Self-Stigma Factors Involved With Common Versus Severe Mental Illness

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Abstract

Various discriminatory stereotypes about mental illness are often internalized by the individuals suffering from diverse diagnoses, leading to self-stigma (i.e., discrimination towards oneself that leads to a decrease in self-esteem, self-efficacy, and shame; Hasan & Musleh, 2017b; Hugget, 2018; Rossler, 2016). Although self-stigma affects individuals suffering from severe and common mental illness, most of the research has focused on severe mental illness (Yanos et al., 2015; Corrigan et al., 2016; Corrigan & Rao, 2012). The purpose of my research was to compare factors involved with the self-stigma experienced by individuals with anxiety and depression (i.e., common mental illnesses) and those with severe mental illness. To accomplish this goal an in-depth review of available research was conducted, using predetermined key terms. There were several significant findings: 1. The discriminatory beliefs involved with these two groups differ markedly (common mental illness is associated with weakness, whereas severe mental illness is associated with dangerousness and an inability to recover), but they appear to contribute to a similar path of internalization. 2. Self-stigma levels and resulting quality of life appears to be similar between those suffering from severe and common mental illness, and more dependent on degree of symptoms and employment status. 3. Self-stigma serves as a barrier to treatment and recovery for both groups early in the process of internalization. Implications for practice and future research are discussed.

Keywords: Self-stigma; anxiety; depression; schizophrenia

Self-Stigma Factors Involved With Common Versus Severe Mental Illness

It is well established in the scientific community and the general population that mental illness is a prevalent public health concern (Chiu et al., 2020). Even with this understanding, members of society, including healthcare providers, perpetuate discriminatory stereotypes towards individuals suffering from various mental illnesses (Hasan & Musleh, 2017b; Rössler, 2016). For instance, even psychiatrists have been found to be less willing to have social contact with individuals suffering from mental illness (Rössler, 2016). As a trusted source of information, this behavior sends a clear message that those suffering from mental illness have undesirable qualities that merit ostracization. Stigma often becomes internalized and leads to what is known as self-stigma: a phenomenon where individuals discriminate against themselves, leading to lower self-esteem, self-efficacy, and shame (Hugget et al., 2018). The factors involved in self-stigma are highly meaningful because they can be a significant barrier to treatment and recovery for individuals suffering from mental illness (Corrigan et al., 2016; Oexle et al., 2018). More specifically, internalizing negative attitudes can lead individuals to hide their condition, be reluctant to seek help, and increase their vulnerability towards negative outcomes (Yoshioka et al., 2016). Thus, self-stigma contributes to marginalization, devaluation, shame, and withdrawal (Hasan & Musleh, 2017b).

Consequently, research has focused on factors involved in the formation of and reduction of self-stigma in individuals suffering from mental illness (Corrigan et al., 2016; Corrigan & Rao, 2012; Yanos et al., 2015). Because severe mental illness, such as schizophrenia, is primarily associated with a high degree of self-stigma, much of the available research has focused on this vulnerable population (Hasan & Musleh, 2017b). The research focusing on reducing self-stigma in individuals is beginning to show promising results (Yanos et al., 2015; Yanos et al., 2012).

Only a small amount of this research suggests that these treatments can help those experiencing more common mental disorders such as anxiety and depression (Yanos et al., 2015; Young et al., 2020). A significant number of Canadians aged 18 and older (11.6%) have reported suffering from anxiety and/or depression, a population also known to suffer from self-stigma; this is in comparison to the only 1% of Canadians that suffer from severe mental illnesses such as schizophrenia (Grant et al., 2016; Mental Health Commission of Canada, 2013; Statistics Canada, 2014). Thus, there is a gap in current understanding around the self-stigma experienced by a high percentage (~11.6%) of the Canadian population.

The current review will focus on the factors involved with the self-stigma experienced by individuals suffering from anxiety and depression and the similarities/differences between this population and those with severe mental illness. The review will focus on answering the following research questions: 1) *What factors are involved with the self-stigma experienced by individuals with anxiety/depression*, and 2) *How are these factors the same/different from self-stigma experienced by individuals with severe mental illness (e.g., schizophrenia)?* A subsequent discussion will consider how these similarities and differences might impact clinical practice and treatment planning.

To effectively compare the self-stigma factors associated with anxiety/depression to those associated with severe mental illness, it is essential to define severe mental illness. Although there is no concrete definition for the term, in the context of most research on self-stigma, severe mental illness incorporates schizophrenia, schizoaffective disorders, and others involving psychosis (Ådnanes et al., 2019; Lucksted & Drapalski, 2015; Yanos et al., 2012). As such, when used in this paper, the term will incorporate schizophrenia, schizoaffective disorders, and others involving psychosis. Alternatively, other disorders such as anxiety and depression are

rountinely included under the umbrella of common mental illness (Baxter et al., 2014). Thus, anxiety and depression will be described this way in the context of this paper.

Self-Positioning Statement

When conducting research and writing a literature review, it is essential to examine yourself in relation to the subject area (Galdas, 2017). Research suggests that researchers' conclusions are often closely correlated with their agendas (Galdas, 2017). Biases and preconceived ideas about the topic can affect all research stages, including searching for and selecting relevant literature (Winchester & Salji, 2016). Accordingly, I reflected upon my biases before and during my research to continually identify their effect on the direction of my work. This direction was rooted in evidence gathered from an in-depth analysis of all available literature on my subject area (Winchester & Salji, 2016).

In my case, I had several biases in this area of research. Many of these biases rooted from personal experience with mental illness. I initially encountered the concept of self-stigma when researching effective treatments for a family member who has schizophrenia. While watching my family member progressively lose their self-esteem and self-efficacy, I endeavored to find treatment types that could help them recover. This exhaustive search led me to the concept of self-stigma. This concept resonates with me as playing a huge factor in the journey of my family member.

My family member's experience with self-stigma contributed to several initial biases for me. First, I saw self-stigma as a societal issue. Because this concept involves the internalization of discrimination based on societal stigma, I felt that the onus of responsibility should be on society. In other words, I saw self-stigma as a result of injustice towards a vulnerable population and believed that efforts to change society's perspective on mental illness would lead to the most

significant reduction in self-stigma. Second, because of experiencing firsthand the effects of discrimination on someone who has a severe mental illness, I saw it as a somewhat inevitable outcome. Although I believed that individuals might have more or less self-stigma based on their individual experiences, I had a hard time imagining someone escaping it altogether. This assumption was likely a result of experiencing the severe effects firsthand. Third, I saw self-stigma as something that is highly difficult to reduce. Based on my family member's experience, I believed that self-stigma becomes part of a person's self-concept and is unlikely to change significantly once established. In my experience with my family member, self-stigma became a vicious cycle, where the experience of self-stigma led to isolation, disempowerment, and a lack of self-efficacy; this ultimately led to a higher degree of self-stigma. I believed this vicious cycle makes self-stigma hard to reduce. Lastly, I had an initial bias, based on my family member's experience, that not telling other individuals about having a mental illness would reduce self-stigma. This came from the assumption that the individual with mental illness would experience less discrimination if their mental illness was not identified.

Although my primary reason for researching self-stigma originated out of concern for my family member, I realized another personal connection to the topic during my early research phases. I struggle with a more common mental illness, generalized anxiety disorder. Self-stigma was never something I had thought of in reference to myself before beginning the research process for my family member and their experience. After doing a small amount of research, I realized that self-stigma is something with which I can identify. I have had experiences with others where I have felt judged and discriminated against because I was having difficulty "pulling it together." I internalized a certain degree of this stigma, which led to a perceived reduction in my self-esteem, and I experienced shame and disempowerment. Part of overcoming

the difficulty I was having in coping with my anxiety involved reducing this sense of shame and increasing my self-esteem and self-empowerment. Because I would consider my experience of this concept as minimal compared to my family member, this created an initial bias that individuals experiencing anxiety do not experience this phenomenon to the same degree as someone with severe mental illness. However, this also led to the belief that self-stigma in individuals struggling with common mental illness is less recognizable and considered during treatment. I remained aware of these biases and questioned them throughout the research process.

Given my personal connection to the topic, another critical area of discussion is my agenda in researching the topic. Being aware of this agenda is crucial in remaining unbiased when engaging in my research. My agenda, around researching self-stigma, was to illuminate the adverse effects that discrimination has on individuals struggling with mental illness. Ultimately, as a person and a clinician, I am motivated to be a part of empowering individuals that are affected by self-stigma. Questioning what effect this agenda might have on my research was crucial in remaining unbiased. For instance, even assuming that empowerment will reduce self-stigma is a bias that I needed to question when engaging with the research. If current literature were not to highlight this as a factor, I would need to question that assumption and report my finding as objectively as possible.

Now that I have identified my biases, I must discuss what I did to reduce their effect on my research. First, to reduce any potential biases, I extended my research on self-stigma to individuals with depression and anxiety. Although I have a personal connection to this topic, most of my biases regarding self-stigma surrounded my personal experience with schizophrenia. Second, research suggests that designing a protocol that is made public before engaging in

research can help reduce potential bias in the search terms used and eventual selection of literature (Drucker et al., 2016). I systematically reviewed the literature based on my established criteria rather than searching for literature that supported my biases. The first step towards that goal was writing an initial prospectus that identified my research area and question. This effort was an essential part of establishing my starting point with a supervisor to discuss and subsequently question any slight change in focus. This effort promoted transparency and reduced the likelihood of bias (Drucker et al., 2016). Lastly, I repeatedly questioned, throughout the process, how my biases might be affecting my research. Awareness is highly critical, and I believe this repeated questioning helped in maintaining awareness. To facilitate this questioning, I journaled and consulted with peers and my supervisor.

Literature Review

To identify and review the current literature on self-stigma and the differences and similarities between common mental illness and severe mental illness, it was important to establish a search strategy before beginning the research. A search for current (i.e., 2016-2021) peer-reviewed articles was conducted via the following databases: Proquest Social Science Journals, Psychology and Behavioral Sciences Collection, ProQuest Research Library, Psychology Collection, Pub-Med, Sage Premier, and the Taylor and Francis Mental Health Collection. Google Scholar was also used to locate articles. The following search terms were applied to locate articles specific to this review: self-stigma, mental illness, impacts, depression, anxiety, schizophrenia, stages, differences, treatment efficacy, factors, discriminatory beliefs, attitudes, barrier to treatment, and interventions. Adaptations of these terms were used to ensure comprehensive results.

The literature review will begin with a definition of self-stigma and a discussion of the stage-model of self-stigma and how it relates to the review of the literature. The focus will then shift towards the differences and similarities between severe and common mental illness at each stage of stigma development. This section will conclude by looking at the research involving the treatment of self-stigma and the similarities and differences between severe and more common mental illness.

Definition of Self-Stigma

To discuss the factors involved in self-stigma, it is crucial to first define it and then explore how it becomes internalized by individuals with various mental illnesses. Self-stigma is a concept that has a long history. The concept of the "looking glass self" goes back to the early 1900s, when Cooley (1902) proposed the idea that our self-concept is shaped by how others see us. Subsequent research on self-stigma has focused on society's stereotypes and how they relate to the internal and behavioral processes that result for individuals struggling with mental illness (Corrigan & Rao, 2012; Ociskova et al., 2013). Negative stereotypes involve discriminatory beliefs that can be harmful to people struggling with mental illness (Corrigan & Rao, 2012). Individuals that agree with these stereotypes develop negative feelings and beliefs that lead to prejudice and discrimination (Corrigan & Rao, 2012; Lucksted & Drapalski, 2015). Individuals with mental illness often experience this discrimination and then internalize the root stereotypes, as a result of agreeing with the stereotypes and then applying them to themselves (Corrigan & Rao, 2012). Once a person internalizes these stereotypes, they can have negative emotional reactions, resulting in reduced self-esteem, reduced self-efficacy, and ultimately decreased self-respect (Corrigan et al., 2016).

A Stage Model of Self-Stigma

Although research supports that perceived discrimination leads to negative perceptions of self, it also questions through which pathway this happens. Corrigan and Rao (2012) have created a general stage model of self-stigma that involves four specific stages that progressively lead individuals towards internalizing self-stigma. The first stage they propose is awareness: this stage involves an understanding that the public believes something negative about an individual, such as they are weak (this differs for different mental illnesses; Corrigan & Rao, 2012; Krendl & Freeman, 2019). The second stage involves agreement with the first stage, where an individual agrees with the stereotype. In the third stage, individuals apply this stereotype to themselves. For instance, they might say, "I am mentally ill, so I must be weak" (Corrigan & Rao, 2012, p. 466). Lastly, these internalized beliefs cause harm to the individual ("I better avoid people because I am not worthy"; Corrigan & Rao, 2012). Two assumptions are present in this model: 1) there is a trickle-down effect, where there is the highest endorsement for the initial stage, followed by a decrease in endorsement for each subsequent stage; and 2) stages that are close together are more associated than those further apart (Gopfert et al., 2019). Research supports this model's application for specific populations such as schizophrenia (severe mental illness) and depression (more common mental illness; Corrigan et al., 2011; Corrigan et al., 2012; Gopfert et al., 2019). Research also suggests that individuals who are prone to internalizing stigma experience shame, blame themselves, fear discrimination, have decreased self-esteem and self-efficacy, and, as a result, avoid social interactions (Corrigan et al., 2016; Hugget et al., 2018; Kalisova et al., 2018; Prasko et al., 2016).

Stage One: Stereotypes and Discriminatory Beliefs

Although research supports the progressive model of self-stigma for diverse populations, the factors involved in each stage sometimes differ depending on the specific type of mental illness (Hasan & Musleh, 2017a, 2017b; Krendl & Freeman, 2019). Thus, it is essential to understand the similarities and differences between severe mental illness (such as schizophrenia) and more common mental illness (such as depression and anxiety) at each specific stage of internalization. Stage one involves examining the differences involved in the stereotypes and discriminatory beliefs about severe and more common mental illness.

Current research suggests that severe mental illness, particularly involving psychosis, is associated with more negative stereotypes than depression or anxiety, a finding supported by previous research (Crisp et al., 2000; Crisp et al., 2005; Hasan & Musleh, 2017a, 2017b; Yoshioka et al., 2016). However, negative stereotypes, although different, are also evident and significant for anxiety and depression (Krendl & Freeman, 2019).

Krendl and Freeman's (2019) work identified stigma-related beliefs associated with diverse mental illnesses. Stereotypes about mental illness differ on two specific dimensions: social desirability and controllability. On the dimension of social desirability, schizophrenia is considered to be more socially undesirable than anxiety and depression (Krendl & Freeman, 2019). This social undesirability is attributed to the perception that individuals with schizophrenia are dangerous and unpredictable (Hasan & Musleh, 2017a; Krendl & Freeman, 2019; Reavley & Jorm, 2011a, 2011b; Reavley & Pilkington, 2014). This stereotype becomes more pronounced for males as they are perceived as more dangerous (Reavley & Jorm, 2011b). Reavley and Pilkington (2014) used Twitter to monitor attitudes towards schizophrenia and depression. Their results showed that 5% of all Twitter messages about schizophrenia involved

this perception of individuals as dangerous. For example, one tweet read “untreated schizophrenia boosts likelihood of future violence” (Reavley & Pilkington, 2014, p. 7). Moreover, another 5% of messages spoke to an unwillingness to make social contact with an individual with schizophrenia. Thus, research suggests that individuals with schizophrenia may feel more ostracized by discriminatory beliefs than those with anxiety and depression (Park et al., 2019).

Research examining the controllability dimension suggests that those with anxiety and depression are perceived to have more control over their disorders (Hasan & Musleh, 2017a, 2017b; Krendl & Freeman, 2019). Krendl and Freeman (2019) suggest that this perception of controllability is even greater for depression than anxiety. It appears that this view of individuals with anxiety and depression results from the stereotype that they are "weak, not sick" (Curcio & Corboy, 2020; Hanlon & Swords, 2020, p. 5145; Latalova et al., 2014; Reavley & Pilkington, 2014). The perception of weakness involves an attitude that people with anxiety and depression could "snap out of it" if they were psychologically stronger (Hanlon & Swords, 2020, p. 647). This belief can lead to self-blame if internalized (Hugget et al., 2018).

A high percentage of individuals in society perceive weakness associated with depression and anxiety. A study monitoring stigma-related statements in tweets over 7 days found the word "weak" in 21% of tweets about depression (Reavly & Pilkington, 2014). Hanlon and Sword's (2020) research on anxiety in adolescents showed that between 11%–17% of the participants endorsed the "weak not sick" stereotype. In other words, they believed that the symptoms experienced by individuals with anxiety are a result of weakness, rather than a genuine medical condition. The higher numbers for depression match Kendall and Freeman's (2017) claim that depression is perceived as more controllable than anxiety. This association of weakness with

depression is particularly challenging for males, as it goes against the masculine gender roles and the belief that "boys don't cry" (Latalova et al., 2014, p. 1399). This is the case for both common and severe mental illness (Latalova et al., 2014).

On the other hand, the perception of schizophrenia as less controllable contributes to a belief that individuals with schizophrenia will never recover (Hanisch et al., 2016; Hasan & Musleh, 2017b; Krendl & Freeman, 2019). Hasan and Musleh (2017b) found that there is a marked difference in people's perceptions of controllability between groups: 44% of their study participants perceived people with schizophrenia as unable to control their mental health compared to 21% of those with depression, and 18% of those with anxiety. Krendl and Freeman (2019) suggest that this leads to the belief that schizophrenia is more personality-based than behavioral and that individuals' symptoms are fixed and not likely to change over time. However, participants in the study by Hasan and Musleh (2017b) attributed greater responsibility for symptoms on individuals with schizophrenia (27%) compared to those with depression (17%) and anxiety (16%); an interesting finding considering the attribution of lower controllability.

Stage Two and Three: Agree and Apply

Self-Esteem. Once individuals become aware of stereotypes, the steps that can follow lead to a progressive degradation of an individual's mental health (Corrigan et al., 2016; Gopfert et al., 2019). Research shows that differences between mental illnesses and the stigma factors involved decrease as individuals proceed through these subsequent stages and begin to internalize stigma (Corrigan et al., 2016; Kalisova et al., 2018; Lannin et al., 2016). One of the first consequences of agreeing with the stereotype is a decrease in self-esteem, which is evident across all populations (Corrigan et al., 2016; Corrigan et al., 2011; Corrigan et al., 2019; Gopfert et al., 2019; Ku & Hong, 2017). Corrigan et al.'s (2016) research on the four stage model of self-

stigma and the resulting affects supports that stereotypes predict diminished self-respect in diverse individuals. They found that the decrease in self-respect was associated with both agreeing with stereotypes and applying them. This suggests that even just agreeing with a stereotype is enough to negatively affect individuals with mental illness, decreasing their self-esteem. It is important to mention that participants were individuals who received a mental health diagnosis by a psychiatrist but the demographics of their specific diagnoses were not provided. Furthermore, although ethnic and socioeconomic diversity were represented, the majority of particpants were European/American and represented a low socioeconomic status. Consequently, it is difficult to generalize the results beyond this group. Gopfert et al. (2019) had a similar finding in that they discovered a strong correlation between stereotype awareness and a decrease in self-esteem. They also suggest that although the narrative associated with different stereotypes is different between mental illnesses, the immediate consequences are similar across populations: the decrease in self-esteem leads to a further decrease in individuals' confidence in their ability to behave competently in situations (Corrigan et al., 2016; Corrigan et al., 2019; Gopfert et al., 2019).

Difference and Disdain. An essential factor involved in the internalization of self-stigma is society's perception that individuals with mental illness are different (Corrigan et al., 2015; Corrigan & Nieweglowki, 2019; Shah et al., 2020). Corrigan and Nieweglowski (2019) developed a scale to measure differentness—the Differentness Self-Stigma Scale (DSSS)—and found that individuals' perception of difference increases as they proceed from awareness to application and then harm. However, unlike the progressive model of self-stigma which shows increased scores at each subsequent stage, the DSSS score was not significant at the awareness stage. This finding suggests that people do not perceive themselves as different until they agree

with the stereotypes. This suggests that it is the stereotypes themselves that highlight the majority of difference in individuals with mental illness and not their experience of symptoms. For example, if an individual with schizophrenia disagreed that individuals with this diagnosis are dangerous and will never recover, they would be less likely to view themselves as different, even though they are experiencing psychosis. Most importantly, the DSSS score was most significant during the application stage, suggesting that individuals feel the most different when they begin applying stereotypes to themselves. Shah et al. (2020) show that this view of difference could be crucial in understanding how people progress from the earlier stages of self-stigma to the later stages.

Because previous research has identified difference and disdain as measures of stigma (Corrigan et al., 2015), Shah et al. (2020) measured disdain as a potential outcome for individuals with diverse mental health conditions. Unlike difference, disdain is associated with degradation and disrespect (Shah et al., 2020). Using 291 participants, Shah et al. measured disdain, using the Disdain Self-Stigma Scale, at each of the four stages of self-stigma development. The authors found that unlike difference, which was endorsed at a higher level in the later stages of internalization, disdain was endorsed less highly. They discovered that once participants reached the application stage, some were willing to accept that they are different but protected themselves from harm by not endorsing a degrading and disrespectful view of themselves. However, those who did endorse disdain at later stages had more significant negative outcomes than those who just endorsed difference. They concluded that disdain appears to be a crucial factor in leading to a greater degree of harm. Corrigan et al. (2015) suggest that the perception of difference is associated with individuals' disempowerment, and it may be this

disempowerment that leads to eventual disdain. Ultimately, it leads to a loss of self-respect and behavioral futility that Corrigan et al. (2016) describe as the "why try effect" (p. 10).

The Why Try Effect. The why try effect describes a result of the futility that happens when individuals with mental illness experience a reduction of self-esteem and an increase of disdain, devaluation, shame, and guilt (Corrigan et al., 2016; Corrigan et al., 2009; Corrigan et al., 2019). More specifically, Corrigan et al. (2016) refer to this phenomenon by speaking to an individual's belief that they are "unworthy or incapable of achieving personal goals because they apply the stereotypes of mental illness to themselves" (p. 10). They examined this phenomenon in relation to the stages of stigma development and found that stereotypes predict both a diminished level of self-respect and the why try effect. Furthermore, they discovered that even agreement with public stigma was associated with the phenomenon. Even before individuals begin applying stereotypes to themselves, the behavioral effects begin to occur. Corrigan et al. (2016) showed that while disdain and a reduction in self-esteem prompt the emotional harm that results from self-stigma, the why try effect prompts the behavioral harm that decreases capability in individuals with mental illness. In a study with 291 participants with diverse mental illnesses, Corrigan et al. (2019) took this conclusion further by showing that afterwards, the why try effect results in the sense of unworthiness and subsequent incapability. The futility then results in depression. Although research supports the conclusion that stages two and three are similar across populations, the research focusing on specific populations, such as individuals with anxiety and depression, is limited.

Stage Four: Harm

Stigma Levels. There is ample research to support the conclusion that self-stigma levels are negatively correlated with quality of life, symptom severity, treatment-seeking, and treatment

efficacy across common and severe populations of mental illness, all of which cause harm to individuals (Holubova, Prasko, Latalova, et al., 2016; Kalisova et al., 2018; Ociskova et al., 2016; Vrbova et al., 2016). However, to look at the factors involved with the harm stage of self-stigma, it is crucial to examine stigma levels and whether they differ across common and severe populations. Although research supports that severe mental illness is associated with more negative stereotypes than common mental illnesses, the research examining stigma levels is not as conclusive. The majority of research comparing self-stigma levels in patients with anxiety, depression, and schizophrenia spectrum disorders suggests that levels are similar (Holubova, Prasko, Ociskova, et al., 2016; Kalisova et al., 2018; Vrbova et al., 2016). This finding is significant, considering that it goes against the logical conclusion that more negative stereotypes would lead to greater self-stigma. However, some researchers have concluded that individuals suffering from mental illness involving psychosis (severe mental illness) show elevated levels of self-stigma compared to those with more common illnesses (Holubova, Prasko, Matousek, et al., 2016; Switaj et al., 2016). These mixed findings might suggest that self-stigma should be a greater consideration for those suffering with psychosis. However, it is clear that self-stigma is a salient issue for those with anxiety and depression, potentially even to the same degree as those suffering from more severe mental illness (Holubova, Prasko, Ociskova, et al., 2016; Kalisova et al., 2018; Kamaradova et al., 2016).

The conclusion that self-stigma is likely not a result of a particular diagnosis prompted researchers to question the similar factors across populations leading to variations in stigma level. First, research showed that self-stigma levels highly correlate with employment status in all three groups (Holubova, Prasko, Ociskova, et al., 2016; Kalisova et al., 2018; Vrbova et al., 2016). This finding affirms the suggestion that the why try effect leads to behavioral futility

(Corrigan et al., 2016). It is a logical assumption that behavioral futility would lead to a decrease in employment; as described, research shows this lack of motivation to try causes harm (greater internalization of self-stigma and decreased self-esteem). Holubova, Prasko, Matousek, et al. (2016) confirmed the correlation between unemployment and self-stigma with a high degree of confidence, more than for any other demographic regardless of diagnosis. Lack of employment can further lead to less social inclusion and greater alienation across populations (Arnaez et al., 2020; Kalizova et al., 2018). Research has found these factors highly associated with self-stigma (Arnaez et al., 2020; Kalizova et al., 2018). Consequently, lack of employment should be considered an enormous risk factor for self-stigma, regardless of diagnosis.

Second, most research shows that stigma levels are affected by the severity of symptoms, independent of the disorder (Grant et al., 2016; Holubova, Prasko, Matousek, et al., 2016; Ociskova et al., 2015; Vrbova et al., 2016). In a cross-sectional study comparing schizophrenia with more common mental illnesses, Vrobova et al. (2016) found that objective (measured by a psychiatrist using the objective version of the Clinical Global Impression – Severity Scale [objCGI-S]) and subjective (measured by the participant's rating using the subjective version of the Clinical Global Impression – Severity Scale [subCGI-S]) levels of symptoms were significantly correlated with the level of self-stigma in people both with severe and common mental illness. This finding has been confirmed in several studies on depression and anxiety, agreeing that overall self-stigma correlates with the severity of symptoms (Holubova, Prasko, Ociskova, et al., 2016; Ociskova et al., 2015). Ociskova et al. (2015) further discovered that having comorbid disorders, such as depression and anxiety, increased self-stigma level. With this said, although most of the research agrees with this conclusion, some studies disagree. For instance, Arnaez et al. (2020) found that the severity of depression did not significantly correlate

with self-stigma. Thus, although it appears that the severity of symptoms is likely a factor across groups, more research examining the different groups is required in this area.

Quality of Life. A crucial area to consider when examining the harm caused by self-stigma is the quality of life experienced by individuals with mental illness (Holubova, Prasko, Matousek, et al., 2016; Holubova, Prasko, Ociskova, et al., 2016; Ociskova et al., 2018; Oliveira et al., 2016). Studies looking separately at anxiety, depression, and schizophrenia all concluded that self-stigma level was negatively correlated with quality of life (Chen et al., 2016; Holubova, Prasko, Matousek, et al., 2016; Holubova, Prasko, Ociskova, et al., 2016; Ociskova et al., 2018). Holubova, Prasko, Matousek, et al. (2016) suggested that the tendency of individuals to regard themselves as inferior, incompetent, and unable to succeed (discussed earlier as the why try effect and disdain) causes individuals to lose hope, self-esteem, and self-acceptance. Ociskova et al. (2015) looked at self-stigma in participants with anxiety disorders and agreed that there is a strong correlation with a loss of hope and self-esteem, ultimately leading to a decrease in self-directedness and quality of life. Like stigma, most research comparing different populations supports the conclusion that individuals with severe mental illness have a similar quality of life than those with more common mental illnesses, depending on the degree of symptom and stigma levels (Holubova, Prasko, Matousek, et al., 2016; Holubova, Prasko, Ociskova, et al., 2016). Latlova et al. (2011) contrasted this finding when they compared the quality of life in patients with bipolar to those with schizophrenia. They concluded that those with schizophrenia had a significantly lower quality of life. The inconsistency could be explained by significant differences in the employment-subscale that contributed to the overall quality of life rating (Holubova, Prasko, Matousek, et al., 2016). Depressive participants rated much higher on the employment subscale, suggesting that participants with schizophrenia had a uniquely challenging

time succeeding within the employment market. Brouwers et al. (2020) agree that the unemployment rate for severe mental illnesses such as schizophrenia is significantly higher than common mental illnesses (seven times and three times, respectively). As described earlier, employment status is highly correlated with self-stigma. Holubova, Prasko, Matousek, et al. (2016) showed that employment status is also highly correlated with quality of life. Thus, although there is not a significant difference in the overall quality of life across groups, there is likely a difference in the opportunity to be employed.

Barrier to Treatment. The lack of willingness for individuals suffering from mental health diagnoses to seek mental health treatment is a serious concern (Arnaez et al., 2020; Clement, 2015). For instance, approximately 60%–75% of people suffering from anxiety-related disorders and 37% with depression never seek professional help (Biftu et al., 2018; Ociskova et al., 2013). Likewise, up to 67% of people with schizophrenia are not receiving adequate care (World Health Organization, 2019). Research suggests that self-stigma can be a significant barrier to individuals across diverse populations seeking treatment (Arnaez et al., 2020; Fung et al., 2008; Lannin et al., 2016; Oakley et al., 2011; Ociskova et al., 2013). Low insight into symptoms combined with low self-esteem and empowerment can lead to secrecy, an unhealthy coping mechanism (Lannin et al., 2016; Oexle et al., 2017). Self-stigma level is negatively correlated with both the initial decision to seek mental health information and counselling information (Clement, 2015; Lannin et al., 2016). Research investigating individual populations, such as schizophrenia, depression, and anxiety, show similar results (Arnaez et al., 2020; Fung et al., 2008; Ociskova, 2013). However, there is some variation in the self-stigma factors between groups that contribute to this conclusion (Fung et al., 2008; Vidovic et al., 2016).

For instance, Fung et al. (2008) concluded that a higher level of self-stigma contributed to a lack of insight into symptoms of schizophrenia. The lack of insight contributed to the negative correlation that self-stigma has with treatment adherence. This effect intensified as individuals proceeded through the stages of internalization. Vidovic et al. (2016) agreed that a high level of stigma and low level of insight contribute to poor treatment adherence in individuals with schizophrenia. The same elements contribute to poor social functioning, lower quality of life, and low self-esteem (Vidovic, 2016).

Although treatment adherence is a crucial element in the treatment of schizophrenia, postponing treatment is more common for common mental illnesses, such as anxiety and depression (Ociskova et al., 2013). Individuals who suffer from anxiety disorders and experience a high degree of self-stigma are at increased risk of avoiding treatment because of their fear of disapproval. On the other hand, Arnaez et al. (2020) looked at depression stigma and the association with barriers to seeking treatment. Self-stigma displayed a stronger association with help-seeking than did perceived stigma, which is in accordance with Fung et al.'s (2008) research on schizophrenia. However, the fear of alienation was the most substantial contributing element of self-stigma, which served as a barrier to treating depressed individuals (Arnaez et al., 2020).

Barrier to Recovery. Research shows that not only does self-stigma serve as a barrier to getting treatment, but it also decreases the efficacy of treatment for individuals with both common and severe mental illness. As discussed, self-stigma is related to self-esteem, poor quality of life, reduced self-efficacy, and hopelessness, all salient recovery features (Corrigan et al., 2016). Thus, researchers have examined whether self-stigma is also associated with a decrease in recovery. Oexle et al. (2018) examined the effect of self-stigma on recovery among 222 individuals on disability for a mental illness over a 2-year period. More self-stigma at

baseline was correlated with a significant decrease in recovery after 1 year. Furthermore, an increase in self-stigma 1 and 2 years later predicted even less recovery.

Self-stigma is also implicated in research examining recovery among specific groups. For instance, Ociskova et al. (2016) examined the effects of self-stigma on resistant anxiety disorders and found that the best predictor of recovery (among dissociation level, harm avoidance, self-stigma, hope, and self-directedness) was self-stigma. Self-stigma as a predictor of recovery was more significant for individuals with a comorbid disorder, such as depression or a personality disorder. As the degree of symptoms increase, so does the self-stigma, regardless of the specific diagnosis. Ociskova et al. (2013) agree that as self-stigma increases, treatment effectiveness for anxiety disorders decreases. As such, the treatment of anxiety disorders is more likely to be successful earlier in the process than later. The effectiveness of treatment decreases significantly as it is delayed (Ociskova et al., 2013).

Researchers studying the same effects in depression and more severe illness, such as schizophrenia, show similar results. In researching the complex treatment of depression, Prasko et al. (2016) showed that patients with pharmaco-resistant depression who had a higher degree of self-stigma showed a poorer response to treatment than those with a lower level of self-stigma. Self-stigma had an inverse relationship with both pharmacological and psychotherapeutic effectiveness. However, it was the discrimination experience contributing to self-stigma that was the most decisive factor that predicted therapeutic change. For example, someone with depression who had experienced multiple interactions with someone communicating that people with depression need to “buck up”would be less likely to experience change in therapy than individuals who had not had these interactions, regardless of whether they agreed with the belief or applied it to themselves. Similarly, a study examining the effects of stigma on the recovery of

individuals experiencing psychosis found that baseline stigma levels predicted the level of recovery 6 months later (Vass et al., 2015). Consequently, the research shows that the degree of self-stigma that an individual experiences reduces treatment efficacy regardless of the disorder.

Treatment

Given the apparent effects of internalizing stigma on self-esteem, empowerment, self-efficacy, quality of life, and recovery for those suffering from mental illness, it has been essential that research focus on different treatments aimed at reducing self-stigma. Many of the proposed treatments have incorporated elements of psychoeducation to counteract misinformation, cognitive techniques to combat self-stigmatizing beliefs, and narration to help people make sense of their past experiences, rewriting themselves as active agents in their lives (Yanos et al., 2015). Treatments with these features include Healthy Self-Concept, Self-Stigma Reduction Program, Narrative Enhancement Cognitive Therapy, Coming Out Proud, and Photo-Voice Intervention. The research evaluating these programs shows positive results. However, few studies include diverse mental illness populations, such as anxiety and depression. Even fewer studies look at these populations independently. No research could be located examining the effects of anti-stigma treatment on anxiety alone. The majority of treatment and subsequent research focuses on severe mental illness involving psychosis.

For instance, Healthy Self-Concept is a manualized group-based intervention designed specifically for people experiencing their first psychotic episode (McCay et al., 2007). McCay et al. (2007) explain that the group focuses on combining psychoeducation and other elements involved in the group process, such as developing altruism and sharing. The psychoeducation element focuses on developing an appropriate interpretation for the illness, minimizing self-stigmatizing attitudes, and developing meaningful life goals. McCay et al. (2007) found that this

group significantly reduced self-stigma in participants with schizophrenia, suggesting this as a promising option for those struggling with self-stigma. Unfortunately, there is no current research on this intervention or research involving other populations, such as anxiety and depression.

Other groups focusing on psychoeducation alone have also shown promising results. For instance, Ivezic et al. (2017) showed that psychoeducation alone significantly reduced internalized stigma scores. However, this group again focused on individuals with schizophrenia. No research could be located examining the effects of psychoeducation on self-stigma in individuals with anxiety. However, there are two studies which focused on depression. First, Howard et al. (2018) discussed a brief biologically-based psychoeducational intervention designed to decrease self-stigma and increase help-seeking in depressed youth. The results showed no significant decrease in self-stigma; however, there was a slight increase in help-seeking intention for depression. Second, Conner et al. (2015) provided a peer education intervention for older adults suffering from depression. Each older adult was paired with an older peer who was considered recovered. This peer support person provided psychoeducation, social support, and motivational interviewing. The results showed a highly significant effect of the intervention on reducing self-stigma. This finding not only provides support for the effects of psychoeducation on depression but also peer support and role modeling.

Ending Self-Stigma (ESS) is a manualized group that also incorporates psychoeducation. This group is facilitated by individuals with some lived experience with mental illness (Yanos et al., 2015). The nine sessions incorporate information sessions, experience sharing (focused on increasing belonging), discussion, support, practicing strategies, such as responding to discrimination, and preparing for at-home practice (Yanos et al., 2015). Lucksted et al. (2011)

reported the initial published research on ESS involving 34 veterans diagnosed with schizophrenia and mood-related disorders, such as depression. Although this research shows significantly reduced internalized stigma and significantly increased empowerment and recovery orientation, the sample size was small and not specific to any one population. Drapalski et al. (2021) recently looked at ESS as a group intervention for individuals with schizophrenia, schizoaffective disorder, and bipolar disorder. The reduction in self-stigma was moderate, but statistically significant amongst the entire group. However, when specifically looking at the group experiencing psychosis, there was a much more significant reduction in self-stigma. This finding suggests that ESS is particularly beneficial for individuals experiencing psychosis.

Psychoeducation has been incorporated into cognitive therapy (CT) and cognitive-behavioral therapy (CBT) groups that have looked at decreasing self-stigma. CT focuses primarily on changing an individual's distorted thinking, while CBT focuses on distorted thinking and behavior (Wood et al., 2016; Young et al., 2020). Psyhoeducation is used in both groups as a way to facilitate these changes (Wood et al., 2016; Young et al., 2020). In a study examining service users' experiences of a CT intervention for self-stigma in psychosis, Wood et al. (2016) offered participants 12 hours of CT over 4 months based on a cognitive model of psychosis. Eight participants were given qualitative interviews, and answers were divided into the themes, *what helped, what hindered, and what came of it* (Wood et al., 2016, p. 238). Overall, the majority of the participants found CT helpful in reducing their self-stigma. Psychoeducation and normalization were identified as the most helpful. This is in accordance with previous research on psychoeducation and its effectiveness in reducing self-stigma, particularly for those experiencing psychosis (Ivezic et al., 2017).

Young et al. (2020) used CBT aimed directly at reducing self-stigma in individuals with depression. Sixty-two Chinese participants with clinical depression were randomly assigned to either a CBT group designed to help participants challenge irrational stigmatized beliefs (10 sessions) or their usual treatment. Results showed that after treatment, the CBT group had significantly lower self-stigma scores than the control group. As such, this study provides strong support for the efficacy of CBT in reducing depression. However, it would be essential to reproduce the results in other populations to ascertain whether they are generalizable or specific to Chinese culture.

Another type of treatment showing promise that has prompted more research than any other area combines many of the approaches we have discussed, psychoeducation and CBT, with the added benefit of narrative therapy. Narrative Enhancement Cognitive Therapy (NECT) is a manualized program that involves four stages: sharing of experiences, psychoeducation, cognitive restructuring, and narrative reauthoring (Yanos et al., 2015). This treatment requires 20 sessions and involves an extensive process that leads to a comparison of participants' beliefs at the start of treatment versus the end of treatment (Yanos et al., 2015). By the end, participants write a new story that provides new meaning, is understandable by others, and is free of self-stigma (Yanos et al., 2015). There is ample research supporting the use of NECT for individuals experiencing psychosis (Ching et al., 2020; Hansson & Yanos, 2016; Yanos et al., 2019). For instance, a controlled trial by Yanos et al. (2019) showed that participants in the NECT groups improved significantly in self-stigma compared to supportive therapy groups. Furthermore, the NECT group showed a reduction in social withdrawal and avoidant coping strategies, which serve as a barrier to recovery. The research involving other populations, however, is lacking. The studies involving diverse diagnoses, including depression and anxiety sufferers, consisted

primarily of people living with psychosis (over 85%; Hansson et al., 2017; Roe et al., 2014; Roe et al., 2017). These studies found that NECT was effective in decreasing self-stigma and increasing things such as self-clarity, but it is difficult to generalize the results to individuals suffering from anxiety and depression considering that they were less than 15% of the sample size.

Given the reduction of empowerment described by the why try effect, recent interventions have focused on this element in their attempt to reduce self-stigma. Coming out Proud (COP) is an intervention that seeks to increase empowerment by encouraging individuals with mental illness to consider disclosure as a method to overcome their self-stigma (Corrigan et al., 2013). It is a brief three-session intervention run by peer facilitators based on the research that suggests that secrecy is a harmful coping strategy that tends to isolate people and increase their self-stigma (Yanos et al., 2015). As a new intervention, there is only a tiny amount of research on this intervention with mixed results. In the first published study of COP, Rüsch et al. (2014) randomly assigned 110 individuals with diverse mental illnesses to a COP group or a treatment as usual group. Unfortunately, this study did not find that COP significantly reduced self-stigma, but it did find other benefits, such as reduced secrecy and stress. On the other hand, using a similar research design, Corrigan et al. (2013) found that COP significantly reduced self-stigma in individuals with diverse mental illnesses. These results suggest more research in this area is necessary and that focusing on specific groups could prove beneficial in self-stigma treatment.

Another intervention gaining popularity in increasing empowerment and decreasing self-stigma in individuals is Photo-voice Intervention. This intervention is peer-based and encourages activism through photography and descriptive narratives (Russinova et al., 2014). Participants

take photos of their everyday experiences with discrimination and bring them back to the group. The participants then generate narratives that describe the photos in relation to themselves and their experiences (Russinova et al., 2014). Psychoeducation is used in tandem with photography to confront stereotypes and teach healthy coping mechanisms (Russinova et al., 2014). Russinova et al. (2014) examined this intervention in a study involving various mental illnesses, including depression and anxiety. The populations were relatively evenly balanced, contributing to the generalizability of the results. Results showed that photo-voice intervention significantly impacts self-stigma and personal growth and recovery compared to a control group. Thus, although this intervention has not been tested on any individual population, it could be a viable option for diverse mental illnesses.

Summary

Looking at the similarities and differences between self-stigma factors in severe and more common mental illnesses has revealed important commonalities and divergencies. Looking at each stage involved in the internalization of stigma has allowed a critical evaluation of the differences and similarities at each point that they become evident (see Appendix). The most prominent differences surround the discriminatory beliefs about severe versus common mental illnesses that define the early stages of stigma development. While people perceive individuals with severe mental illness as permanently altered and dangerous individuals who will never recover, they see those with more common mental illnesses as "weak" and capable of changing their outcome if only they were stronger (Hasan & Musleh, 2017a, 2017b; Kredl & Freeman, 2019). These very different perceptions are both evidently harmful, as research shows that regardless of diagnosis, individuals progress through the same stages, leading to

disempowerment and decreased self-efficacy and self-esteem (Corrigan et al., 2016; Gopfert et al., 2019).

Although one might assume that the more negative beliefs about severe mental illness would lead to differences in self-stigma level, the majority of the research showed that these levels are similar between common and more severe mental illnesses (Holubova, Prasko, Ociskova, et al., 2016; Kalisova et al., 2018; Kamaradova et al., 2016). The stigma level was more reliant on the level of symptoms than the specific disorder (Grant et al., 2016; Holubova, Prasko, Ociskova, et al., 2016; Ociskova et al, 2015; Vrbova et al., 2016). Similarly, self-stigma appeared to predict a lower quality of life in both populations. Most of the research showed no significant difference between groups in this domain (Holubova, Prasko, Matousek, et al., 2016; Holubova, Prasko, Ociskova, et al., 2016). However, there was a significant difference found between the two groups surrounding employment, which is associated with quality of life and self-stigma (Arnaez et al., 2020; Kalisova et al., 2018). Those with severe mental illness likely have more significant difficulties in obtaining employment, leading to greater isolation (Brouwers et al., 2020).

In both common and severe mental illnesses, it became evident that self-stigma serves as a barrier to both accessing treatment and treatment efficacy (Arnaez et al., 2020; Lannin et al., 2016; Ociskova et al., 2013). Some research showed that the hesitancy to engage in treatment because of a fear of alienation was higher for common mental illnesses than for severe mental illness (Arnaez et al., 2020; Ociskova et al., 2013). In comparison, research on treatment efficacy showed that self-stigma similarly reduces treatment efficacy regardless of the disorder (Corrigan et al., 2016; Ociskova et al., 2016).

In conclusion, self-stigma has a severe effect on recovery regardless of the diagnosis (Ociskova et al., 2013; Ociskova et al., 2016; Oexle et al., 2018; Prasko et al., 2016; Vass et al., 2015). However, most of the research surrounding treatment has focused on severe mental illness. By researching various treatments, it became evident that many of them significantly reduced self-stigma in those experiencing psychosis-related disorders, whether they involved psychoeducation, cognitive restructuring, narrative reprocessing, or empowerment (Conner et al., 2015; Ivezic et al., 2017; McCay et al., 2007; Rüsch et al., 2014; Yanos et al., 2015). Although there is some preliminary support that these same groups can help those with depression (Young et al., 2020), there is almost no research examining the treatment of self-stigma for individuals with anxiety. Both are populations known to suffer from the effects of self-stigma. Thus, it is essential to consider the differences and similarities between common and severe mental illnesses to infer what this means to treat stigma in more common mental illnesses.

The first section of this paper has revealed similarities and differences in the research on self-stigma experienced by those suffering from severe and more common mental illness. These findings have significant implications for the field of counselling psychology and current practice that require discussion. In the next section of the paper I will discuss these implications, the resulting practice recommendations, and next steps for research, and finally reflect on how my perceptions and biases have changed throughout my research.

Implications for Counselling Psychology

The research has revealed several implications for the field of Counselling Psychology. By examining the factors involved with each stage of self-stigma, it became clear that there were commonalities and differences between severe and common mental illness that provide essential information regarding the treatment of mental illness and the mediating factor of self-stigma.

These implications involve the importance of self-stigma in treating common mental illness, the importance of considering the difference in discriminatory beliefs between common and severe mental illness, the effect that this could have on implementing treatment, public policy, and anti-stigma campaigns, and that the individual differences between diagnoses need to be taken into account when planning treatment.

The Importance of Self-Stigma in Treating Common Mental Illness

Much of the research regarding stigma and mental illness surrounds the prejudices and resulting self-stigma experienced by individuals suffering from severe mental illness (Chen et al., 2016; Fung et al., 2008; Ociskova et al., 2015; Vrbova et al., 2016). Alternatively, very little research has focussed on the treatment of self-stigma for individuals suffering from common mental illness (Hansson et al., 2017; Young et al., 2020). This lack of research is particularly present for those struggling with anxiety. This is likely a result of the association that severe mental illness has with more negative stereotypes than disorders like anxiety and depression (Hasan & Musleh, 2017b).

This review suggests that this imbalance in the research may be unwarranted. As discussed, current evidence suggests that the degree of self-stigma is more dependent on symptoms than it is on type of mental illness and that the level of self-stigma is comparable between severe and common mental illness (Grant et al., 2016; Holubova, Prasko, Matousek, et al., 2016; Ociskova et al., 2015; Vrobova et al., 2016). Moreover, evidence also supports that self-stigma, regardless of diagnosis, results in decreased quality of life, resistance to treatment, and reduced treatment efficacy (Holubova, Prasko, Matousek, et al., 2016; Holubova, Prasko, Ociskova, et al., 2016; Kalisova et al., 2018; Kamaradova et al., 2016). Given these similarities across groups, the lack of research on the treatment of self-stigma for common mental illness

supports the assumption that researchers, and likely practitioners, have underrated the impact of self-stigma on the recovery of common mental illness. This flaw in judgment has enormous implications: the self-stigma experienced by those struggling with common mental illnesses has not received the necessary attention and could be contributing to adverse outcomes for a large group of individuals. These findings imply that researchers and practitioners need to consider self-stigma an essential factor when considering treatment for more common mental illness, just as they do with more severe mental illness.

This lack of consideration could explain some of the resistance to treatment common with anxiety and depression. Resistance to treatment affects one-third of older individuals who suffer from depression and over one-third of those suffering from anxiety disorders (Coplan & Reddy, 2006; Mulsant & Pollock, 1998). Even CBT, which is considered the most efficacious treatment for resistant depression and anxiety, does not benefit a large percentage of those struggling with common mental illnesses (Coplan & Reddy, 2006; Li et al., 2018). The resulting implication is that even CBT, normally an effective treatment, will not work if the focus is on an individual's symptoms rather than the self-stigma they are experiencing. Thus, focusing treatment on the disorder itself without considering the stigma that accompanies it can increase adverse outcomes.

Implications for Stage One: Stereotypes and Discriminatory Beliefs

The Importance of Considering the Difference in Discriminatory Beliefs and Gender

Evidently, researchers and practitioners should consider self-stigma when treating both common and severe mental illness. However, this review suggests a significant difference between common and severe mental illness that needs consideration before attempting to reduce self-stigma: the discriminatory beliefs experienced by individuals (Krendl & Freeman, 2019;

Reavley & Jorm, 2011b). In reviewing the literature, it became clear that society views individuals with severe mental illness as unpredictable, dangerous, unable to recover, and less socially desirable than those with common mental illness (Krendl & Freeman, 2019). Alternately, individuals in society view those with common mental illness as "weak" and able to control their disorders if only they were "stronger" (Curcio & Corboy, 2020; Hanlon & Swords, 2020; Reavley & Pilkington, 2014). These are both disempowering messages leading to the same outcome: self-stigma. On the one hand, individuals with severe mental illness who internalize these messages believe that it is out of their control to ever improve, which can lead to the why try effect (Corrigan et al., 2016; Corrigan et al., 2009; Corrigan et al., 2019). On the other hand, those with more common mental illnesses who internalize these messages believe that they are innately weak and unable to do what others can do due to a lack of strength (Hanlon & Swords, 2020). Like severe mental illness, this can disempower individuals and lead to the why try effect (Corrigan et al., 2016).

Most importantly, the discriminatory narratives that lead to the same outcome are entirely different, implying that individuals with common and severe mental illness should be grouped separately to reduce stigma. Merging the two groups could lead to confusion in trying to change the narrative at hand. For instance, someone with psychosis might need information suggesting that they are not dangerous, and with appropriate treatment, they can recover. Alternately, someone with depression or anxiety might need to hear that their difficulties are not a result of weakness; they, instead, are natural responses to changes in the nervous system due to various factors. The difference in these narratives has implications for treatment considerations, public policy, and campaigns designed to reduce public and institutional stigma around mental illness.

There is another important difference to consider involving gender. With both common and severe mental illness, males are more likely to experience more prounounced stereotypes (Latalova, 2014; Reavley & Jorm, 2011b). With severe mental illness, this is a result of the belief that males are more dangerous than females (Reavley & Jorm, 2011b). Whereas, with common mental illness, this is a result of the expectation by society for males to be "stronger" than females (Latalova et al., 2014). These beliefs exacerbate the steretypes already associated with both categories of mental illness. As such, mental health professionals should be particularly attuned to self-stigma in males experiencing both common and severe mental illness because they are likely at increased risk for negative outcomes.

Implications for Stage Two and Three: Agree and Apply

The Importance of Early Intervention and Anti-Stigma Campaigns, Regardless of Diagnosis

One of the significant conclusions made in this review targets a similarity across groups: even just agreeing with stereotypes can negatively affect individuals with diverse mental illnesses (Corrigan et al., 2016; Gopfert et al., 2019). This finding suggests that individuals, regardless of diagnosis, can experience a decrease in self-esteem even if they have not yet applied the stereotype to themselves. Furthermore, the why try effect that leads to behavioral futility and lack of motivation for recovery also happens before individuals apply stereotypes to themselves (Corrigan et al., 2016). This suggestion has substantial implications for counselling psychology: it implies that treatment should target self-stigma early in the process, even before self-stigma is evident, regardless of the disorder. This finding also highlights the importance of interventions targeted to the general public that focus on decreasing the stereotypes that are causing an immediate decrease in self-esteem for individuals suffering from diverse diagnoses.

There have been a variety of anti-stigma campaigns throughout the world, focused on reducing stigma in the general public, including *Beyond Blue* (targeting beliefs about depression and anxiety; http://www.beyondblue.org.au; Stuart, 2016), *Like Minds, Like Mine* (targeting beliefs and inclusiveness in regards to general mental illness; Thornicroft et al., 2014), and *Program Against Stigma and Discrimination Because of Schizophrenia — Open the Doors* (targeting beliefs about schizophrenia; Gaebel et al., 2008). These programs show promise: *Beyond Blue* and *Like Minds, Like Mine* have both shown significant improvements in knowledge and attitude outcomes (Thornicroft et al., 2014). Systematic reviews targeting the effect of such interventions have demonstrated that both psychoeducation and social contact effectively reduce stigmatizing attitudes and behavior (Stuart, 2016; Thornicroft et al., 2014). However, results from these reviews suggest that contact between people with and without mental illness is the most effective intervention for adults (Stuart 2016; Thornicroft et al., 2014). Contact-based interventions, mainly when there is equal status, common goals, and interaction between groups, can disconfirm negative stereotypical beliefs and lead to a change in behavior, such as reducing social distance (Pettigrew & Tropp, 2006; Stuart, 2016).

The Importance of Considering the Perception of Difference

Although this review makes clear that early intervention is essential, the findings also support that individuals' perceptions of difference, regardless of diagnosis, is a salient factor in the development of self-stigma (Corrigan et al., 2015; Corrigan & Nieweglowski, 2019; Shah et al., 2020). Once individuals start to apply stereotypes to themselves, perception of difference increases and is correlated with the internalization of stigma (as the perception of difference increases, so does stigma; Corrigan & Nieweglowski, 2019). This finding implies that the perception of difference is an essential consideration in reducing public stigma and self-stigma.

This understanding was addressed by Corrigan et al. (2017) when they researched whether continuum messages (e.g., mental illness is on a scale from mild to severe, with most people identifying with some of the characteristics) had a more positive effect on stigma than categorical perspectives (e.g., you either have a mental illness or you do not). Continuum messages had a significantly greater effect on the view that individuals with mental illness are different. They also had significantly greater effects on recovery beliefs (the perception of whether it is within someone's control to recover). This review suggests that recovery beliefs are particularly relevant for individuals with severe mental illness, given the discriminatory belief that they will never recover (Hanisch et al., 2016; Hasan & Musleh, 2017b; Krendl & Freeman, 2019). Thus, the findings support that continuum messages, particularly when paired with contact, could be an effective way to reduce stigma by reducing the perception of difference. This conclusion would stand for both common and severe mental illness. However, it would be particularly salient for severe mental illness, given the potential change in recovery beliefs.

The Importance of Empowerment

The perception of difference is a critical factor in the development of self-stigma in both common and severe mental illness; however, this review suggests that it is the disdain that results from the perception of difference that leads to harm (Corrigan et al., 2015; Shah et al., 2020). Unlike the perception of difference, which became higher as internalization stages progressed, disdain decreased at later stages (Shah et al., 2020). This finding has significant implications for counselling psychology: some individuals are willing to accept that they are different from others, but protect themselves from harm by disregarding the negative stereotypes that lead to disempowerment. This finding implies that perception of difference, without the endorsement of negative stereotypes, can be transformed into empowerment (Shah et al., 2020). For example, a

protest-based activity, such as the Australian program *StigmaWatch*, equips individuals and their families to suppress stigma through the objection and denouncement of discrimination in the media (Stuart, 2016). Programs like this not only have the power to increase empowerment and reduce disdain in individuals with diverse mental illness (Shah et al., 2020), they can also decrease discrimination in the media (Hocking, 2013). Although this program targets media portrayal of mental illness, any protests leading to the empowerment of individuals could decrease the disdain towards oneself experienced by individuals. As previously, the difference in discriminatory beliefs would suggest that individuals would likely benefit from forming groups specific to the discriminatory beliefs.

Implications for Stage Four: Harm

The Importance of Considering Symptom Severity

As discussed, the resulting harm from self-stigma (self-stigma levels, quality of life, barrier to treatment, and barrier to recovery) appears to be similar across populations (Arnaez et al., 2020; Corrigan et al., 2016; Grant et al., 2016; Holubova, Prasko, Matousek, et al., 2016; Holubova, Prasko, Ociskova, et al., 2016; Ociskova et al., 2016). This review supports the conclusion that self-stigma is more dependent on symptom levels than on diagnosis (Grant et al., 2016; Holubova, Prasko, Matousek, et al., 2016; Ociskova et al., 2015; Vrobova et al., 2016). More specifically, the greater the severity of symptoms, regardless of diagnosis, the greater the self-stigma. As such, practitioners must be aware that self-stigma is likely a factor for anyone who is experiencing severe symptoms and could be serving as a barrier to treatment and recovery. Because self-stigma is a strong predictor of recovery for diverse mental illness, practitioners should consider it a key factor in treatment across diverse groups (Prasko et al., 2016). This conclusion is a departure from the assumption by researchers that exposure to stigma

is greater for individuals with severe mental illness (Drapalski et al., 2021). With this said, some differences between diagnoses in the harm stage of self-stigma need to be considered.

The Importance of Taking Into Account the Differences Between Common and Severe Mental Illness

There are several findings from the review that have implications that are specific to those suffering from schizophrenia, depression, and anxiety. These include employment, comorbid disorders, level of insight, and fear of alienation. First, employment is significantly correlated with the level of stigma across diagnoses (Holubova, Prasko, Matousek, et al., 2016). This understanding implies that employment should be a significant consideration in treating self-stigma and diverse mental illness. Programs such as Individual Placement and Support (IPS), developed in the United States, show promise across various settings to lead to competitive employment for individuals experiencing mental illness (Modini et al., 2016). Unemployment rates are much higher for individuals with severe mental illness (Holubova, Prasko, Matousek, et al., 2016); in turn, unemployment should be a greater consideration for practioners that are working with individuals suffering from severe mental illness. Thus, there is a basis for programs, such as IPS, focusing on severe mental illness. However, because this factor is significant, although varied across diagnoses, programs focussing on employment for those struggling with common mental illness should also exist.

Second, comorbid disorders are associated with greater self-stigma (Ociskova et al., 2015). Practitioners should be particularly attuned to self-stigma in individuals with dual diagnoses. More specifically, this review suggests that the treatment of self-stigma should be considered a prominent focus for those suffering from comorbid disorders, such as anxiety and depression. Anxiety and depression often co-occur, and in combination, are associated with poor

treatment outcomes (Choi et al., 2020). Self-stigma, therefore, needs to be a key consideration when treating common mental illness, particularly given the prominence of dual diagnoses with this group.

A third factor that has important implications for a specific group is the finding that self-stigma is associated with a lack of insight into symptoms for individuals struggling with severe mental illness (Fung et al., 2008; Vidovic et al., 2016). Lack of insight is negatively correlated with treatment adherence and leads to poor social functioning, lower quality of life, and low self-esteem (Vidovic et al., 2016). As such, treatment for severe mental illness should focus on increasing insight into symptoms.

The last finding that has implications for a specific diagnostic category is that postponing treatment is more common for disorders such as anxiety and depression (Ociskova et al., 2013). Because self-stigma serves as a barrier to treatment, it should be a particularly important consideration for a group already known for postponing treatment. Moreover, this should be an even greater consideration for those suffering from anxiety disorders: because of a unique fear of disapproval, this group is at an increased risk of avoiding treatment (Ociskova et al., 2013). This realization is particularly relevant because fear of alienation is the most substantial element of self-stigma that serves as a barrier to treatment (Arnaez et al., 2020).

Summary

This review has provided several implications for counselling psychology. The most prominent implication is that self-stigma is a more consequential feature in common mental illness than commonly believed. Other implications focus on the importance of early intervention for both common and severe mental illness, the importance of separating the two groups when designing treatment and anti-stigma campaigns, and the importance of taking into account the

differences between the harm caused by self-stigma in common and severe mental illness when considering self-stigma. These implications and the research considering treatment provide information that can help practitioners in the treatment of common and severe mental illness.

Recommendations for Treatment

Self-stigma should be considered a salient feature of treatment for common and severe mental illness. The evidence discussed in this review also provides a strong basis for several recommendations for practitioners in treating common and severe mental illness. These recommendations include features applicable to individuals across diagnoses and recommendations that are specific to diagnoses.

Recommendations for Diverse Diagnostic Populations

One of the first major implications for clinicians working with diverse diagnoses is to take self-stigma into account early in the process. This implication suggests that providing messages that are strengths-based and counter to discriminatory beliefs early in therapy with both common and severe mental illness is crucial in addressing self-stigma before the why try effect occurs. As evidenced in research surrounding treatment, this involves empowering clients through psychoeducation, reframing, or reauthoring (Yanos et al., 2015). Making sense of their lives and rewriting themselves as active agents appears particularly powerful in promoting empowerment, which has been considered the primary antidote to self-stigma (Yanos et al., 2015). If this is not done early in therapy, clients may internalize self-stigma and have difficulty remaining goal-oriented due to losing hope, self-efficacy, and self-esteem (Corrigan et al., 2019).

Second, once clients become resistant to treatment, practitioners should consider the possibility that self-stigma has become internalized and progressed to the stage of causing harm. As discussed, the more severe the symptoms, regardless of the diagnosis, the more likely that

self-stigma is evident. In this case, research shows that identifying with a group, and promoting a united front against self-stigma, is an important element of finding empowerment and rejecting the stereotypes associated with mental illness (Shah et al., 2020). Thus, clinicians should consider, at this stage, referring clients to group therapy designed to decrease self-stigma before continuing treatment; otherwise, clients may adopt the belief that therapy does not work and increase the why try effect. At the very least, there is evidence that promoting anger against stereotypes, at this stage, could serve as protection against self-stigma (Shah et al., 2020). Because hope is a key factor in the recovery of diverse mental illness (Acharya & Agius, 2017), clinicians must not progress through multiple sessions with no improvement, without addressing the underlying barrier to recovery.

Third, as practitioners, it is important to behave as an ally for clients. This role generally involves someone from an advantaged group offering support and resources to a disadvantaged group (Mizock & Page, 2016). There are several ways to do this. Given the evidence that clinicians sometimes endorse stereotypes, such as perceptions of dangerousness and blame (Kingdon et al., 2004), the first step in this process is to question their own discriminatory beliefs about mental illness. By gaining sensitivity to the issue, clinicians can be better support for their clients and more effective in aiding to erase stigma (Kingdon et al., 2004). Another important factor in this effort is to help people counteract the beliefs associated with stigma without suggesting that the stigma is the fault of the person and something they need to correct (Corrigan & Rao, 2012). It is important to highlight that stigma is an error of society and not the person experiencing it (Corrigan & Rao, 2012). Lastly, it is crucial to take a back seat in correcting mental illness stigma (Corrigan, 2016). It is imperative that mental health professionals do not contribute to the hero/victim narrative by becoming the hero, while the client is seen as a victim

(Mizock & Page, 2016). An important element of empowerment is that the individuals experiencing the discrimination drive the effort to reduce it: it is the voices of these individuals that need to be considered in informing treatment and setting policies, and taking action that affects their lives (Corrigan, 2016). Essentially, the client becomes the hero. However, with this said, practitioners can use their credibility to highlight the stories of recovery and rally others to counter stigma (Corrigan, 2016).

This element of incorporating clients' voices into treatment provides support for treatments like Photovoice Intervention and Coming Out Proud, which encourage activism and provide rich narratives (Russinova et al., 2014). As discussed earlier, Photovoice Intervention has shown promise for diverse groups. At the very least, clinicians could work to incorporate things like photography and descriptive narratives into treatment as a way to confront stereotypes and build healthy coping mechanisms (Russinova et al., 2014).

The importance of individuals with lived experience leading self-stigma change efforts was evidenced in research focused on treatment (Corrigan et al., 2013; Rüsch et al., 2014; Russinova et al., 2014). Many programs, such as ESS, are facilitated by individuals with some lived experience of mental illness (Drapalski et al., 2021; Yanos et al., 2015). These programs show significantly reduced self-stigma and increased empowerment for individuals (Drapalski et al., 2021; Lucksted et al., 2011). Thus, future treatment groups should focus on peer involvement whenever possible.

Recommendations for Specific Groups

There are some important differences regarding self-stigma for common and severe mental illness. These differences are particularly important to consider when implementing

treatment, given that most of the research regarding treatment has focused on treating individuals with severe mental illness.

Severe Mental Illness

The available research suggests that groups focussing on psychoeducation and CBT might be particularly helpful for individuals suffering from severe mental illness (Wood et al., 2016; Yanos et al., 2015). This conclusion may result from the lack of insight individuals struggling with severe mental illness have into their symptoms. As discussed, lack of insight for this group was associated with increased self-stigma and poor social functioning, leading to social isolation (Fung et al., 2008). Thus, psychoeducation about symptoms could be an important element of gaining insight into symptoms.

Another element specific to severe mental illness is the belief that individuals are dangerous, unpredictable, and will never recover. Practitioners need to educate themselves on these beliefs and consider them when working with individuals with severe mental illness. By doing this, therapists can counteract these messages throughout treatment. These particular beliefs also support using peer facilitators, such as those used in groups like ESS. Because individuals might have internalized the belief that they can never recover, having contact with a peer who has recovered and is behaving in an empowered leadership role could be extremely therapeutic. This suggestion implies that if other groups such as NECT, which incorporates psychoeducation, cognitive restructuring, and narrative reauthoring, incorporate peer facilitators, they could be even more effective for individuals with severe mental illness.

Common Mental Illness

There is very little research regarding the treatment of self-stigma in common mental illness. Consequently, one could argue that practitioners are unaware of the prevalence of the

self-stigma experienced by individuals with common mental illnesses. The first and most important step is for clinicians to educate themselves on the discriminatory beliefs and resulting self-stigma frequently experienced by people with common mental illness to use this knowledge to inform treatment. This action would be particularly important when working with individuals experiencing both anxiety and depression, as comorbid disorders are linked to an increase in self-stigma (Ociskova et al., 2015). As discussed, society sees individuals with common mental illnesses as "weak" and who could recover if they were only stronger (Hanlon & Swords, 2020; Kredl & Freeman, 2019). This evidence emphasizes the importance of clinicians highlighting their clients' strengths and reinforcing the idea that dealing with depression, anxiety, or both requires an immense amount of strength with which the average person probably cannot relate. This information also underscores the importance of psychoeducation, focusing on the underlying neurological, biological, and environmental risk factors involved with common mental illness, emphasizing the multiple factors linked with depression and anxiety.

Another factor unique to common mental illness is that individuals are more likely to fear alienation (Arnaez et al., 2020; Ociskova et al., 2013). This factor stresses the importance for clinicians to focus on self-stigma early in the process of treatment, as it serves as the most substantial contributing element of self-stigma that acts as a barrier to treatment. Thus, even before self-stigma is evident, normalizing symptoms and highlighting the prevalence of depression or anxiety is crucial in helping individuals recover. However, as discussed earlier, when individuals show resistance to treatment, which is common in those with anxiety and depression, clinicians should consider assessing for self-stigma and referring clients to a group that focuses on this specifically.

With this said, there are very few groups focussing on self-stigma in these populations exclusively. As described earlier, common mental illness should likely be grouped separately from severe mental illness because of each group's unique discriminatory messages and specific needs. As such, clinicians with knowledge in these areas need to lead the way in designing groups specific to the needs of those experiencing common mental illnesses. There is already evidence to support that groups incorporating psychoeducation, cognitive restructuring, and narrative reauthoring have shown promising results, particularly for depression (Hansson et al., 2017; Roe et al., 2014; Roe et al., 2017). Given the similarities and often comorbidity between anxiety and depression, it would be logical to conclude that these groups could be beneficial for those with anxiety.

Fundamental Next Steps for Research

The current review has highlighted the need for several areas of future research. Perhaps the most fundamental gap in the research exists around the self-stigma experienced by individuals with common mental illness. There is ample research examining the factors involved with self-stigma for those with severe mental illness, and although there is some research looking at factors for common mental illness, there is a definite imbalance. This review would suggest that this imbalance is not warranted.

The majority of the research looking at the difference between self-stigma experienced by individuals with common mental illness versus individuals with severe mental illness focusses on the difference in discriminatory beliefs (Hasan & Musleh, 2017a, 2017b; Krenl & Freeman, 2019). It appears that researchers have assumed that because there are more negative stereotypes for individuals with severe mental illness, they experience greater self-stigma than individuals with common mental illness. Therefore, research and treatment of self-stigma have been aimed

at this vulnerable population. However, as discovered in this review, most research suggests that the stigma levels are similar amongst these populations (Holubova, Prasko, Ociskova, et al., 2016; Kalisova et al., 2018; Kamaradova et al., 2016). This finding is significant but also requires future research. Because a small amount of research shows stigma levels are higher for those with severe mental illness (Oliveira et al., 2016; Switaj et al., 2016), more research examining stigma levels in diverse populations is required to make confident conclusions about stigma levels.

The similarity in stigma levels was reiterated in research looking at quality of life: most research suggests that these two groups have a similar quality of life that is more dependent on stigma and symptom levels than it is on diagnosis (Holubova, Prasko, Matousek, et al., 2016; Holubova, Prasko, Ociskova, et al., 2016). However, given the presence of a small amount of research suggesting that individuals with severe mental illness have a lower quality of life than those with common mental illness (Latlova et al., 2014), more research in this area is necessary and could be illuminating. For instance, because barriers to employment are more significant for those with severe mental illness (Brouwers et al., 2020), further research could examine if this might account for some of the variances. Furthermore, looking at the unique factors involved with particular diagnoses beyond employment, such as isolation, could lead to a better understanding of why these levels are similar. Are the same factors contributing to the similar levels or is it different factors that are unique to each population? This question is important for future research because the specific factors could suggest different implications for intervention and treatment.

Another clear similarity in this review was the fact that self-stigma across groups (common and severe) serves as a obstacle to treatment and recovery (Arnaez et al., 2020; Fung et

al., 2008; Lanin et al., 2016; Ociskova et al., 2013; Oexle et al., 2018; Prasko et al., 2016). A small amount of research showed unique factors for these specific groups that interacted with self-stigma and its effects, such as lack of insight for schizophrenia and fear of alienation for anxiety and depression (Arnaez et al., 2020; Vidovic et al., 2016). However, more research on the factors that interact with self-stigma specific to individual groups could provide important information that could significantly impact how practitioners treat these separate groups. An example of this is how low insight into symptoms increases the likelihood that self-stigma will serve as a barrier to treatment for individuals with schizophrenia. This is evidently not the case for those with depression and anxiety. Understanding more of these factors would further specialize treatment not only for severe mental illness but also for common mental illness, increasing its effectiveness.

In reviewing treatment for self-stigma, it became clear that the research is remarkably unbalanced between diagnostic groups. Researchers have started to focus on social and psychological recovery, rather than symptoms, for individuals with severe mental illness (Ching et al., 2020). Treating self-stigma has become a strong focus in this group, which has been reflected in the research on treating self-stigma (Ivezic et al., 2017; Ku & Hong, 2017; Yanos et al., 2019: Yanos et al., 2012). On the other hand, treatment for anxiety and depression generally focuses on reducing symptoms (Weitz et al., 2018). The information in this review suggests that the same harmful effects are evident in those with common mental illness; thus, future research and treatment must begin to reflect this conclusion. In other words, research on the treatment of self-stigma in those with depression and anxiety is crucial in decreasing the harmful effects associated with this group, such as a lower quality of life and resistance to treatment. Through

research on different types of treatment in this individual population, we can begin to understand the specific nuances of treating self-stigma in this group.

Lastly, an important area of discussion that is not adequately addressed in this review is diversity, including factors such as culture and sexuality. Self-stigma does not occur in a vacuum and is affected by several intercepting variables aside from diagnostic categories (Hinton, 2017; Mackenzie et al., 2019). For the purpose of this review, I intentionally did not include search terms such as *culture, gender,* or *sexuality*, because I was looking at a comparison between two specific groups: common and severe mental illness. This is not to suggest that these factors do not play a role in self-stigma. Research suggests that they in fact do (Hinton, 2017; Mackenzie et al., 2019). For example, different cultures incorporate different values and beliefs that affect stereotypes and discrimination (Hinton, 2017). This was reflected when Yu et al. (2021) conducted a meta-analysis of 108 data sets examining the factors involved with the experience and development of stigma in 22 different cultures. They found that collectivistic cultures have an increased level of self-stigma around mental illness compared to individualistic cultures. Findings like this highlight the importance of future research incorporating diversity when examining factors involved in self-stigma factors with specific diagnoses.

Reflexive Self-Statement

I had several biases before beginning my research for this review. These biases were primarily a result of my personal experience with mental illness: as described, I suffer from anxiety and have a family member that struggles with schizophrenia. My family member's struggle with disempowerment and low self-esteem fueled my research in this area. This personal connection is where I assumed that the majority of my biases existed. However, the greatest surprise for me was in reference to my own experience with anxiety. I would not have

guessed that self-stigma levels for common mental illness were similar to those for severe mental illness. My research challenged this idea, and my insight into my own experiences began to illuminate in a whole new way. For instance, I began to pick things out, such as the discriminatory beliefs that I have experienced and internalized. I was aware that these beliefs existed and that I had at some point agreed with the idea that I am just not as resilient as the average person. I also realized that I was unaware of the effect that this had on me and my recovery. After doing this research, I have gained a new awareness that I had difficulty becoming empowered in my recovery because of low self-esteem and the why try effect. In retrospect, it was reauthoring work with a narrative therapist that led to the empowerment that facilitated my recovery and drove my passion for becoming a psychologist. I now understand that she likely decreased my self-stigma.

Although this was the most significant revelation, several other initial biases were challenged by the research during the research process. First, I viewed self-stigma as an inevitable outcome of someone struggling with severe mental illness. This assumption was challenged because the research showed that expressing anger towards the discriminatory stereotype can mitigate the internalization of stigma. Second, I saw self-stigma as something unlikely to change once internalized. I realized, through my research, that several different types of treatment show efficacy in reducing self-stigma. Third, I believed that not telling others about having a mental illness would reduce self-stigma due to less discriminatory experiences. The research did not support this assumption. It became clear that openly protesting against discrimination and identifying with a group could increase empowerment and decrease self-stigma. Furthermore, the need for secrecy as a result of stigma serves as a barrier to treatment.

The evidence suggesting the importance of being open and finding empowerment through protest, or a treatment like photo-voice, supported one of my initial biases. Beginning the research, I believed that self-stigma is a societal issue. Given that the discriminatory beliefs affect individuals and their behavior, before they even apply the stereotypes to themselves, I continue to believe that the onus for this issue is on society and the discriminatory beliefs that exist. In this way, my initial agenda of wanting to be part of empowering individuals affected by self-stigma continues. However, I have made two specific changes in my thinking as a result of the review. First, I understand the importance of practitioners and researchers taking a backseat in this fight and empowering those experiencing self-stigma to lead the charge. Second, my initial passion did not envelop those with common mental illness the way it does now. I now see that my initial bias that self-stigma is less recognizable in common mental illness was true; however, after this review, I feel that this is unwarranted and likely part of the discriminatory beliefs.

Conclusion

Self-stigma is a serious issue that has serious consequences for individuals struggling with both common and severe mental illness (Arnaez et al., 2020; Holubova, Prasko, Matousek, et al., 2016; Holubova, Prasko, Ociskova, et al., 2016; Lannin et al., 2016; Ociskova et al., 2016; Prasko et al., 2016; Vass et al., 2015; Vrbova et al., 2016). Although the majority of current research is aimed toward severe mental illness, stigma levels are similar amongst groups and are more dependent on the level of symptoms than they are on diagnosis (Grant et al., 2016; Holubova, Prasko, Ociskova, et al., 2016; Ociskova et al., 2015; Vrbova et al., 2016). Self-stigma leads to a similar reduction in quality of life, serves as a barrier to treatment, and reduces treatment efficacy, for both groups (Arnaez et al., 2020; Corrigan et al., 2016; Fung et al., 2008;

Holubova, Prasko, Matousek, et al., 2016; Holubova, Prasko, Ociskova, et al, 2016; Lannin et al., 2016; Ociskova et al., 2013; Ociskova et al., 2016). Consequently, the treatment of stigma should be an important consideration for both groups, and current research on treatment should extend to diverse populations and examine the similarities and differences between groups.

The similarities and differences discovered in this review have important implications for treatment. First, the path, regardless of diagnosis, that leads to self-stigma is similar: internalizing discriminatory beliefs, perceiving oneself as different, and experiencing disdain towards oneself, leading to a decrease in self-esteem and the why try effect (behavioral futility; Corrigan et al., 2016; Gopfert et al., 2019; Kalisova et al., 2018; Lannin et al., 2016). Although this leads to significant harm for some individuals, others counteract feeling disdain towards themselves by becoming empowered against the stereotype (Shah et al., 2020). Thus, early treatment is key in becoming empowered against the stereotypes early in the process. Treatments like photo-voice, COP, and NECT, regardless of the diagnosis, show promise in empowering individuals before self-stigma leads to significant harm (Corrigan et al., 2013; Russinova et al., 2014; Yanos et al., 2015).

Second, the discriminatory narratives that lead to self-stigma are significantly different between diagnoses. While society views individuals with common mental illness as weak but able to recover, they view those with severe mental illness as dangerous and unable to recover (Curcio & Corboy, 2020; Hanlon & Swords, 2020; Krendl & Freeman, 2019; Latalova et al., 2014; Reavley & Pilkington, 2014). Consequently, common and severe mental illness need to be separated when considering treatment for individuals or anti-stigma campaigns and protests. This separation will allow for a specific counteracting narrative, depending on the discriminatory belief.

Third, while insight into symptoms serves as a barrier to treatment and treatment efficacy for those with severe mental illness, fear of alienation serves as a barrier for treatment for those with common mental illness (Arnaez et al., 2020; Fung et al., 2008; Ociskova et al., 2013; Vidovic et al., 2016). Future research must focus on discovering more unique factors that work as an intermediary between self-stigma and treatment. Even with the minimal current research there are things that practitioners can alter, such as normalizing symptoms for those with depression and anxiety to help them become less afraid of alienation (Bersani & Delle, 2021).

Lastly, although there is limited information on the treatment of self-stigma for common mental illness, the research suggests that psychoeducation groups may be more helpful for severe mental illness, likely a result of the benefit of gaining insight into symptoms and becoming aware that recovery is possible (Drapalski et al., 2021). Early research suggests that treatment involving psychoeducation, cognitive restructuring, narrative reprocessing, or empowerment would likely benefit those with common mental illness (Corrigan et al., 2013; Hansson et al., 2017; Roe et al., 2014; Roe et al., 2017; Yanos et al., 2015; Young et al., 2020).

In conclusion, discrimination takes effect early in the process of self-stigma (Corrigan et al., 2016; Gopfert et al., 2019). Consequently, it is important to remember that the onus of these discriminatory beliefs is on society, and we must continue to engage in anti-stigma campaigns that will reduce these beliefs and attitudes (Stuart, 2016; Thornicroft et al., 2014). This review shows that contact between individuals with mental illness and other members of society is an important part of this process (Stuart, 2016; Thornicroft et al., 2014). Having a voice and maintaining a united front against discriminatory beliefs is an important part of empowering individuals regardless of their diagnosis (Shah et al., 2020). Practitioners can support clients on

this journey by taking a back seat and helping clients become empowered to lead this fight against stigma and informing future policy.

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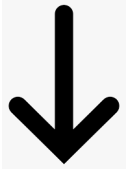
Appendix

Stages in Developing Self-Stigma: Similarities and Differences for Common and Severe Mental Illness

Stage One: Stereotypes and Discriminatory Beliefs (Corrigan & Rao, 2012)

Based on two dimensions: Controllability and Social Desirability (Krendl & Freeman, 2019).

Severe Mental Illness	Common Mental Illness
• Perceived as "dangerous and unpredictable" (Hasan & Musleh, 2017a; Krendl & Freeman, 2019). • Dangerous stereotype is more pronounced for males (Reavley & Jorm, 2011b). • Stereotypes are more negative compared to common mental illness (Hasan & Musleh, 2017a; Yoshioka et al., 2016). • Perceived to have less control over symptoms and unlikely to recover (Krendl & Freeman, 2019). • Perceived as less socially desirable than common mental illness, and experience greater ostracization (Krendl & Freeman, 2019).	• Perceived as "weak" (Hanlon & Swords, 2020). • Association of weakness is particularly difficult for males as a result of gender roles (Latalova et al., 2014). • Perceived to have greater control over symptoms and able to recover if only they were psychologically stronger (Hasan & Musleh, 2017b; Krendl & Freeman, 2019). • Depression perceived as more controllable than anxiety (Krendl & Freeman, 2019).



Stage Two and Three: Agree and Apply (Corrigan & Rao, 2012)

Severe Mental Illness	Common Mental Illness
Agree: "People that have schizophrenia are dangerous and never recover."	Agree: "People with anxiety and depression are weak."
Apply: "I am dangerous and will never recover."	Apply: "I am weak."
(Corrigan & Rao, 2012; Krendl & Freeman, 2019)	(Corrigan & Rao, 2012; Hanlon & Swords, 2020)

- Progression through these stages is similar for both groups, aside from the discriminatory narratives (Corrigan et al., 2016).

Decrease in Self-Esteem:

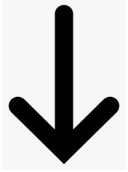
- One of the first consequences of agreeance with stereotype is a decrease in self-esteem and diminished self-respect (Corrigan et al., 2016; Corrigan et al., 2018).
- Decrease in self esteem leads to decrease in confidence and ability to behave competently (Corrigan et al., 2016; Corrigan et al., 2018; Gopfert et al., 2019).

Perceive Difference:

- Once individuals agree with the stereotype, they begin to perceive themselves as different (Corrigan & Nieweglowski, 2019).
- This perception of difference is associated with the internalization of stigma (Corrigan et al., 2015; Shah et al., 2020).
- Perception of difference increases as individuals proceed from agreeance to application and then harm (Corrigan & Nieweglowski, 2019).

Disdain Towards Self:

- Feeling different can lead to disdain towards oneself (Shah et al., 2020).
- Some individuals build resiliency to disdain by gaining empowerment. These individuals are less likely to progress to the harm stage regardless of diagnosis (Corrigan et al., 2015).
- Disdain leads to behavioral futility, also known as the "why try effect" (Corrigan et al., 2016).



Stage Four: Harm (Corrigan & Rao, 2012)

Severe Mental Illness	Common Mental Illness
"Because I'm dangerous and will never recover, I may as well give up and not even try."	"Because I am weak, I will never be able to pull it together and may as well give up."
(Corrigan & Rao, 2012; Krendl & Freeman, 2019)	(Corrigan & Rao, 2012; Hanlon & Swords; 2020)

Stigma Levels:

- Similar across groups (common and severe; Holubova, Prasko, Ociskova, et al., 2016; Kalisova et al., 2018; Kamradova et al., 2016).
- More dependent on severity of symptoms and employment regardless of diagnosis (Grant et al., 2016; Holubova, Prasko, Motousek, et al., 2016; Vrobova et al., 2016).
- Lack of employment leads to less social inclusion and greater alienation across groups (both factors highly associated with stigma levels; Arnaez et al., 2020).
- Unemployment rate is higher for severe mental illness (Brouwers et al., 2020).
- Comorbid disorders associated with greater stigma levels (Ociskova et al., 2015).

Quality of Life:

- Similar quality of life across groups (Holubova, Prasko, Ociskova, et al., 2016; Holubova, Prasko, Matousek, et al., 2016).
- Self-stigma is negatively correlated with quality of life regardless of diagnosis (Chen et al., 2016; Holubova, Prasko, Ociskova et al., 2016; Holubova, Prasko, Matousek, et al., 2016; Ociskova et al., 2018).
- Employment status is highly correlated with quality of life across groups (Holubova, Prasko, Matousek, et al., 2016).

Barrier to Treatment:

- Self-stigma serves as significant barrier to treatment across diverse groups (Arnaez et al., 2020; Fung et al., 2008; Ociskova et al., 2013).
- Self-stigma is negatively correlated with decision to seek help across groups (Clement, 2015).
- Postponing treatment is more common for depression and anxiety due to a greater fear of alienation (Ociskova et al., 2013).
- Postponing treatment is correlated with low level of insight into symptoms for those with severe mental illness (Vidovic et al., 2016).

Barrier to Recovery:

- Effectiveness of treatment decreases as self-stigma increases regardless of diagnosis (Ockiskova et al., 2016).
- Self-stigma was found to be the greatest predictor of recovery across groups (Prasko et al., 2016; Vass et al., 2015).
- Self-stigma is a greater barrier to recovery for those with comorbid disorders (Ociskova et al., 2016).