing") (Pescosolido et al. 2013). Endorsement of the incompetence stereotype can lead family members or care providers to assume a paternalistic role and behave in a controlling or coercive manner by unnecessarily assuming guardianship, payeeship, or other decision-making roles. People with mental illness are denied access to more independent living options when assumed that they are not competent to live on their own. Similarly, in the workplace, employees with mental illness endure teasing, hostile attitudes, and comments insulting their cognitive abilities (Jenkins and Carpenter-Song 2009).

Permanence and Constancy Finally, mental illnesses are viewed by the public as severe and chronic ("Those people with schizophrenia never really recover – it's just a downward spiral") (Hayward and Bright 1997). When the public see mental health conditions as unchangeable, there may be less emphasis on rehabilitation, treatment, and recovery. Independent living opportunities may be forgone in favor of long-term treatment models such as nursing homes and institutions because of this mind-set. When we see mental illness as unchangeable, we may be more prone to categorize those with a psychiatric diagnosis as different – and justify different behavior toward them. Those who conceptualize mental illness as biologically based, and thus less changeable, may be at greater risk for displaying stigma toward people with mental illness (Schomerus et al. 2014).

Moderators of Stigma Development

Additional variables moderate the development and expression of stigma. Goffman (1963) first suggested visibility as an important factor. Those people who are visible because of personal appearance or self-identification will be more closely associated with stigma's effects. We discuss the concept of visibility further in our section on label avoidance. Controllability, fear, and familiarity also contribute to stigma expression and are discussed below (Bos et al. 2013; Corrigan et al. 2001).

Controllability and Responsibility Controllability refers to the extent to which group membership and its prejudice is under the person's agency. For example, lung cancer is generally perceived as high in controllability under the assumption that lung cancer is caused by preventable smoking behavior. In contrast, breast cancer is viewed as less controllable (Mosher and Danoof-Burg 2007). When the public believes that serious mental illness results from personal weakness (and thus is more controllable), they are more likely to stigmatize (Jorm and Griffiths 2008). Similar to controllability, those who are perceived as somehow responsible for the stigmatizing condition are also judged more harshly (Corrigan and Watson 2005). Blame and shame are results of public opinions that people with a psychiatric diagnosis choose their condition or could achieve recovery if they just took their medication or tried to work harder on treatment goals. Weiner (1995) distinguishes between onset and offset responsibility. Whereas onset responsibility refers to how responsible the person is for the development of condition or group membership, offset responsibility is how well they are able to manage recovery. People with obesity, for example, are seen as having both high onset and offset responsibility; therefore, they may be more stigmatized than other conditions in which onset and offset responsibilities are lower (Malterud and Ulriksen 2011).

Fear Groups associated with dangerous-related stereotypes, such as those with drug addiction and mental illness, tend to experience greater stigma (Janulis et al. 2013). When the dangerous stereotype is agreed with and applied to someone, fear will result. Fear then translates into stigma (Corrigan et al. 2002). For example, social distance measures show research participants who report fear of people with schizophrenia are less willing to have someone diagnosed with schizophrenia as a neighbor, friend, or romantic partner (Corrigan et al. 2002).

Familiarity Members of the public who know someone with mental illness or have personal experiences themselves with psychiatric problems generally have more positive attitudes toward those with mental illness desire lower levels of social distance (Corrigan et al. 2001; Broussard et al. 2012). Familiarity is defined as experience and knowledge related to mental illness and occurring on a continuum. Those with lived experience with depression will have higher familiarity than those who have an acquaintance with the disorder or who have done reading on the subject. The link between familiarity and social distance is important when designing anti-stigma interventions, as familiarity can be fairly easily enhanced.

Discrimination

Discrimination occurs when overt behaviors reflect stereotypes and prejudice in ways that limit or devalue the stigmatized group members. In the female driver example, women may be discouraged or prohibited from pursuing careers in the transportation industry or be subject to snide comments from male passengers. Attitudes and biases influence behaviors directed toward people with mental illness as well (Stull et al. 2013). Discriminatory behavior applied to those with mental illness is divided into three categories: avoidance and withdrawal, segregation, and coercion (see Table 3.2). We examine these three categories of stigma in detail and discuss the concept of interactional discrimination.

Avoidance and Withdrawal Avoidance and withdrawal may impact people in employment, housing, school, health care, and public space. Employers will not hire, landlords will not rent, and schools will deny admission or fail to provide appropriate support services. When someone with a visible mental illness walks down the sidewalk or sits down on the bus, people may cross the street or move to another seat, distancing themselves from that person. Avoidance and withdrawal are driven largely by the fear stereotype ("I don't want that person with mental illness threatening my tenants or shooting up my workplace"). Avoidance may also be driven by annoyance or disgust. In one large international survey, over half of those with schizophrenia felt that others avoided them because of their diagnosis (Harangozo et al. 2014). Neighbors do not want a mental health center or group home located in their area, because it will blight their community and bring down property values. Supervisors can deny reasonable employment accommodations, threaten to fire the employee, and withhold opportunities for advancement when someone discloses a mental illness or goes through a period of hospitalization while employed (Russinova et al. 2011). People with mental illness also experience discrimination within the health-care system, suffering from disparities in quality of care and health-care options (Barry et al. 2010; Druss et al. 2002).

Table 3.2 Discrimination categories and examples

Category	Examples
Avoidance and withdrawal	Employers will not hire
	Landlords will not lease
	Doctors will not treat
	Members of community avoid social interaction
Coercion	Involuntary hospitalization
	Outpatient commitment
	Forced medication
	Guardianship of person or finances
Segregation	State hospitals
	Mental health ghettos
	Jails

Segregation Segregation reflects large-scale, systematic avoidance and paternalism. Although large mental asylums of the past have been replaced by more community-based options, those with psychiatric disabilities may have symptoms that preclude earned income or may experience discrimination in hiring and housing (Corrigan et al. 2006a, b, c; Newman and Goldman 2009). Having few options for housing, people with psychiatric disability may be segregated in nursing homes, group homes, or other residential housing that provides few opportunities for inclusion and social participation with the community. Additionally, people with mental illness disproportionately end up in poor neighborhoods with substandard housing, violence, and limited access to transportation and health care (Draine et al. 2002; Topora et al. 2014). Although this has changed with the advent of supported employment, historically, people with psychiatric disabilities were segregated in sheltered workshops rather than employment in more integrated settings.

Coercion Stereotypes depicting those with mental illness as incompetent, weak, incurable, or violent lead to coercive practices. Involuntary hospital commitments were historically wrought with claims of coercion. While legislation to protect rights has expanded in the past decades, specific practices associated with involuntary hospitalization such as seclusion, restraint, forced medication, and harsh police interactions are still overly controlling (Strauss et al. 2013). In an examination of psychiatric inpatients in one Veteran's Administration hospital, nearly half had been transported to the hospital by law enforcement, 28 % had been physically restrained, and 22 % had been forced to take medications (Strauss et al. 2013). Emotional reactions to involuntary hospitalization, more than the specific coercive practices themselves, are connected to well-being for people with mental illness (Rüsch et al. 2014).

Mandatory treatments outside the hospital setting are common in the USA. Involuntary outpatient commitment or community treatment orders are sometimes applied to those leaving the criminal justice system or inpatient treatment, While court-ordered treatment may have a positive impact on symptoms and social functioning, these consumers may perceive the practice as overly coercive, endorse greater stigma, and enjoy a lower quality of life (Hiday and Ray 2010; Link et al. 2008; Swartz and Swanson 2004). The method by which the mandatory treatment is presented and implemented may also impact the perception of coercion, suggesting the need for peer involvement and development of more accountable and transparent practices (Munetz and Frese 2001).

Subtle forms of coercion occur in the community as well. In the practice of representative payeeship, a designated individual or organization (such as a mental health agency) manages money for the person with mental illness to ensure that basic needs for housing and food are met (Luchins et al. 2003). However, a representative payee can potentially withhold money unless the person engages in treatment or acquiesces to the payees' preferences (Swartz and Swanson 2004). In regard to police interactions, people describe coercive practices in which they are rushed, given little opportunity to explain the situation, or addressed disrespectfully

(Watson et al. 2010). Additionally, when people with mental illness feel discouraged from starting a family (Harangozo et al. 2014), excluded from a parenting role (Jeffery et al. 2013), or given depot medications (Patel et al. 2010), these actions are often perceived as coercive by the diagnosed individual.

Interactional Discrimination

Some of the examples of avoidance, segregation, and coercion involve subtle behavior change that emerges during interactions with a stigmatized person. Link and Phelan (2014) use the term interactional discrimination to describe this phenomenon, a concept which parallels the concept of microaggression as described in the racial discrimination literature (Wong et al. 2014). Microaggressive acts might involve white people locking their door or clutching their purse when a young, black male walks by. During interactional discrimination for someone with a visible mental illness, a store clerk may speak with an air of superiority, disgust, annoyance, or reticence. Over time, interactional discrimination solidifies the differences between stigmatized and "normal," leading to social exclusion or erosion of social status (Link and Phelan 2014). When these subtle behaviors occur on a daily basis, the person with mental illness may avoid contact with the store clerk and others who talk to them in a patronizing way. As a result, the person can become socially isolated, angry, or ashamed. In fact, verbal and nonverbal stigma messages within the context of anonymous social interactions were the most commonly cited by people with schizophrenia as a source of daily stigma (Jenkins and Carpenter-Song 2009).

Interactional discrimination can also be experienced in communications with more proximal social relationships. Over one-third of people with schizophrenia have felt disrespected by mental health workers (Harangozo et al. 2014), which may come in the form of disregard for personal preferences or doubt of decision-making capabilities. In the workplace, people with mental illness report disrespectful language, jokes, and other small interactions that contribute to an uncomfortable work environment (Russinova et al. 2011). Supervisors sometimes doubt the worker's ability to meet work demands, expecting the person with a mental diagnosis to work harder in order to compensate (Russinova et al. 2011).

Types of Stigma

Thus far, we have focused primarily on the type of public stigma. We now examine the effect of public stigma on the stigmatized individual, their family, and society at large. We define and discuss different types of stigma, including self-stigma, label avoidance, structural stigma, courtesy stigma, double stigma, stigma power, and automatic stigma (see Table 3.3).

Table 3.3 Types of stigma

Stigma type	Definition
Public stigma	Public endorsement of prejudice and discrimination toward minority group
Self-stigma	Person in minority group internalizes public stereotypes/ prejudices and applies them to his or her life
Label avoidance	Person with mental illness avoids engaging in activities that reveal his/her diagnosis
Structural stigma	Public and private sector policies that unintentionally restrict opportunities of the minority group
Courtesy stigma	Stigma experience by those who are in close contact with the stigmatized group (mental health workers, friends, family)
Stigma power	A means through which stigmatizers maintain social power through control, exploitation, and exclusion of the stigmatized group
Automatic stigma	Stigmatizing thoughts, feelings, and behaviors that occur automatically with little or no conscious awareness
Double stigma or multiple stigma	Stigma which is compounded by membership in more than one stigmatizing group (LGBT, poor, obese, etc.)

Self-Stigma

When individuals with mental illness are aware of public stereotypes (i.e., public stigma) and incorporate those stereotypes into their self-concept, internalized or self-stigma results (Munoz et al. 2011). Three steps are involved in the development of self-stigma (see Fig. 3.2). The person with mental illness is *aware* of the public stigma ("People with depression are lazy"), must then *agree* with the stigma ("Yes, that's true – depressed people are lazy"), and finally *apply* the stigma to their own lives ("I have depression, so I'm lazy") (Corrigan and Calabrese 2005; Corrigan et al. 2006a, b, c). Internalized stigma can hurt self-esteem ("I'm a lazy slob") (Drapalski et al. 2013; Boyd et al. 2014) or invoke feelings of shame and self-contempt (Rüsch et al. 2014). Self-efficacy suffers ("I can't beat this feeling") (Drapalski et al. 2013), and the person experiences the "why try" effect (Corrigan et al. 2009): "Why should I try to get out of the house and visit friends? They will not want to associate with a person like me" or "Why try to get a job? I'm disabled." Those endorsing higher self-stigma are less empowered to take action and make important life choices (Rüsch et al. 2014; Drapalski et al. 2013). One recent longitudinal study lends support to the process whereby public stigma becomes internalized (Vogel et al. 2013). In a sample of college students, public stigma endorsement at the initial interview predicted self-stigma 3 months later, whereas self-stigma at 3 months was not predictive of initial public stigma levels. Self-stigma appears relatively stable over time (Lysaker et al. 2012) and has been connected to lower quality of life (Rüsch et al. 2014).

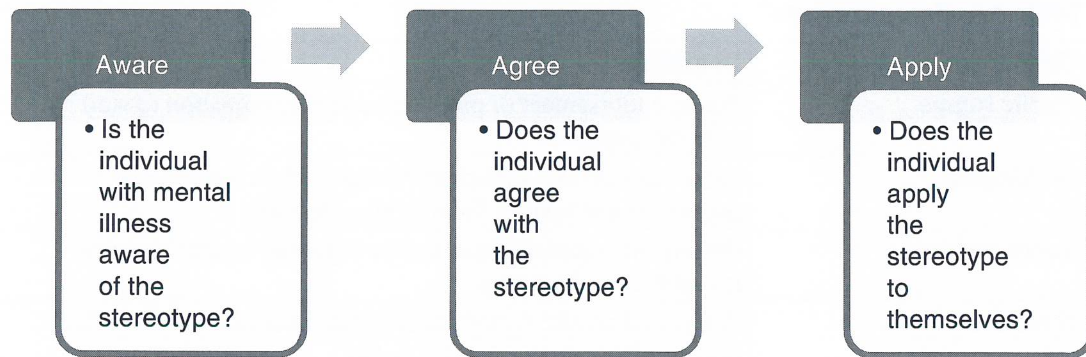

Fig. 3.2 Steps in development of self-stigma

Label Avoidance

When a person with mental illness is conscious of the stigma surrounding the diagnosis, they may engage in label avoidance to evade the stigmatic label. Consequently, psychiatric care is compromised as individuals avoid entering treatment centers, taking psychiatric medications, or asking employers for job accommodations. A majority of people with schizophrenia express some desire to conceal their diagnosis from others (Harangozo et al. 2014). In fact, members of the public who more readily assign labels to those with mental illness are also more likely to believe that people with schizophrenia are dangerous and desire a greater social distance from them (Angermeyer et al. 2004; Pattyn et al. 2013). To elude the label, some refrain from seeking services, do not utilize services fully, or drop out completely (Corrigan et al. 2014; Clemente et al. 2014; Parcesepe and Cabassa 2013; Ben-Zeev et al. 2012). Being seen as someone who takes psychiatric medications is particularly stigmatizing and may lead to discontinuation or sporadic use of medications (Jenkins and Carpenter-Song 2009). In a study exploring posttraumatic stress and depression among US Army members, barriers to care included leaders who discouraged the use of mental health-care services and the fear that mental health assistance would be viewed as a weakness and damaging to participants' military careers (Chapman et al. 2014). A large population study in the Netherlands and Belgium examined relationships between self-stigma and help-seeking (Reynders et al. 2014). Although the two countries have comparable access to quality mental health services, Flemish individuals experience greater shame and self-stigma as well as engage in lower rates of help-seeking behavior than their Dutch counterparts. Accompanying suicide rates in Belgium are significantly higher than those in the Netherlands, pointing to the salience of label avoidance.

Labeling is a function of visibility; those with more apparent symptoms will be readily labeled and will have more extensive supports available in terms of health care, family, and friends. However, these same individuals will be more vulnerable to the pernicious effects of public stigma in the form of social rejection and discrimination from those outside their support network. This is referred to as the labeling paradox (Perry 2011). A person with schizophrenia who is poorly groomed and is responding to auditory hallucinations may have an easier time enrolling in

treatment, qualifying for disability benefits, and receiving intensive services than an individual whose disability is less pronounced. However, when this same person rides the subway train or applies for job, he will likely experience negative reactions because of the greater visibility.

While some individuals have little choice in the labels applied to them, others with less visible symptoms must make decisions about whether to talk about a mental health diagnosis. In the employment arena, those who disclose a psychiatric disability are entitled to reasonable accommodations under the Americans with Disabilities Act (ADA) to help them perform the job. This can include time off to attend doctor appointments, job protection in case of hospitalization, or a job coach to provide support. When people with psychiatric disabilities engage in label avoidance, they conceal their condition fearing discrimination but also forego these important benefits (Cummings et al. 2013). Similarly, when people do not talk about their experiences with mental illness, they avoid being labeled but cannot reap the returns of social support. Some individuals use an informal process to evaluate how, and if, they should disclose their diagnosis (Michalak et al. 2011), while formal programs to facilitate disclosure decisions have also been developed (e.g., Corrigan et al. 2013). This judicious process of disclosure can depend on the situation or setting and even the person receiving the information (Michalak et al. 2011).

Structural Stigma

When the policies of governmental and private institutions restrict the opportunities of people with mental illness, either intentionally or unintentionally, this leads to structural stigma (Angermeyer et al. 2014a, b; Corrigan et al. 2004). Jim Crow laws in the USA are an example of intentional structural stigma that prevented African Americans from equal access to employment, education, and public resources. One example of intentional structural stigma in relation to mental illness is statutes that restrict parental rights because of past history of mental illness (Corrigan et al. 2005). 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 public stigmas 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), diminished quality of care (Thornicroft 2013), access to care (Link and Phelan 2001), or exclusion from community participation (Zubritsky et al. 2006). Those with mental illness and other disabilities sometimes live in institutionalized care such as nursing homes, despite the fact that they can live in more integrated housing in the community if provided the support and opportunity (Cremin 2012). Olmstead v. L.C. (1999) in the USA directed states to offer individuals with disabilities who were living in nursing homes access to community living rather than institution (Zubritsky et al. 2006).

Another example of structural stigma is lack of mental health parity. Historically, mental health coverage through insurance companies has not been on par with that of physical health coverage (Barry et al. 2010). Health insurance systems cap mental health expenditures and yearly visits to lower than those for physical health conditions or fail to provide coverage at all for mental health or substance abuse. Link and Phelan (2001) argue that less money is allocated to research and treatment for mental illness in comparison to other health disorders and mental health professionals opt out of public systems that offer less lucrative employment options. Legislation and court decisions such as the Mental Health Parity Act of 2008 and the Patient Protection and Affordable Care Act have recently challenged structural stigma by expanding insurance coverage and reducing out-of-pocket costs for those with mental illness (Cummings et al. 2013). However, disparities in mental health funding and insurance coverage continue to exist; all individuals with psychiatric disabilities are not uniformly protected (Cummings et al. 2013).

Courtesy Stigma

Goffman (1963) coined the term *courtesy stigma* to describe the negative stereotypes, prejudice, and discrimination experienced by those who are associated with the stigmatized person. Courtesy stigma, also called stigma by association or associative stigma, may apply to friends, family, service providers, employers, or other individuals who appear connected to the stigmatized group (Pryor et al. 2012; Halter 2008; Kulik et al. 2008; van der Sanden et al. 2013). Kulik and colleagues (2008) describe courtesy stigma occurring within the workplace when coworkers associate with the stigmatized person; stigma “spills over” onto them. Excluding and providing social distance between ourselves and stigmatized others may serve to avoid courtesy stigma (Pryor et al. 2012). Mental health providers experience courtesy stigma when they feel shameful about sharing their professional identity with others or avoid being seen with their clients in public situations. A survey of nurses revealed that of ten nursing specialties, psychiatric nursing was perceived as the least preferred, and psychiatric nurses were described as less skilled, less logical, less dynamic, and less respected than those of other specialties (Halter 2008).

Family Stigma Family stigma is a special case of courtesy stigma that applies to parents, siblings, spouses, children, and other relatives of those with mental illness (Corrigan and Miller 2004). Family stigma manifests in the form of ridicule, gossip, or disinterest about the impacted family member. It may also appear in structural ways such as lack of respite services, self-help support groups, and bureaucratic hurdles to obtaining care for family members (Angermeyer et al. 2003). Ethnic minority families may experience stronger family stigma than those of European heritage (Wong et al. 2009).

Stereotypes vary according to family member role (Corrigan et al. 2006a, b, c). For example, parents of children with mental illness experience blame for onset of illness (onset responsibility), whereas spouses and siblings are seen as more responsible for offset. Historically, parental blame for creating a home environment as cause of mental illness was much stronger in the public sentiment than it is today; however, these ideas continue to persist (Mukolo and Heflinger 2011). To some degree, spouses and siblings are perceived as unsupportive or detrimental to their loved one's recovery toward mental illness, whereas children of those with mental illness are seen as contaminated by their parent's illness (Burk and Sher 1990; Corrigan et al. 2006a, b, c). When the public views mental illness as having a genetic basis, they are more likely to believe that a child of someone with schizophrenia or depression will develop the same illness and will thus apply a higher level of courtesy stigma (Koschade and Lynd-Stevenson 2011).

Just as individuals with mental illness internalize public stigma into self-stigma, family members may also feel shame when they blame themselves for contributing to a family member's illness (Moses 2013). Family members who feel greater stigma by association may be at greater risk of distancing themselves from their loved one and experiencing greater psychological distress (van der Sanden et al. 2013). When families fear stigmatizing labels, they may try to keep the diagnosis a secret, avoiding seeking help for their family member and for themselves (Corrigan et al. 2014).

Double Stigma

Those who belong to more than one socially disadvantaged group may have multiple identity statuses and experience double stigma (Gary 2005; Roe et al. 2007; Sanders et al. 2004). About half of people with serious mental illness report discrimination resulting either from mental health status, physical disability, substance abuse problems, ethnic or sexual minority status, or other stigmatizing conditions (Sanders Thompson et al. 2004). Research on the combination of obesity and mental illness concludes that advocacy should address multiple sources of stigma (Mizock 2012). In these cases, the effects of stigmatization could be multiplicative or differentially impact facets of life (Mizock 2012; Glover et al. 2010). Sexual minority status may also impact leisure and social activities, whereas psychiatric disability stigma would be more relevant for employment.

According to minority stress theory, members of ethnic minorities experience stress as a result of low social status (Meyer 2003). The stress of being a minority may in turn lead to psychological distress and impact performance in social situations such as the workplace (Velez et al. 2013). For those with mental illness who are also of minority ethnic status, this additional stress may exacerbate mental health symptoms and increase likelihood of discriminatory treatment. Consistent with this model, USA Marines members who experience racial discrimination during military service are more likely to develop mental health problems (Foynes et al. 2013).

Stigma Power

Link and Phelan (2014) suggest that those in power marginalize others. Stigma power functions to keep people *down*, *in*, and *away*. Stigmatized individuals are kept *down* through denial of resources such as wealth and status, are kept *in* through secrecy of their condition, and are kept *away* to avoid contamination, either physically or socially by the condition (Link and Phelan 2014). Likewise, Kelly (2006) argues that special interest groups supporting mental health have limited power and that people with mental illness have been systematically limited from participation in important life areas. Supporting these assumptions, in a large UK survey, people with mental illness reported fewer social resources (i.e., social capital) than those without a mental diagnosis. Especially when stigma was perpetrated by friends and family and when there was less community participation due to the anticipation of stigma, people with mental illness experienced lower levels of social capital (Webber et al. 2014). Thus, although this idea should be more thoroughly explored empirically, the subtle and systematic processes of stigma power are important to include in the discussion of stigma.

Automatic Stigma

Whereas explicit attitudes are within the realm of conscious control, implicit attitudes are those that occur beyond the individual's conscious awareness (Brener et al. 2013). An example of explicit stigma is the conscious belief that a person with mental illness is helpless or dangerous. In contrast, implicit bias or automatic stigma would be the unconscious tendency to limit a person's autonomy (e.g., control over finances, medications, etc.).

Implicit stigma is manifest in more subtle and concealed forms and requires different measurement techniques than explicit, self-report measures (Stier and Hinshaw 2007). Proponents of implicit attitude measures contend that prejudices are revealed when research participants are unable to consciously mask their socially unacceptable beliefs (Stier and Hinshaw 2007). A key tool designed to measure implicit stigma is the Implicit Association Test (IAT) (Greenwald et al. 1998), consisting of computer-administrated association tasks between opposite targets and attributes (Schnabel et al. 2008). The IAT has been used to measure many types of automatic stigma, including those relating to racial, gender, and socioeconomic differences. The test measures the amount of time that it takes to respond to a stimulus, allowing researchers to quantify the strength of the association. For example, if participants respond more quickly to the key corresponding to blameworthy when seeing a mental illness-related stimulus, then this would indicate a stronger association between people with mental illness and blameworthiness (Teachman et al. 2006).

Although the IAT is a popular method of implicit measurement, very few studies have examined the predictive validity of the test. Greenwald and colleagues (2009)

concluded that the IAT performed better on certain socially sensitive topics (e.g., racial bias), while explicit self-report measures predicted attitudes on topics such as consumer preferences and intimate relationships. Oswald and colleagues (2013) conducted a meta-analysis to further determine the IAT's predictive validity on a broader range of domains related to racial discrimination and how these compared to explicit measures. However, this meta-analysis did not reveal a link between IAT scores and verbal or nonverbal behavior. In order to completely trust in the interpretations of the IAT, greater improvement is required in the correlations between implicit and explicit measures of racial discrimination (Oswald et al. 2013). Despite this controversy over the IAT, it is still a common tool used to measure implicit attitudes including those related to mental illness.

Stull and colleagues (2013) applied the IAT to a study examining bias among assertive community treatment (ACT) practitioners and its influence on the endorsement of control treatment mechanisms. ACT is intensive case management, or care coordination for individuals with mental illness that includes extensive monitoring of medications, control over the patient's finances, and outpatient commitment (i.e., involuntary treatment of community members). Research shows implicit bias was found to predict a higher endorsement of the more controlling aspects of ACT treatment (Stull et al. 2013). Additionally, clinical professionals and graduate students with higher implicit bias were more likely to overdiagnose patients (Peris et al. 2008). In another study, Brener and colleagues (2013) found that although mental health-care workers showed positive explicit attitudes, the IAT uncovered implicit bias. Negative implicit attitudes predicted decrease in helping intent among the workers, while explicit attitudes did not (Brener et al. 2013). These findings suggest that implicit attitudes of mental health-care workers may have a stronger influence, relative to explicit bias, on the quality of care that is provided for individuals with mental illness.

Researchers have also examined automatic self-stigma or unconscious negative attitudes toward the self. A study by Rüsch and colleagues (2010) administered implicit measures to people with serious mental illness to examine whether internalized stigma manifests through automatic processes. The results of two brief IATs showed that implicit and explicit self-stigma independently predicted a lower quality of life (Rüsch et al. 2010). Overall, both implicit public stigma (particularly stigma from providers) and implicit self-stigma may prove destructive for those with mental illness; more research on automatic stigma is particularly needed to further evaluate its relationship to outcomes.

Stigma Across Diagnoses

We know that being diagnosed with a mental illness often results in prejudice and discrimination, but differences in stigma exist across diagnoses. In regard to personality disorders, mental health-care professionals often see these patients as

uncooperative, hostile, manipulative, and complaining (Fairfax 2011). Alonso and colleagues (2008) noted certain increases in perceived public stigma between individuals with mood and anxiety disorders. Greater stigma was reported among individuals with anxiety disorders in the absence of mood disorders, and the reports increased among individuals with mood disorders in the absence of anxiety disorders. However, even greater stigma was reported among individuals that possessed both a mood and anxiety disorder diagnosis showing that a comorbid diagnosis results in greater discrimination (Alonso et al. 2008). A common misperception of an individual with bipolar disorder (BD) is that he or she is psychotic when, in fact, bipolar I is the only category of BD with prevalence of psychosis. This often leads individuals with BD to be misdiagnosed with a more severe illness. Nevertheless, even if they acquire the correct diagnosis, these individuals often learn to cover up their symptoms and emotions in order to avoid the misconceptions that society places on them (Jasko 2012).

Stigma of Suicide

Many individuals with mental illness have experienced suicidal thoughts or attempted suicide, pointing to the importance of examining public opinions toward suicide and its interaction with mental illness stigma. Using fake obituary vignettes, people who took their own lives were viewed more negatively than those who died from cancer (Sand et al. 2013). Over half of the college students said they would not have a romantic relationship with someone who has attempted suicide in the past year; 20 % would deny a suicide attempter from obtaining US citizenship (Lester and Walker 2006).

Although the stereotypes of people who think about, attempt, or completed suicide may have substantial overlap with those of mental illness, suicide stigma seems to include additional components related to morality, impulsivity, attention seeking, and religious devotion (Witte et al. 2010; Sudak et al. 2008). People who attempt or complete suicide may be seen as refuting religious teachings, selfishly leaving behind loved ones or dependents, or failing to carefully consider all the options. Those who take their own lives are variously identified as irresponsible, cowardly, brave, isolated, and dedicated (Batterham et al. 2013). Thus, stigma of mental illness in general may be compounded by the stigma applied to people who think about or attempt suicide.

Support for those who attempt or consider suicide can be limited by their anticipation of stigma. Just as with mental illness, people who have attempted suicide often conceal or minimize these experiences to avoid labeling and subsequently miss out on opportunities for support or treatment (Czyz et al. 2013). Religious communities and families who endorse stigma of suicide may discourage expression and treatment of suicidal ideation, limiting access to care.

Additionally, courtesy stigma appears to effect the grief process of family survivors. Family members experience negative reactions themselves from extended community upon loss of loved ones to suicide, including tense relations and withdrawal of support (Feigelman et al. 2009). Family members may internalize stigma and blame themselves for the death or for missing any warning signals. when family members of survivors experience more stigma, they also experience greater levels of grief, depression, and suicidal thinking themselves (Feigelman et al. 2009).

Some suggest that life insurance policies that deny payment for suicide deaths reflect intentional structural stigma related to suicide. Others have asserted that funding disparities reflect structural stigma of suicide. For example, the Center for Disease Control (CDC) budget for research on HIV was 50 times higher than that for suicide, despite suicide being the 11th leading cause of death in the USA (Curry et al. 2006). Overall, these findings point to the importance of examining the stigma of suicide as a factor above and beyond the stigma of mental illness.

Summary

The understanding of mental illness stigma has evolved significantly since Goffman's original categorization. Although stereotypes of mental illness vary across diagnoses, three stereotypes are often applied to those with mental illness: (a) people with mental illness are dangerous or unpredictable, (b) people with mental illness are incompetent, and (c) mental illness is chronic and incurable. Prejudice and discrimination occur when people endorse these stereotypes and then act on them. This can mean avoiding the individual in hiring and housing situations, segregating the individual into a special community or institution, or coercing the individual into treatment.

Often times, public stigma can be so influential that the individual also begins to incorporate it into their own self-concept, leading to the construct of self-stigma and causing them to resist the label of mental illness (i.e., label avoidance). The stigma of mental illness can also spill over onto the individual's family and others by association. Mental illness stigma may be further complicated by the fact that people with mental illness may fall into more than one stigmatized group, experiencing prejudice and discrimination based on race, age, ethnicity, physical disability status, or the presence of suicidality. Additionally, stigma power works to socially subjugate those with mental diagnoses, while automatic stigmas operate below the level of consciousness. Although a discussion of erasing stigma is beyond the scope of this chapter, we hope that understanding the types and mechanisms of stigma is useful for starting the discussion of stigma change (Fig. 3.3).

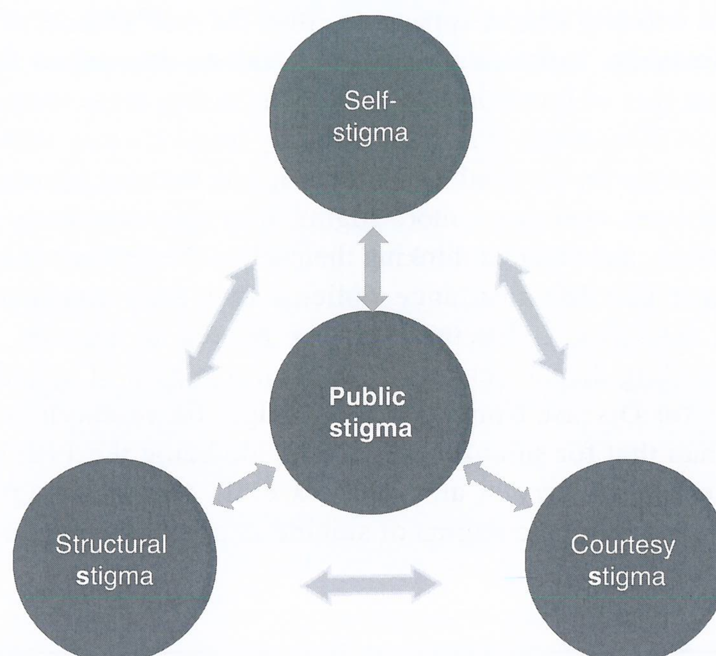

Fig. 3.3 Relationship between types of stigma (Adapted from Pryor and Reeder 2011)

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