Chapter Three: Consequences of Stigma

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Stigma, an insidious societal force, profoundly impacts both individuals and communities. Stigma associated with mental health conditions and substance use disorders continues to be a pervasive issue that significantly affects individuals at multiple levels (structural, public/social, self). This chapter delves into the multifaceted consequences of stigma, shedding light on how it permeates structural, public, and personal spheres. Understanding the extent of these impacts is crucial for developing effective interventions and fostering a more inclusive and supportive society for those grappling with these challenges.

1. Understanding the Different Types of Stigma

Stigma, as defined in Chapter 1, can be classified into three main types: structural stigma, public stigma (also referred to as social stigma by some scholars, such as Livingston 2020), and self-stigma.

Structural Stigma

Structural stigma is embedded within the rules, policies, and procedures of social institutions, which arbitrarily restrict the rights and opportunities of individuals living with mental health and substance use issues. It represents the societal and institutional manifestation of attitudes, beliefs, and behaviours that perpetuate prejudice and discrimination. Unlike individual prejudice or discrimination, structural stigma involves higher-order discrimination linked to human rights. It is reinforced through laws, internal policies, the procedures of private and public institutions, and the practices of professionals and decision-makers. Although overt instances of structural stigma may have diminished, they have left a legacy of disparity and covert structural barriers that continue to create inequality and injustice for those affected by mental health and substance use issues (Livingston

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2020; National Academies of Sciences, Engineering, and Medicine 2016; Thornicroft et al. 2022).

Public/Social Stigma

Public or social stigma occurs when community members endorse negative stereotypes and act in discriminatory ways towards people with mental health and substance use issues. This form of stigma creates fertile ground for both self-stigma and structural stigma. Widespread endorsement of stereotypes, such as the belief that those with mental health issues are dangerous, leads to regressive reforms and punitive policies, including reduced funding for mental health services or the expansion of coercive interventions. Such policies can reinforce social stigma, inhibiting progressive reforms and inclusive healthcare policies such as the expansion of harm reduction strategies. Public stigma encompasses attitudes held by the general public and specific subgroups, such as first responders or clergy, whose norms may differ from those of the broader society.

Public stigma persists partly because structural stigma, in the form of laws, regulations, and policies, appears to endorse prejudice and discrimination. It is characterised by the link between stereotypes, negative attitudes, and discriminatory behaviours against people with mental health conditions. This stigma can manifest as avoidance, maintaining social distance, paternalistic approaches (benevolent stigma), or supporting coercive policies. Public stigma can be understood through three components: knowledge (or ignorance), attitudes (prejudice), and behaviours (discrimination). Ignorance often results from a lack of detailed knowledge or misinformation spread by popular discourse, while prejudice involves negative emotional reactions. Discriminatory behaviours lead to social exclusion and rejection, causing harm by being both anticipated and experienced (Livingston 2020; National Academies of Sciences, Engineering, and Medicine 2016; Thornicroft et al. 2022).

Self-Stigma

Self-stigma involves the perceptions and experiences of individuals living with mental health and substance use issues, acting as a significant barrier to seeking help and adhering to treatment. People with lived experience

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of mental health conditions or substance use disorder frequently cite fear of stigma and anticipation of negative reactions—such as being perceived as crazy or weak, feeling embarrassed or ashamed, and fearing others' opinions—as major reasons for not seeking treatment. As these individuals become aware of public stigma and related discriminatory practices, they internalise the perceived stigma and apply it to themselves.

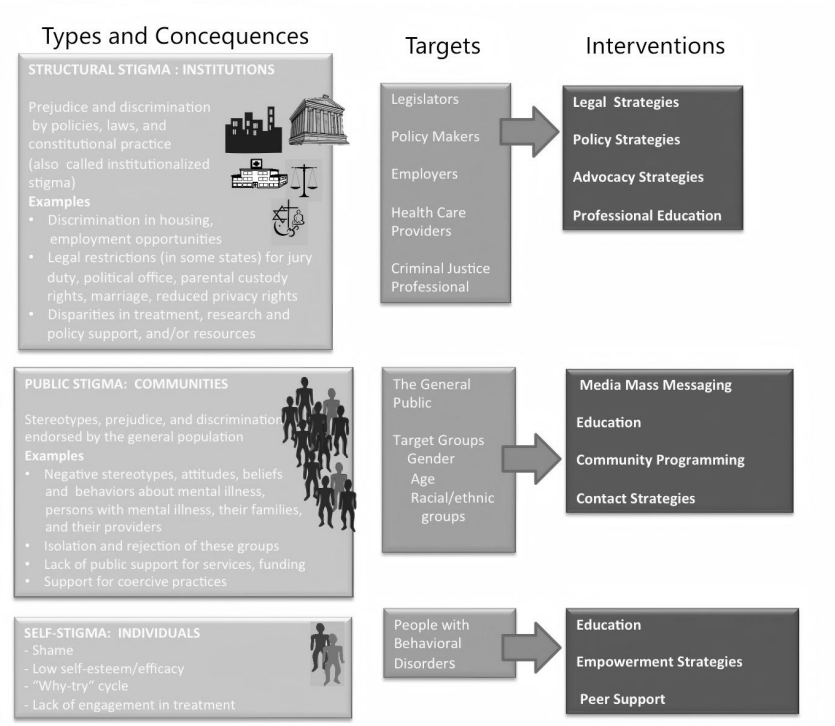

Figure 1: Types, consequences, targets, and interventions of stigma (National Academies of Sciences, Engineering, and Medicine 2016, p. 43).

Self-stigma occurs when individuals with mental health conditions acknowledge negative stereotypes, agree with them, and turn them against themselves. This internalisation can lead to the abandonment of important life goals, such as seeking employment or forming friendships, due to feelings of unworthiness or the perceived inability to succeed. Negative beliefs diminish self-esteem and self-efficacy, causing individuals to question the value of trying. However, not all reactions to societal stigma are negative;

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some individuals may respond with righteous anger, which can enhance self-esteem. Overcoming self-stigma involves developing stigma resilience, a process that empowers people with mental health conditions to counter internalised stigma and take positive actions in their lives (Livingston 2020; National Academies of Sciences, Engineering, and Medicine 2016; Thornicroft et al. 2022).

Figure 1 illustrates these three main types of stigma and their consequences, as well as potential targets for change and interventions aimed at altering stigmatising attitudes, beliefs, and behaviours.

2. Consequences and Impacts of Stigma

As discussed in Chapter 2, substance use disorders, referred to as 'disorders due to substance use' in the ICD-11, are considered a form of mental illness. Thus, it is essential to explore the consequences and impacts of stigma related to both mental illness and SUD.

Structural Impacts

Globally, individuals with mental health conditions often face restrictions in employment, voting, property ownership, marriage, and divorce. These conditions can cause long-term impairments, impacting daily life and social contexts and leading to disabilities. Structural stigma also manifests in the underfunding of mental health research and treatment compared to physical health. People with mental health conditions have less access to healthcare and often receive lower quality services than those with physical health conditions, contributing to a significant mortality gap—ten years overall and 20 years for severe conditions. This structural disadvantage is perpetuated across generations, exacerbated by the interrelationship between poverty and poor mental health (Thornicroft et al. 2022).

Structural stigma includes persistent prejudice and discrimination in public and private institutions, healthcare systems, and the criminal justice system.

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Structural Stigma in Public and Private Institutions

Despite misconceptions about the dangerousness and violence of people with mental illness, these individuals are at higher risk of victimisation and unfair treatment by authorities. Plaintiffs with mental illness often face poorer legal outcomes in employment discrimination suits compared to those without mental illness. Discrimination in housing and employment is more prevalent among people with mental illness, leading to higher rates of homelessness. Additionally, stigmatising attitudes from landlords often result in poor housing conditions. Structural stigma is evident in segregated housing and community resistance to mental health facilities, exemplified by the 'not in my backyard' (NIMBY) phenomenon (Link/Phelan 2001; National Academies of Sciences, Engineering, and Medicine 2016).

In employment, many individuals with mental health conditions choose not to disclose their condition due to fear of discrimination. This can result in difficulties finding or retaining employment, limiting economic opportunities. Individuals may face unequal work opportunities, be assigned less responsibility, be denied promotions, and experience workplace bullying. Lack of employment and income due to stigma contributes significantly to poverty among people with mental health conditions (Thornicroft et al. 2022).

In the arena of higher education, laws like the Americans with Disabilities Act (ADA) prohibit discrimination against students with psychiatric disabilities and require reasonable accommodations for these individuals. However, fewer than one in four students with a mental illness seek treatment or support services. These students often report less social engagement, lower graduation rates, inadequate services, and harsher academic discipline.

As for people with substance use disorders, they face structural stigma in many forms, including barriers to treatment such as lack of insurance, high treatment costs, and limited access to programmes. Fear of workplace discrimination and previous negative job experiences are additional challenges. Legislative measures like the ADA are often more restrictive for SUD than for mental illness (National Academics of Sciences, Engineering, and Medicine 2016).

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Structural Stigma in Healthcare and Treatment Systems

In the US healthcare system, stigma contributes to disparities in funding for mental versus physical disorders and fosters negative attitudes among healthcare professionals. Structural stigma results in low-quality care for mental and substance use disorders, limited access to treatment, fragmented bureaucracy, overuse of coercive care approaches, and inadequate funding compared to physical healthcare. These factors negatively impact clinical and personal recovery outcomes, increasing the frequency and duration of illness and hospitalisation. Nevertheless, there is evidence of these effects from North America, Europe, and East Asia, suggesting that structural stigma negatively affects clinical and personal recovery outcomes globally. Stigma is associated with increases in the number of episodes of being unwell, the duration of condition, and psychiatric hospitalisation (National Academies of Sciences, Engineering, and Medicine 2016; Thornicroft et al. 2022).

Parity laws for mental and substance use disorders aim to combat structural inequities in healthcare coverage. States with parity laws have higher service utilisation rates among low-income groups. However, increased access to care does not guarantee high-quality, evidence-based treatment.

Structural stigma is also evident in the lower prioritisation and funding of behavioural health services and research compared to physical health. This underinvestment limits the availability of evidence-based services, particularly in facilities serving vulnerable populations. Stigma leads to low insurance reimbursements, contributing to shortages of mental health providers. Even with available providers, insurance benefits for behavioural health services are often more restrictive than for physical health (National Academies of Sciences, Engineering, and Medicine 2016).

Structural Stigma in Criminal Justice Systems

In the criminal justice system, structural stigma is evident in the disproportionate representation and treatment of people with mental illness. More than half of jail and prison inmates in 2005 had mental health problems, with many experiencing multiple arrests and limited access to treatment. People with mental illness in correctional facilities face higher rates of abuse, solitary confinement, longer sentences, and parole denials compared to inmates without mental illness. Community supervision often involves

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more intense scrutiny and higher rates of technical violations for individuals with mental illness.

Policies treating substance use disorders primarily as criminal issues contribute to a stigmatising environment. Harsh antidrug messages and criminal sentences for drug use marginalise people with SUD, promoting social exclusion and perpetuating stigma (National Academies of Sciences, Engineering, and Medicine 2016).

Public/Social Impacts

Public stigma leads to social segregation and diminished self-efficacy among people with mental and substance use disorders. Stigmatising beliefs about their competency restrict opportunities and may lead to coercive treatment. Despite the importance of social support for recovery, stigma contributes to social exclusion for individuals with substance use disorders and their families.

Misconceptions about mental health conditions, such as beliefs about dangerousness or incompetence, exacerbate public stigma. These misconceptions hinder understanding and acceptance of mental health conditions as treatable. Public stigma often results in social rejection, abuse, and neglect, including verbal and physical humiliation, sexual abuse, and violence. Young people with mental health conditions face additional stigma, impacting their relationships, social inclusion, and willingness to seek support.

Fear of social rejection is a significant stigma experience among adolescents, affecting their social identity and capital. Stigma from family members and school staff further complicates their ability to seek help and engage in community activities. The intergenerational perspectives on mental health highlight differences in understanding and support between young people and their parents (National Academics of Sciences, Engineering, and Medicine 2016; Thornicroft et al. 2022).

Personal Impacts

Self-stigma significantly affects individuals by lowering self-esteem and self-efficacy, leading to harmful psychological feelings of embarrassment and shame. This reduction in self-esteem and self-efficacy can result in what Corrigan refers to as the 'why try' effect, where individuals refrain

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from attempting important activities due to an expectation of failure. This loss of confidence negatively impacts hope, quality of life, recovery, stigma resistance, and social functioning, and may increase suicidality (Corrigan et al. 2009; National Academics of Sciences, Engineering, and Medicine 2016; Thornicroft et al. 2022).

Among individuals with mental health and substance use disorders, low self-efficacy is linked to failure in pursuing work or independent living. Conversely, higher self-esteem correlates with goal attainment (e.g. symptom reduction, financial and academic success), improved quality of life (e.g. satisfaction with work, housing, health, and finances), and increased help-seeking behaviour. Research indicates a negative relationship between stigma and help-seeking behaviours. Self-stigma also hinders recovery and community integration. Those who disclose their experiences report lower levels of self-stigma. Members of racial and ethnic minorities, youth, men, military service members, and health professionals are disproportionately deterred from seeking help due to fear of stigma. Additionally, public stigma influences both the reported experiences of stigma and self-stigma, as well as the reluctance to use services (National Academics of Sciences, Engineering, and Medicine 2016).

Self-stigma is closely related to public stigma. Individuals with mental health conditions who perceive greater public stigma view their condition as more threatening. They report higher levels of self-stigma and hopelessness, poorer recovery, and reduced quality of life. These effects are often mediated by self-stigma and lack of social support. For those who anticipate or experience high levels of discrimination, psychological distress and shame increase, while empowerment and quality of life decrease. In more collectivistic cultures, the connection between self-stigma and experienced discrimination is stronger. Self-stigma is a prominent barrier to service to accessing mental health services from both parents' and professionals' perspectives, manifesting as shame about needing help, perceived parental failure, and fear of being labelled. Additionally, lack of information and awareness about services are significant barriers to accessing care. From the professionals' perspective, effective advertisement and service promotion through media such as leaflets, posters, the internet, local newspapers, radio stations, newsletters, and parenting forums facilitate access to services (National Academics of Sciences, Engineering, and Medicine 2016; Thornicroft et al. 2022).

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3. The Enduring Effects of Stigma

Link and colleagues (1997) conducted a longitudinal study involving 84 male patients with dual diagnoses of mental illness (primarily schizophrenia) and substance abuse. These patients completed one year of treatment in their assigned programmes, with 48 in a therapeutic community and 36 in a community residence. The demographic breakdown of the sample revealed that 63% were African American, 23% were Hispanic, and the remaining 14% were white or of other ethnicities. The average age was 34, and the mean educational attainment was slightly less than eleven years. A significant portion (58%) had a diagnosis of non-affective psychotic disorder (mainly schizophrenia), 14% had a major mood disorder (mainly bipolar disorder and major depression), and the remaining 28% had other diagnoses (Link et al. 1997, p. 181).

The study involved interviews conducted at the beginning of treatment when patients were highly symptomatic and addicted to substances, and again after one year of treatment, when symptoms had significantly reduced and patients were largely free from drugs and alcohol. The study measured the primary independent variable of stigma and several control variables, including substance abuse, social functioning, and various dimensions of psychiatric symptomatology. The dependent variable chosen was depressive symptoms, measured by the Center for Epidemiological Studies Depression scale (CES-D), due to its theoretical and empirical relevance to stigmatisation (Link et al. 1997, p. 180).

The authors conceptualised the stigma process through three components: culturally induced beliefs about devaluation and discrimination (measured by a 15-item scale), experiences of rejection (a 12-item scale), and coping mechanisms with stigmatisation, including secrecy (an 8-item scale) and withdrawal (a 4-item scale) (see Figure 2). The results indicated that 65% of participants believed most people look down on those who abuse substances, 72% believed most employers would not hire such individuals, and 62% thought most young women would not marry someone with a history of drug abuse. Additionally, 6% reported being denied medical treatment, 16% were denied an apartment, and 24% received lower wages due to their drug abuse history. Opinions were split on whether to keep a history of drug abuse a secret, with 52% saying yes and 48% saying no, and a large majority (76%) thought it unwise to inform a potential employer about past drug problems. Furthermore, 57% would avoid apply-

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ing for a job if they knew the employer did not want to hire former drug addicts (Link et al. 1997, pp. 183–184).

Perceived Devaluation/Discrimination

1. Most people believe that former mental patients cannot be trusted.
2. Most women would not marry a man who has been a patient in a mental hospital.
3. Most people believe that a man who has been hospitalized for mental illness is dangerous.
4. Most people think less of a person after he has been hospitalized for mental illness.
5. Most people look down on people who have been hospitalized for mental illness.
6. Most people think that mental patients are just as intelligent as the average person.
7. Most employers will not hire a person who has been hospitalized for mental illness.
8. Do you believe that many people are afraid of those people who have been patients in mental hospitals?
9. Most people believe that drug addicts cannot be trusted.
10. Most women would not marry a man who has been addicted to drugs.
11. Most people believe that a man who has been addicted to drugs is dangerous.
12. Most people think less of a person after he has been hospitalized for drug problems.
13. Most people look down on people who have been hospitalized for drug problems.
14. Most people think that drug addicts are just as intelligent as the average person.
15. Most employers will not hire a person who has been addicted to drugs.

Rejection Experiences

1. Did some of your friends treat you differently after you had been a patient in a mental hospital?
2. Have you ever been avoided by people because they knew you were hospitalized in a mental hospital?
3. Have people used the fact that you were in a mental hospital to hurt your feelings?
4. Have you ever been refused an apartment or a room because you had been a patient in a mental hospital?
5. Do you sometimes avoid people because you think they might look down on people who were in a mental hospital?
6. After being hospitalized for mental illness were people uncomfortable around you?
7. Did some of your friends reject you after they found out you were using drugs?
8. Did some of your family give up on you when they found out you were using drugs?
9. Were some people afraid of you when they found out you used drugs?
10. Have people treated you unfairly because they knew you were a drug addict?
11. Do you sometimes avoid people because you think they might look down on people who have had a drug problem?
12. Have some employers paid you lower wages because they knew you had a drug history?

Secrecy

1. Do you sometimes hide the fact that you were a patient in a mental hospital?
2. Do you think it is a good idea to keep your history of mental hospitalization a secret?
3. Would you advise a close relative who had been treated for mental illness not to tell anyone about it?
4. Do you wait until you know a person well before you tell them you have been a patient in a mental hospital?
5. Do you sometimes hide the fact that you were once addicted to drugs?
6. Do you think it is a good idea to keep your history of drug use a secret?
7. Would you advise a close relative who had a serious drug problem not to tell anyone about it?
8. Do you wait until you know a person well before you tell them about your problem with drugs?

Withdrawal—Employment

1. Would you apply for a job if you knew the employer was going to ask about your history of mental hospitalizations?
2. Would you apply for a job if you knew the employer didn't like to hire former mental patients?
3. Would you apply for a job if you knew the employer would ask about your history of drug use?
4. Would you apply for a job if you knew the employer didn't like to hire former drug addicts?

Figure 2: Item wording for the stigma variables (Link et al. 1997, p. 188).

At the one-year follow-up, there was no decline in the perception of stigma, stigma coping orientations, or recall of rejection experiences (see Table 1). Despite improvements in their mental health and substance use disorders, patients continued to be affected by stigma. Thus, the authors suggested that stigma has enduring effects that cannot be easily reversed.

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Table 1: Means, standard deviations, and paired t-test for stigma scales at baseline and one-year follow-up (Link et al. 1997, p. 184).

Variable	Baseline Means (s.d.)	Follow-Up Means (s.d.)	Significance of Paired *t*-tests (*p*)
Perceived Devaluation/Discrimination	2.72 (.40)	2.76 (.41)	n.s.
Rejection Experiences	.46 (.27)	.42 (.26)	n.s.
Secrecy	.57 (.28)	.57 (.31)	n.s.
Withdrawal	.43 (.37)	.44 (.37)	n.s.

The study hypothesised that stigma has lasting effects on depressive symptoms, even with effective mental health and substance abuse interventions. The authors tested this hypothesis in a longitudinal study of males who showed significant short-term improvement in psychiatric and substance abuse conditions from treatment entry to one-year follow-up. The results supported the hypothesis, revealing that perceived devaluation/discrimination and reported discrimination experiences continued to negatively impact these people despite overall improvement due to treatment.

An alternative explanation for the association between stigma measures and depressive symptoms posits that stigma measures might be confounded with psychiatric symptoms. In this view, perceptions of stigma are influenced by symptomatology—depressed individuals are sensitive to slights, and paranoid individuals suspect others of harmful intentions. However, the study found little change in stigma measures from baseline to one-year follow-up, casting doubt on this alternative explanation. The stability of stigma measures despite significant symptom improvement suggests that the impact of stigma is not merely a reflection of symptomatology (Link et al. 1997, p. 186).

When someone is labelled with a mental illness or substance use disorder, beliefs about societal treatment become personally relevant, leading to heightened expectations of rejection. This anticipation of rejection undermines confidence, disrupts social interactions, and impairs social and

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occupational functioning. Actual experiences of rejection often accompany these negative labels (Link et al. 1997, p. 179).

Stigma was once considered a minor issue, with some scholars arguing that its effects were small and transient (Gove 1982). However, the study found that devaluation/discrimination and rejection experiences significantly contributed to depressive symptoms at follow-up, surpassing the impact of baseline depressive symptoms. These findings suggest that stigma has substantial effects comparable to other stress-related factors typically considered important in social science research. While the effects might dissipate over a longer period, their persistence at one year indicates they likely endure beyond this point and should be taken seriously in the context of mental health and substance abuse treatment (Link et al. 1997, p. 187).

In conclusion, the study highlights the fundamental importance of addressing stigma for individuals with mental illness and substance use disorder. Despite improvements from treatment programmes, stigma remains a significant issue that affects patients' quality of life and the long-term benefits of treatment. Healthcare providers are thus challenged to address stigma directly to enhance treatment outcomes. The findings also support a modified labelling perspective, showing that stigma has enduring negative effects on depressive symptoms, demonstrating a 'package deal' of positive and negative outcomes resulting from official labelling.

4. Conclusion

In conclusion, the chapter underscores the profound and enduring effects of stigma on individuals with mental health conditions and substance use disorders. From structural barriers in healthcare and employment to personal struggles with self-esteem and social acceptance, stigma manifests in numerous detrimental ways. Addressing these issues requires a concerted effort to dismantle structural barriers, promote public awareness, and support individuals in overcoming self-stigma. By doing so, we can pave the way towards a more equitable and compassionate society, where individuals are not defined by their conditions but are empowered to thrive.

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Bibliography

Corrigan, Patrick W./Larson, Jonathon E./Rüsch, Nicolas (2009): Self-stigma and the "why try" effect: Impact on life goals and evidence-based practices. In: World Psychiatry, Vol. 8, pp. 75-81. DOI: 10.1002/j.2051-5545.2009.tb00218.x.

Gove, Walter (1982): Deviance and Mental Illness: A Critique. Beverly Hills, CA: Sage.

Link, Bruce G./Phelan, Jo C. (2001): Conceptualizing Stigma. In: Annual Review of Sociology, No. 27, pp. 363-385.

Link, Bruce G./Struening, Elmer L./Rahav, Michael/Phelan, Jo C./Nuttbrock, Larry (1997): On Stigma and Its Consequences: Evidence from a Longitudinal Study of Men with Dual Diagnoses of Mental Illness and Substance Abuse. In: Journal of Health and Social Behavior, Vol. 38, pp. 177-190. DOI: 10.2307/2955424.

Livingston, James, D. (2020): Structural stigma in health-care contexts for people with mental health and substance use issues: A literature review. Ottawa: Mental Health Commission of Canada.

National Academies of Sciences, Engineering, and Medicine (2016): Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Washington, DC: The National Academies Press. DOI: 10.17226/23442.

Thornicroft, Graham/Sunkel, Charlene/Aliev, Akmal Alikhon/Baker, Sue/Brohan, Elaine/el Chammay, Rabih/Davies, Kelly/Demissie, Mekdes/Duncan, Joshua/Fekadu, Wubalem/Gronholm, Petra C/Guerrero, Zoe/Gurung, Dristy/Habtamu, Kassahun/Hanlon, Charlotte/Heim, Eva/Henderson, Claire/Hijazi, Zeinab/Hoffman, Claire/Hosny, Nadine/Huang, Fiona-Xiaofei/Kline, Sarah/Kohrt, Brandon A/Lempp, Heidi/Li, Jie/London, Elisha/Ma, Ning/Mak, Winnie W S/Makhmud, Akerke/Maulik, Pallab K/Milenova, Maria/Morales Cano, Guadalupe/Ouali, Uta/Parry, Sarah/Rangaswamy, Thara/Rüsch, Nicolas/Sabri, Taha/Sartorius, Norman/Schulze, Marianne/Stuart, Heather/Salisbury, Tatiana Taylor/Vera San Juan, Norha/Votruba, Nicole/Winkler, Petr (2022): The Lancet Commission on ending stigma and discrimination in mental health. In: The Lancet, Vol. 400, pp. 1438-1480. DOI: 10.1016/S0140-6736(22)01470-2.

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