Introduction

When I first started writing about mental illness fifteen years ago, mental health issues were something one didn't normally talk about. Mental health was not a subject on many people's radars, and experience with mental illness symptoms and suicidality were usually something one tried to hide from others. At that time, the moral imperative seemed to me to be to raise mental health awareness. As a sufferer of many mental illnesses over the years, including major depression, generalized anxiety disorder, eating disorders, bipolar disorder (with depressive, manic, and mixed episodes), and (more recently) schizoaffective disorder, I thought it was my duty to try to raise awareness of mental health issues to get people to talk about them publicly. As a professor, I shared my own experiences with my students when relevant in classes; I organized some mental health awareness events on my campus; and I wrote about my experiences in various venues. It seemed that talking about mental health problems was key to addressing them.

Fifteen years later, the landscape has changed. Mental health is on everyone's radar. People commonly talk about mental illness and mental health and well-being. Campuses regularly host mental illness awareness events, and students commonly share about their own experiences with their professors. Mental health crisis and suicide hotlines have proliferated, and more and more resources are directed toward making therapy and medication more available to more people. People are talking about mental health and mental illness. Nonetheless, rates of mental illness and despair have increased,[1] and mental illness stigma endures. Talking about the problem did not solve it.

[1] The rate of anxiety in the United States increased from 15.6 percent of adults in 2019 to 18.2 percent in 2022. During this same time frame, the rate of depression increased from 18.5 percent of adults to 21.4 percent. Rates of anxiety and depression were highest among those aged eighteen to twenty-nine, more elevated in women than in men, greater in those with only a high school education, and higher in those with low socioeconomic status (US Centers for Disease Control and Prevention 2024).

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While people are more aware of mental illness stigma than ever before, stigma still proliferates. One might think that the fact that mental health problems are so common, that people are talking about mental health and mental illness, and that more and more people are open about having mental illness should lead to a decrease in mental illness stigma. If so many people have mental health problems, having mental illness should not be ostracizing. If so many people are aware of the presence and dangers of stigmatization, they should be able to avoid stigmatizing others and themselves. Being more aware of mental disorders and symptoms should decrease stigma and challenge stereotypes about mental illness. It should be easier for people suffering from mental health problems to feel acceptance toward themselves, find support, and address their problems. Yet it is not. Despite the commonality of mental health problems, the increased awareness of mental health and illness, and the extensive resources directed toward addressing mental health problems, mental illness is still ostracizing, and mental illness stigma, negative stereotypes, prejudice, and discrimination continue to circulate within the culture.

There are two primary places where stigma persists. One is in the context of severe mental illness, like schizophrenia and bipolar disorder, especially where mental illness and homelessness intersect.[2] People who have severe mental illness that prevents them from living and working within the community, who as a result lack a home and/or a job, are commonly feared and shunned, and socially outcasted from the community. Negative stereotypes of individuals who are homeless and have mental illness abound. These include stereotypes that they are incompetent; that they are needy and dependent on others; that they are dangerous and violent; that they have an illness that is incurable and progressively worsens over time; and that they are defective human beings who have something intrinsically wrong with them. Such stereotypes are reinforced when individuals are also men and/or Black. People who have severe mental illness are typically the object of fear, avoidance, blame, shame, and disgust.

Even when people with mental illness are not homeless, they are still often the targets of negative stereotypes, prejudice, and discrimination in many areas of their lives. The more severe their illness is perceived to be, or the more blameworthy they are seen as being, the more stigma they receive.

[2] Over one-fifth (20 percent) of the population of chronically homeless people have a severe mental illness such as schizophrenia, bipolar disorder, or major depression, while about 16 percent have a substance abuse disorder (Saldua 2023).

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At one time it was thought that reconceptualizing mental illness as a brain disease would decrease stigma, because it seems to shift blame for the condition away from the person, but in fact it has only increased it (Corrigan and Watson 2004; Glannon 2008; Read et al. 2006; Thachuk 2011). The view that mental illness is a brain disease suggests to many that people who have mental illness are inherently different from others, defective, unable to change or get better, and blameworthy or at least worthy of shame for having something intrinsically wrong with them (Gergel 2014; Haslam and Kvaale 2015).[3] However, the contrary psychosocial conception of mental illness as a result of trauma, family dynamics, or inadequate coping skills can be just as damaging. When mental illness is seen in this way, people are typically regarded as having a character flaw, as defective, as incompetent, as being weak or weak willed, or as immoral (Gergel 2014). Both dominant conceptions of mental illness are highly stigmatizing because they both suggest associated traits that are thought of as extremely negative.

Public stigma – stigma directed toward people with mental illness by others – persists in many places. People with mental illness experience stigma in the workforce, in housing, in healthcare settings, in educational environments, in their families, among friends, and in society at large. While many people in society are more understanding and empathetic of mental illness than ever before, in part because mental illness and mental health and well-being are talked about so much now, many other people are still stigmatizing. Sometimes this is due to a lack of knowledge about mental illness and what the lives of people who have mental illness are like; or due to a shortage of empathy and understanding; or due to the internalization and endorsement of dominant American ideals of independence, self-sufficiency, and personal responsibility that mental illness seems to violate. Whatever the cause, public stigma continues to exist despite higher rates of mental illness occurrence and despite the fact that we talk about mental illness and mental health and well-being more than ever.

The other area where stigma stubbornly persists is in the internalization of mental illness stigma by people who have mental illness themselves. People internalize mental illness stigma either when they endorse negative

[3] Haslam and Kvaale note that the brain disease model triggers essentialist thinking in which those with mental illness are thought to be radically different from others in an essentialist way that is not changeable, so that people with mental illness are seen as not being able to control their condition and cannot recover from their illness. This leads to attitudes of fear, blame, and rejection toward those with mental illness (Haslam and Kvaale 2015).

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stereotypes and prejudice as applying to themselves or when their thoughts, feelings, and behavior are shaped by stigma. Such internalization occurs even when no one is actually stigmatizing the person. A person with mental illness can fear being judged on account of their illness even when no judgment actually occurs. The very worry about being judged is enough to give stigma a life of its own that infiltrates a person's consciousness and changes how they think, feel, and interact with others.

Negative stereotypes about mental illness circulate within a culture even when no one actively endorses those stereotypes. The cultural and historical contexts of mental illness stigma give stigma a power that commonality of mental disorder occurrence, awareness of mental health and mental illness, awareness of mental illness stigma, and resources directed toward treating and destigmatizing mental illness cannot erode. People are inescapably aware of mental illness stigma and its associated stereotypes and are constantly worried about being judged in relation to them. Even when no actual people hold stigmas against a person with mental illness or apply stereotypes to them, the mere fact that such stigma and stereotypes are a possibility – the mere fact that one could possibly be judged in relation to them – is enough to give this stigma and its associated stereotypes power over a person.

In twenty-first-century American culture, fear of being judged by others is common. Social media has made people, especially young people, more self-conscious than ever. This self-consciousness – awareness of how one is perceived by others – feeds a constant worry that one will be judged by others. Young people are especially prone to being anxious about other people's judgment of them, but even older people have adopted this self-consciousness about how they come across to others. Worries about other people judging oneself lead a person to be more aware of the existence of negative stereotypes that could possibly be applied to them, and more worried that such stereotypes will be applied to them. When people have mental illness, they are aware of the negative stereotypes of mental illness that circulate within a culture, and anxious about how those stereotypes can be applied to them when others perceive and judge them.

This book analyzes the process of stigmatization, both public and internalized, in the twenty-first century in Western culture, especially in the United States. Stigma is as pervasive as ever, despite greater awareness than ever of mental illness and associated stigma, and despite greater resources directed toward treating and destigmatizing mental illness. Ever since the COVID-19 pandemic in 2020–21, significant attention has been paid to mental health, yet young people and old alike are more prone

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to having mental health issues than ever before. The pandemic caused significant isolation and loneliness; fed unhealthy behaviors, ruminating thoughts, and dysregulated emotions; created obstacles to self-care; and caused a crisis of self-consciousness where young people especially fear being judged negatively by others. At the same time, more public attention has been paid to mental health issues in recent years, including the creation of the 988 emergency mental health crisis hotline in the United States, and more resources have been directed toward treating, understanding, and destigmatizing mental health problems. Nonetheless, such problems – and the stigma accompanying them, especially the internalized stigma that people project onto themselves – persist.

In addition, in the 2020s, homelessness has reached epidemic proportions in cities and towns across the United States (and the Western world), with unsightly encampments littering the landscape. While homelessness has many different root causes, mental illness and substance abuse are two significant factors in many people's experiences of homelessness. Mental illness stigma intersects with homelessness stigma and unemployment stigma to cause significant prejudice, shunning, avoidance, and discrimination of the people subject to these interlocking stigmas. People who are part of other minority groups, such as Black men, encounter even more public stigma due to their multiple social identities. This book assesses some of the reasons why both public stigma and internalized stigma endure in the twenty-first century, showing how negative stereotypes about mental illness are pervasive in American and Western culture regardless of many people's active disavowal of them.

Stigma and Social Norms

Mental illness stigma marks people with mental illness as bad and inferior for failing to live up to social norms that are endemic to life in the twenty-first century in a democratic, capitalist society. The American ideal of the independent, self-sufficient, rational, and autonomous person lives on throughout Western culture. This person is a rational chooser who can set goals for themselves and work toward achieving these goals through their own hard work.[4] They are self-directed, can get their own needs met,

[4] This conception of the self as a self-determined rational chooser comes from liberalism (rooted in Thomas Hobbes's and John Locke's philosophies) and more recently neoliberalism (rooted in Friedrich Hayek's economic theory) (Dean 2008, 48–49). The self-determined rational chooser is situated within a neoliberal economic framework that prioritizes privatization and commodification of goods, services, and institutions; privatization of responsibility and care; the values of freedom,

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and are successful at achieving the ends they set for themselves.[5] This makes them strong, independent, and self-sufficient. They are in control of their actions, as well as their thoughts and emotions, able to self-regulate both emotions and behavior, and able to think through reasons and evidence to develop rational beliefs. As a consequence of their choices, they are personally responsible for their actions and experiences.[6] They are sane in that their perceptions of reality match the perceptions of others. They are rational in that they can calculate costs and benefits to do a reasoned analysis of what action to take; they can think through and account for consequences of different actions; they can reason from premises to conclusions; and they can weigh and account for reasons and evidence in forming and revising their beliefs. While the ideal of the rational agent may be shifting with a more nuanced understanding of human differences, those who are viewed as *less* rational and having *less* agency compared to others are still heavily denigrated.

Moreover, the ideal person is a source of safety and stability, enabling the safety of both themselves and others and stable in disposition and behavior so that they are seen as reliable and trustworthy. They are a provider to others and contribute to society through productive and efficient action. This ideal of agency and personhood emerges from Western liberal thought stemming from the Enlightenment but has morphed to support the needs of a capitalist society in the twenty-first century. This ideal is also strongly associated with an ideal of masculinity, in contrast to a feminine ideal that would support a more relational and interdependent self. The economically rational, autonomous, sane, self-controlled, self-regulated, self-directed, self-sufficient, independent, strong, safe, and stable person who is able to get their own needs met and who is responsible for their own actions is the ideal of what a human being in the Western world in the twenty-first century should be.

This conception of the self is an idealized notion in the sense that choice, control, self-regulation, self-direction, independence, self-sufficiency, action, and responsibility are viewed as ideas abstracted away from particulars, without regard to the real-world constraints on these that people

choice, and competition; and faith in the marketplace as the domain where choices and actions are made (Braedley and Luxton 2010).

[5] This ideal of the self as a self-determined end-setter is rooted in Immanuel Kant's theory of rational autonomy as that which makes humans distinctly *human* (Kant 1993).

[6] Thomas Lemke describes this responsibilization in terms of a neoliberal conception of the self as personally responsible for its care, esteem, worth, actions, and choice rather than these being a product of social forces where society carries some social responsibility for the outcomes of these (Lemke 2001; see also Harper and Speed 2012, 13–14).

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actually face in their life experience (O'Neill 1993, 309; O'Neill 1987). These idealized conceptions of aspects of the self typify what Charles Mills calls an idealized model in ideal theory, where the ideal constitutes a moral exemplar that is seen as representing the social world without reference to real-world constraints that complicate these aspects of the self (Mills 2018; Mills 2005). Idealized models in ideal theory contrast with descriptive models of morality and politics that attempt to describe the world as it *is*, rather than as it *should be*, in relation to real-world constraints. Idealized models of the self consist of abstractions that ignore and preclude the particularities and complications of people's life experience, including limited capabilities; an intricate social environment and complicated social relationships; experiences of oppression, domination, and other injustices; real-world obligations and duties of care to others; role responsibilities; and other constraints on the expression of the self. This book on mental illness stigma philosophizes from the way stigma actually operates in the world rather than from ideal theory.

Mental illness appears to violate the social norms described above in many ways. These norm violations constitute the many negative stereotypes associated with mental illness. Such stereotypes include the view that people with mental illness are crazy, out of control, irrational, immoral, and irresponsible; that they lack sufficient agency and autonomy to be fully human; that they are damaged, weak, and unable to accomplish ends they set for themselves; that they are incompetent; that they are needy and dependent on others; that they are dangerous and violent; that they have an inherent defect; and that their illness is incurable, permanent, and worsens progressively over time. These all mark a person as bad and inferior, and lesser compared to others. They violate the social norms of what a human being should be in the Western world in the twenty-first century. When people internalize these norms, they adopt stigma against those who violate the norms, whether that is projected onto other people or onto themselves.

Stigma and the Main Themes of This Book

The first major theory of stigma comes from Erving Goffman in his seminal work *Stigma* (1963). He defines stigma as the discrediting and devaluing of a person on account of having a trait that is deemed negative to have. Stigma is a taint on a person's identity that creates a failing, a shortcoming, or a handicap on a person's social identity. Goffman identifies three areas where people may be stigmatized: their bodies (what are perceived as "physical deformities"), their character (such as

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having a weak will, excessive emotion, or lack of self-control), and their "tribe" – their race, nation, or religion (Goffman 1963, 3–4). Goffman locates mental illness stigma as a stigma of weak or defective character, but in our contemporary biomedical model of mental illness we might also understand mental illness as a stigma of the body. In twenty-first-century Western culture, mental illness as stigmatized can be seen as a blemish on both the body and the mind/character.

Traits such as race, gender, class, sexual orientation, ability status, mental health status, citizenship, and agency status can all be stigmatizing in certain contexts, where some identity characteristics are less valued and less credible than others. Discrediting someone involves thinking of them as having less credibility, authority, and legitimacy as a member of a community, as an autonomous agent, and even as a human being. When a person discredits another based on having a socially undesirable trait, they judge the trait to be bad and apply this judgment to the person who seems to have the trait. Devaluing a person involves seeing them as marked by badness and consequently viewing them as lesser compared to other people, having less moral standing, being less of an agent, being less of a person, or even being less than human. Stigma can therefore be understood as marking a person as both discreditable and bad (devalued) on account of possessing the stigmatized trait.

Stigma is relational; the discrediting and devaluation of people who share a certain social trait occurs as a result of viewing some people as abnormal for having the trait in relation to other people who do not have that trait and who are thus seen as normal. When normalcy is defined in part by the absence of a certain trait, the presence of that trait makes a person appear abnormal; abnormality is thus defined in relation to normalcy and involves making a normative judgment about what constitutes normalcy versus deviance. While an abnormality could be viewed as a mere difference, not inherently bad, in the context of stigma abnormality is always seen as bad. Stigma marks a person as abnormal, where the abnormality is seen as a bad thing, and thus bad to have, in relation to those who lack the stigmatized trait, who are viewed as normal and thus good.

As Goffman points out, stigmatized traits always have the *potential* to be discrediting and devaluing, and are thus *discreditable and devaluable*, making a person vulnerable to being judged negatively on account of having or seeming to have the trait (Goffman 1963, 4; Liamputtong and Rice 2022, 116–117). When people have a stigmatized trait that is not easily visible to others, they are discreditable without necessarily being

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discredited. Stigmatized traits are also *discrediting and devaluing*, where a person is in fact discredited and devalued when the trait is visible to others or at least appears to be present. In such a case, a person is not simply *vulnerable* to being judged by others; they *are* judged by others. The visible presence or seeming presence of a stigmatized trait invites judgment, making judgment inevitable and unavoidable.

A person does not have to possess the stigmatized trait in order to be judged; it is sufficient if they are *believed* to have the stigmatized trait, whether or not they in fact do. Judging a person as having a stigmatized trait occurs whenever the person making the judgment *believes* the person being judged has the trait or could possibly have the trait. Seeming to have a stigmatized trait or being vulnerable to being seen as having a stigmatized trait is sufficient for a person to be judged and stigmatized.

Notably, people who are or may be stigmatized hold the same beliefs about normalcy and stigma that others do. When they live in a culture that stigmatizes a certain trait, they often learn to stigmatize that trait themselves, even if they also happen to possess the trait. Goffman notes that when they are aware that they have the trait, this can result in shame and a fissure of identity (Goffman 1963, 7). The person can experience a split between what they want for themselves – to be normal – and what their self is actually like – having a seeming abnormality. This split between who they in fact are and who they want to be can cause significant problems with self-concept, self-regard, self-worth, and agency. The application of stigma to oneself can be understood as self-stigma, which is a form of internalizing stigma that I discuss below.

When a person is not aware that they have the trait, or when they do not self-identify as having the trait, they may feel distance from the trait and deny that it applies to them. Since they have internalized the stigma associated with the trait, viewing the trait as a bad thing to have, they are motivated to want to distance themselves from the trait so that it cannot be seen as applying to them. In the context of mental illness, this often involves the person denying that they have a mental illness so that the stigma associated with mental illness will not be seen as applying to them. People can go to great lengths trying to prove that they lack the stigmatized trait and engage in all kinds of rationalizations to explain away behaviors that might indicate a trait like mental illness. Stigma provides a strong motivation to deny having a stigmatized trait like mental illness.

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Stigma and Power

Stigma exists in the context of power. Different components of stigma occur in the context of social, political, economic, and epistemic power relations where people who *do* the actions associated with stigma have more power of various kinds than people who are stigmatized against (Link and Phelan 2001, 375; Hipes 2016, 5). Not only does power make stigma possible but stigma also reinforces power. Stigmatizing individuals is a way of disempowering them, which perpetuates status quo relationships of power, sustaining the power and privilege of those who do the stigmatizing. Stigma thus constructs, reinforces, and reifies power relations.

Power is the ability to affect outcomes. Social power involves affecting the outcomes of other people, while political power affects the outcomes of communities, and economic power affects economic outcomes. Epistemic power is the power to affect knowledge transmission and creation and systems of meaning-making. The act of stigmatizing others reinforces and strengthens the ability of people who are not stigmatized to affect outcomes in these different contexts. This includes outcomes that bear on what those who are stigmatized can do and know, as well as how they can interact with others, what roles they can play within a community and culture, and what material and economic resources they have access to.

One way that stigma affects power relations is through the generation and perpetuation of various kinds of injustices. One form of injustice people who are stigmatized experience is epistemic injustice. Stigma undermines the ability of stigmatized people to participate in epistemic activities, including creating and transmitting knowledge, giving testimony, asking questions, sharing ideas, developing theories, and meaning-making. When a person is stigmatized, they experience what Miranda Fricker calls an identity-prejudicial credibility deficit, which is a lack of credibility afforded to people who have a social identity that is denigrated due to negative stereotypes and stigma (Fricker 2007, 30–41). This prevents them from being regarded as equal participants in epistemic practices, leading to participatory epistemic injustice, where they are viewed as insufficiently competent to make worthwhile epistemic contributions (Hookway 2010). It also leads to the testimonial injustice related to the informational perspective, where their testimony is not taken seriously and given uptake by others (Fricker 2007, 9–29; Hookway 2010). In addition, it creates hermeneutical injustice, where a person is prevented from having the hermeneutical resources to make sense of their experience (Fricker 2007, 147–174). People who are stigmatized against experience a myriad of

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epistemic injustices that diminish their epistemic power and their ability to participate as equals in epistemic practices.

Stigma also affects power relations in the contexts of distributive injustice and structural injustice. The discrimination that stems from stigma causes distributive injustice by preventing stigmatized people from having access to the same resources and opportunities that others have access to or that they would have access to if they were not discriminated against (Moreau 2020, 124–151; Segev 2014). This makes it so that stigmatized people often cannot get their basic needs met or meet a minimum threshold for basic functioning, violating standards of distributive justice.[7] Discrimination also creates structural injustice, where social structures are organized in a way that disproportionately burdens people who are stigmatized and puts them in a position of unfair subordination to others (Moreau 2020, 39–75; Young 2011, 43–74). Iris Marion Young notes that people experience structural injustice when they are socially situated in ways such that the confluence of individuals' and institutions' actions creates structural constraints on what they can do so that they have more obstacles that they have to overcome (Young 2011, 43–74). Stigma generates distributive and structural injustices that diminish access to resources and opportunities and restrict agency and autonomy.

Power relations benefit those who have more power in relation to others and marginalize those who have less. A person does not need to engage personally in stigmatizing acts and attitudes in order to benefit from the existence of stigma. Not being stigmatized against – being seen as normal – is sufficient for a person to benefit from the existence of stigma. Stigma reinforces the power and privilege of all people who are not objects of stigma, regardless of whether they participate in stigma, because of the way it normalizes who they are and what behavior they engage in while subjugating others.

The act of being stigmatized reduces the ability for people who are the objects of stigma to affect what people, including themselves, can do, have, and know. Thus, stigma reduces their myriad forms of power. Insofar as stigmatized people are already marginalized, stigma reinforces that marginalization, perpetuating their lessened status, lack of privilege, and decreased social, political, economic, and epistemic power. Stigma keeps the people who are objects of stigma oppressed, marginalized, and subjugated while enhancing the power of those who are seen as normal.[8]

[7] For example, John Rawls argues that primary goods that meet people's basic needs are necessary for people to have equal opportunity in a liberal society (Rawls 1971, 90–95).

[8] In addition, power affects the extent to which a person stigmatizes others. Because they have less power in society, women tend to be less stigmatizing of others than men are (Hipes 2016, 12–13).

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Stigma and the Self

In addition to creating various injustices for people who are stigmatized, stigma also causes another significant harm in the ways that it shapes people's sense of self and personal identity, and the agency and autonomy that correspond to these. Stereotypes reduce people to the social trait that is stereotyped, such as mental illness, and to the stereotyped characteristic associated with the social trait, such as incompetence, dependence, or dangerousness. This erases people's particular identities and erodes the nuance and complexity of their experience.

Stereotypes cause what Elizabeth Anderson calls an "expressive harm" of shaping the mental states and behavior of both those who can be stereotyped and those who can subject others to stereotypes (Anderson 2010, 44–66). Stereotypes circulate within a culture regardless of whether individuals endorse or apply them, giving them a pervasive and persistent power of influencing people's thoughts, feelings, and behavior. Both people who can be stereotyped and those who are in a position in which they can subject people to stereotypes are obligated to acknowledge the existence of stereotypes and the ways that they color social interactions.

Moreover, stereotypes reinforce what Natalie Stoljar calls "oppressive social scripts" that determine how a person's past behavior is perceived and create expectations for how a person will act in the future (Stoljar 2015). These scripts attribute mental states and behavior to a person based on dominant conceptions of what a person who has the stereotyped trait must be like. As a result, this defines how a person's identity and agency are perceived by others, and, when internalized, forms a person's own self-concept and self-understanding of their agency and identity.

Kinds of Stigma

Theorists make several distinctions among different kinds of stigma. Public or social stigma is stigma that others apply to a person who has or seems to have a culturally devalued trait, while self-stigma is stigma that a person internalizes and applies to themselves (Conklin 2021, 17; Corrigan and Kleinlein 2005, 16–17; Thornicroft et al. 2022, 1442–1443). People project public stigma onto others when they believe or act on negative stereotypes (sometimes without endorsing them) about the people whom they are stigmatizing. Public stigma causes prejudice, where people adopt negative attitudes and have negative emotions directed at those whom they stigmatize; discrimination, where people treat some groups of people in different,

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unequal, and worse ways compared to others; microaggressions, where people speak and behave in subtly prejudicial ways that nonetheless cause harm; and epistemic injustice, where people treat others as less credible and as having less epistemic agency.

While individuals who are vulnerable to stereotyping are commonly victims of public stigma, prejudice, microaggressions, discrimination, and epistemic injustice, they can also stigmatize themselves by internalizing stigma. One form of internalizing stigma is self-stigma, where individuals believe that negative stereotypes about people who have a culturally devalued and undesirable trait are true and they apply those stereotypes to themselves (Corrigan and Nieweglowski 2021, 417; Veroniki et al. 2010; Thornicroft et al. 2022, 1442). When people have self-stigma, they judge themselves poorly on account of having the stigmatized trait, and this often leads to alienation, negative attitudes and emotions toward oneself, depression and anxiety, social withdrawal, and even suicidality.

Another distinction that is often made is between experienced stigma and discrimination, and anticipated stigma and discrimination (Farrelly et al. 2014; Fox and Earnshaw 2023; Thornicroft 2009). Experienced stigma or discrimination is stigma or discrimination that a person actually experiences, where they have had an experience in the past of being stigmatized or discriminated against by others. Experienced stigma and discrimination are tightly connected to public stigma, where the type of stigma or discrimination they experience is imposed on them by others, or by the public. Public stigma, or the process of others stigmatizing a person, necessarily leads to experienced stigma, where the person experiences the stigma imposed on them by others.

Anticipated stigma or discrimination is stigma or discrimination that a person believes they will experience in the future, where they expect that others will stigmatize or discriminate against them if or when others know about the person having the devalued trait. Stigma and discrimination are often anticipated when a person has had experiences of being stigmatized or discriminated against, where they expect to experience more of the same. However, it can also arise absent any actual experience of stigma or discrimination, particularly when a person internalizes stigma and is self-conscious about stigma being applied to themselves by others. Anticipated stigma can persist even when no actual public stigma exists because of the perniciousness of the internalization of stigma and people's self-consciousness about being judged by others.

People internalize stigma when they accept or are resigned to the idea that stigma can be applied to them. In the literature on stigma, theorists

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sometimes use "internalized stigma" and "self-stigma" interchangeably (e.g., Beltzer 2020; Fox and Earnshaw 2023), but they are actually distinct. A person can internalize stigma through at least two mechanisms. One of these mechanisms includes self-stigma, or endorsing negative stereotypes that a person applies to themselves, while the other involves seeing oneself through the eyes of others and seeing how others may apply stigma to oneself because of the way one is viewed by others. When stigma is internalized, a person sees it as applying to themselves, but this application can occur either through their own judgment of themselves or through seeing how others may judge them and either accepting or being resigned to that presumed judgment. In this way, a person can internalize stigma even when they do not believe the negative stereotypes it is based on are true and even when they do not have negative feelings (prejudice) toward themselves. They simply maintain an awareness that they may be judged, where that awareness influences their thoughts, feelings, and actions.

This latter form of internalized stigma is closely related to anticipated stigma. When a person is aware that they may be judged according to negative stereotypes, they may form expectations that others will indeed judge them in the future. In this way, they may anticipate being stigmatized against. However, the two terms are separable. A person can be aware of the possibility of being judged without necessarily *expecting* others to do so. To distinguish these two ways of internalizing stigma, I will call the application of stereotypes and prejudice to oneself "self-stigma" and refer to the acceptance or resignation that others may apply stereotypes and prejudice to oneself, where this awareness informs their mental states and behavior, as "attendant stigma," in that the person has no choice but to pay attention to the fact that they have the potential to be judged and stigmatized by others. For both kinds of internalized stigma, the stigma is integrated into and guides one's thoughts, feelings, actions, and even identity.

All of these forms of stigma – including experienced/public stigma and discrimination, anticipated stigma and discrimination, and internalized stigma – cause a multitude of harms and problems for people, including people who are stigmatized on account of having mental illness. Experienced/public stigma and discrimination are associated with decreased housing stability and increased homelessness, less access to opportunities such as education and resources such as loans, more challenges with recovery, low quality of life, and reduced community functioning (Beltzer 2020, 679; Mejia-Lancheros et al. 2021). Internalized stigma often decreases hope, self-esteem, empowerment, and quality of

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life. In addition, internalized stigma can result in negative attitudes about treatment, less willingness to seek treatment, and decreased treatment adherence. This impairs a person's ability to receive effective treatment, helps perpetuate symptoms, and thus reinforces public stigma. Anticipated stigma can lead to internalized stigma and causes psychological distress and negative physical health (Beltzer 2020, 679). It also often causes individuals to self-limit activities, reducing their options and creating barriers to participation, thus limiting agency and autonomy. Many of these harms are explored in this book.

Components of Stigma

Bruce G. Link and Jo C. Phelan identify several components of stigma: labeling, stereotyping, separation (or moral distancing), status loss (including dehumanization), and discrimination (Link and Phelan 2001, 367). I would add three additional components to this list: prejudice, which is the affective response one has to people who are labeled as different and viewed as inferior because of that difference; microaggressions, which are the subtle speech and behavior perpetrators commit that cause harm to those who are targeted; and epistemic injustice, which is the injustice of not being taken seriously as a knower. Many of these components of stigma apply to internalized stigma as well, where people self-label, apply stereotypes to themselves, feel morally distanced from others, view themselves as lesser (often resulting in lowered self-worth), and self-limit what activities and relationships they feel they have a right to participate in or be part of. Here we will look at these components of stigma more closely in the context of public stigma, where others stigmatize an individual for having a culturally undesirable social trait. In Chapter 1, I examine these components of stigma both in the specific context of mental illness and in the context of internalized stigma.

Labeling and Stereotyping

Stigma begins with labeling, when people identify and label differences between various groups of people, noticing and naming different traits that groups of people share (Link and Phelan 2001, 367–368). These differences are understood in a cultural context that views certain traits as undesirable, leading to the adoption of negative stereotypes of people who have these traits and the application of these stereotypes to specific individuals. Because stereotypes circulate within a culture independently of individuals' endorsement of them, labeling someone as a member of a social group that

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shares a culturally undesirable social trait (such as having mental illness) automatically invokes negative stereotypes. When people are seen as being a member of a group that shares a culturally undesirable social trait, they make automatic associations between that social trait and cultural generalizations that are made about people who have that trait, and apply those associations to specific individuals who have that trait in the process of stereotyping. Labeling and stereotyping are thus inherently linked.

Theorists writing on stereotype content identify two dimensions that are typical in the content of stereotypes: warmth and competence. Warmth has to do with a person's sociability, friendliness, good-naturedness, trustworthiness, sincerity, and morality, while competence involves a person's capability, assertiveness, agency, intelligence, skill, efficacy, independence, confidence, achievement, prestige, and competitiveness (Boysen 2017, 100; Canton, Hedley, and Spoor 2023, 481; Fiske 2018, 67; Follmer and Jones 2017, 493).[9] People who are seen as "normal" and as fitting the various social norms described above – such as those with adequate rational agency; and those who are American, middle class, and/or White – are regarded as having both high competence and high warmth (Fiske 2018, 68). This marks them as normal and acceptable, and attitudes toward them are usually warm, welcoming, respectful, and even worthy of admiration.

Many stereotypes emphasize one dimension as high and the other as low, giving rise to mixed emotional reactions that value and denigrate people at the same time. When people are viewed as having high warmth and low competence – such as the elderly, the disabled, young children, and certain ethnic groups like Mexicans, Latinos, and Africans – they are typically pitied and sympathized with, leading to paternalistic expressions and actions. When people are viewed as having low warmth and high competence – such as rich people and business people, and certain ethnic groups like Asians, Germans, and Jews – they are often regarded with respect and envy, but also distrust, resentment, and even fear (Cuddy, Fiske, and Glick 2002; Fiske 2018, 68). Fear results because lack of warmth is sometimes tied to a perception of dangerousness (Sadler, Meagor, and

[9] Note that competence is defined here in a broad way as encompassing various attributes of capability, agency, and effectiveness. This is different from how competence is defined in legal contexts in relation to people with mental illness, where the term refers to decision-making capacity (Buchanan and Brock 1989, 18; Halpern 2001, 103). In general terms, competence refers to the ability to be successful at tasks (Edwards 2010, 275–276). In the context of stereotyping people with mental illness, competence refers to how a person functions in various life domains, including social interactions, social relationships, work, school, civic life, and leisure activities. In this book, I use the term competence to refer to general functioning in daily life activities, except where discussing the stereotype content model.

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Kaye 2012, 916). People who are seen as having both low warmth and low competence – such as homeless individuals, drug addicts, refugees, and undocumented immigrants – are regarded as the lowest of the low, leading to attitudes of disgust and contempt (Fiske 2018, 68). People with mental illness can fit any of these categories depending on what mental illness they have or are seen to have and depending on what other social identities they have and how the stigma associated with these intersects with mental illness stigma.

Prejudice

Prejudice, sometimes used synonymously with the term "bias," is a negative attitude toward people who share a certain group membership that is viewed unfavorably because of negative preconceived notions about members of that group (Allport 1958, 8). It can also be understood as thinking poorly of certain people based on their group membership without warrant, or without having a morally justifiable reason (Allport 1958, 7; Hehman and Neel 2024, 1237; Katsekas and Lemay 1996, 2). Prejudice can be operationalized through two judgments people make, based on what they think of the group they are judging (the "out-group") and how this compares to what they think of the social group that they themselves belong to (the "in-group") (Hehman and Neel 2024, 1237; Allport 1958).

Prejudice is primarily affective, involving emotions, reactive attitudes, and unconscious/automatic associations (Corrigan and Kleinlein 2005, 16–17). Some of the emotions prejudice invokes are fear, anger, disgust, and contempt. Prejudice is also manifested through bodily expressions such as verbal tone, word choice, body comportment, gestures, and body language. How people are socialized, what family values they grow up with, what religious beliefs they hold, what political affiliations they align themselves with, and what educational experiences they have all influence what prejudices people have (Katsekas and Lemay 1996, 3).

People form prejudice as a result of judging others as inferior. This judgment of inferiority leads people to develop automatic negative associations of those who share the stigmatized trait associated with the social group that one is prejudiced against, causing negative emotions like fear, anger, disgust, and contempt, and negative reactive attitudes like blaming and shaming. Prejudice contributes to behavioral responses of shunning and avoiding people who have the undesirable trait and treating them differently and negatively compared to other people, creating

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discrimination. Prejudice is the affective aspect of stigma that links the cognitive aspect of stereotyping and the evaluative aspect of judging people with the behavioral aspect of discrimination and microaggressions.

While prejudice can be knowingly held and endorsed, it is often held unconsciously and unknowingly through implicit bias. Implicit bias is a negative attitude that a person holds toward those who share a socially undesirable and negatively stereotyped social trait, usually held unconsciously and unreflectively (Holroyd 2012; Holroyd, Scaife, and Stafford 2017; Levy 2017). Despite being outside the person's awareness, implicit bias colors how a person feels and thinks about, and interacts with, those against whom they are biased. As a result, they hold negative affective reactions to the person – in other words, prejudice – including negative emotions like fear, anger, disgust, and contempt, and negative reactive attitudes like shaming and blaming. This affects their behavior toward the person so that they are more avoidant of, judgmental of, aggressive toward, or punishing toward the person, or have other negative action tendencies toward the individual. Prejudice and implicit bias influence people's perceptions of others so strongly that some philosophers are skeptical that we can ever have accurate understanding of those against whom we hold biases, or that we can ever avoid epistemic and other injustices toward those against whom we are biased (Pasnau 2022; Saul 2013).

Moral Distancing and Outcasting/Social Exclusion

People who have culturally undesirable traits and are labeled based on these traits are viewed as separate and fundamentally different from those who do not have these traits, creating a separation of "us" versus "them" (Link and Phelan 2001, 368–370). This creates moral distance between those who do not possess a culturally undesirable trait and those who do. This moral distancing often serves to "other" the people who are seen as different, so that they are viewed as abnormal or having a problem or defect on account of that difference. Separation and moral distancing are often self-reinforcing, as "other"-ing people who appear different from oneself can reify one's own status as being unlike "them" so that one's own status is taken to be "normal" and correct while "theirs" is taken to be abnormal and wrong. The more that people are seen as different from others, the more distant they seem to be from what is taken to be "normal."

Separation or moral distancing often results in outcasting and social exclusion. Outcasting a person involves seeing them as someone who does not belong to the community and rejecting them and their ability to

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participate in social, moral, and epistemic practices of the community. Social exclusion often arises through shunning and avoidance by others. It can also occur when the person with the culturally undesirable trait outcasts themselves in anticipation of being outcasted by others and withdraws socially from the community. Outcasting and social exclusion can diminish agency and autonomy, create loneliness and stress, cause or exacerbate mental disorder symptoms, and decrease quality of life.

Status Loss and Dehumanization

Regarding some people's differences as abnormalities and marking them as bad for having these perceived abnormalities grants these individuals a loss of status, where they are seen as inferior to others in various ways (Link and Phelan 2001, 370–371). Some of the ways people can be seen as inferior to others include being perceived as less capable, less resourced, less resourceful, less intelligent, less rational, less of an autonomous agent, less moral, less having a unique identity, and even less than human. Having a diminished status can seem to others to justify trying to avoid interacting with those who have lesser status, resulting in social exclusion, or to justify different, worse, and unfair treatment of those with lesser status, resulting in microaggressions, discrimination, and epistemic injustices.

Status loss often results in dehumanization, which is the degradation of a person's humanity. Dehumanization can be understood broadly as a setback of significant human interests (Mikkola 2016, 145 and 164) or more narrowly as treating a person as subhuman, such as by comparing them to a monster, animal, machine, or trickster.[10] The less warmth and competence a person is perceived to have, the more they are dehumanized (Fiske 2018, 69; Kuljian and Hohman 2023). Warmth and competence both correspond with having characteristically human qualities such as rationality, self-control, agency, autonomy, compassion, benevolence, morality, unique identity, and personhood.

In the context of mental illness stigma, it is sufficient to understand dehumanization as treating people with mental illness as subhuman. Here

[10] David Livingstone Smith describes dehumanization as thinking of someone as subhuman by comparing them to a monster or animal (Smith 2016; Smith 2014). In the social psychology literature, dehumanization is distinguished between animalistic dehumanization, which denies a person as having uniquely human characteristics such as having civility, morality, and sophisticated thinking, comparing them to animals that act on instinctive impulses; and mechanistic dehumanization, which views a person as cold, rigid, inert, and lacking agency, comparing them to inanimate objects, machines, and automatic robots (Haslam 2006; Kuljian and Hohman 2023). The idea that humans can be tricksters as another way of being perceived as subhuman is my own.

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they are viewed as being lesser than other people on account of seeming to have less competence, rationality, sanity, self-control, agency, autonomy, morality, unique identity, and personhood compared to others due to their mental illness. People with mental illness are commonly subject to dehumanization due to the perception that they lack various characteristically human abilities and attributes such as these (Boysen, Chicosky, and Delmore 2023; Boysen et al. 2020). Being viewed as deficient in these ways can make a person seem more like a monster, an animal, a machine, or a trickster, rather than a human being. These ways of viewing a person as subhuman can seem (in some people's eyes) to justify worse and unfair treatment, including microaggressions, social exclusion, discrimination, and epistemic injustice, as a result.

Microaggressions

Microaggressions are subtle displays of stigma through speech or behavior that demeans a person in a way that often does not get noticed by perpetrators or bystanders. Microaggressions are a form of behavioral discrimination constituting speech or behavior that treats someone differently from and worse than others. Types of microaggressions include microassaults (speech or behavior that is conscious and intended to cause harm), microinsults (speech or behavior that demeans a person's marginalized identity in a subtle way that often goes unnoticed), and microinvalidation (speech or behavior that discounts or dismisses a person's thoughts, feelings, and experience) (Sue et al. 2008, 330–331; Sue et al. 2007, 274). The invisibility of microaggressions is part of what perpetuates them, as perpetrators are often well-intended people who do not recognize that they are acting in unconscious ways that cause harm (Fleras 2016, 9–10; Sue et al. 2007, 275). This can cause people to adopt a defensive attitude when they are called out on their microaggressions (Friedlaender 2018, 13) and contribute to what Jean Harvey calls "civilized oppression," or daily acts of oppression that are subtle and often unconscious yet persist over time as they perpetuate status quo power relations (Harvey 2007, 31–33).

While perpetrators often do not realize they are committing microaggressions (particularly microinsults or microinvalidation), those who are targeted by microaggressions are often all too aware of their presence and their power to harm. Some of the harms they create include feelings of powerlessness, feelings of invisibility, forced compliance and loss of integrity, and pressure to represent one's group (Sue, Capodilupo, and Holder 2008, 333–334). They both perpetuate larger structural inequities (Friedlaender 2018, 7–8) and

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promote "everyday suffering" (Fleras 2016, 9). Microaggressions create cumulative harm, where a single discrete act may not make much of a difference, but being subject to microaggressive behavior over time has a significant impact (Friedlaender 2018). Sometimes perpetrators of microaggressions believe that people who are targeted are overreacting to their single, discrete action because they are unaware of the systemic and sustained effects of multiple microaggressions committed over time.

Because of their invisibility, and because perpetrators of microaggressions often deny that they are committing these actions, those who are targeted by microaggressions sometimes question themselves, wondering if they really experienced what they thought they experienced. In this way, they second-guess and doubt themselves (Sue et al. 2007, 279). This self-doubt further diminishes their power and status, as the perspective of perpetrators who deny they did anything wrong gets privileged over the perspective of those who are targeted, who second-guess what they thought they experienced (Fleras 2016, 3). Through this, microaggressions reinforce existing power relationships that privilege those who act in ways that harm already marginalized people who are subject to both conscious and unconscious stigma.

Discrimination and Injustice

Moral distancing, status loss, and prejudice often result in discrimination, where people who have the culturally devalued trait and who are labeled as different and lesser than others are treated not only differently and unequally compared to others but also negatively (Link and Phelan 2001, 372–373). Discrimination is different, worse, and unfair treatment of certain groups of people based on their possessing a culturally devalued trait. This treatment can be understood in many different ways. Discrimination can involve treating certain groups of people in ways that make them worse off than they would be without that treatment (Lippert-Rassmussen 2014a). It can be seen as a distributive injustice in which certain groups of people receive an unfair distribution of resources and opportunities (Segev 2014) or as a distributive injustice in which certain groups of people receive insufficient basic goods to be able to be equal participants in society (Moreau 2020, 124–151). Discrimination can also be seen as a violation of dignity in which certain groups of people are demeaned (Hellman 2008, 6). It can be viewed as a structural injustice involving unfair subordination (Moreau 2020, 39–75). And it can be regarded as a loss of deliberative freedom (Moreau 2020, 77–119) or as an impingement of autonomy.

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Discrimination is itself an injustice, but it is also deeply connected to other types of injustice, especially distributive and structural injustices. Discrimination often results in material, economic harms of allocating access to resources and opportunities in unequal and unfair ways. This breaches standards of distributive justice. Discrimination also tends to involve subjugating some people to the power and authority of other people, based on how they are socially situated within unjust social structures that benefit some people at the expense of burdening others. This violates standards of structural justice.

Distributive justice demands that all people have at least a certain threshold of necessary goods where their basic needs are met and they have the goods necessary to be able to achieve the outcomes of a just society. In a welfarist conception of justice, this means having a sufficient amount of goods to be able to satisfy one's reasonable preferences and live lives of equal desirability (Arneson 1989; Dworkin 1981a). In a liberal conception of justice, this means having enough resources to overcome handicaps and risks to live a life of one's choosing based on one's own conception of the good (Dworkin 1981b). This involves having sufficient primary goods to be able to have equal opportunities to hold various social positions and offices in a Rawlsian conception of justice (Rawls 1971, 90–95) or to be able to inhabit various social roles (Reader 2007, 55). In a needs-based theory of justice, this requires having the array of basic goods necessary to have agency and autonomy (Brock 2005; Copp 1992), or to be able to have one's human rights fulfilled (Kelly 2004). There are a multitude of ways distributive justice can be understood, but all involve having fair outcomes, where people have access to the goods they require to live minimally decent and ideally worthwhile lives (Pogge 2008, 43–44).

Distributive injustice is the injustice a person faces when resources, opportunities, and support are distributed among people in an unfair way that makes certain people unable to access an adequate amount of these goods sufficient to meet their needs. With distributive injustice, people are unable to get their basic needs met and unable to achieve the demands of justice, whether that be preference satisfaction; living a life of equal desirability; living a life based on one's own conception of the good; having the opportunity to hold social roles, positions, and offices; having agency and autonomy; or having one's human rights fulfilled. This denies people the ability to live a worthwhile or even minimally decent life.

Discrimination also often involves structural injustice in which social structures unfairly and disproportionately put more constraints on the actions of certain groups of people than others. This unfairly subordinates

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people who are more burdened by social structures to those who benefit from these structures and treats those who benefit from structures as having more moral worth than those who are burdened by them. When social structures harm some while benefitting others in systematic ways based on how people are socially situated within the relevant social structures, this violates the moral principle that structural benefits and burdens should be distributed fairly, treating all people equally, so that all people have sufficient options for action.

Structural injustice is the injustice a person experiences as constraints on their agency due to the way social structures operate. While distributive justice concerns having just outcomes, structural justice involves the justness of the social structures and processes that lead to these outcomes. Social structures consist of the way individuals, institutions, and systems are positioned in relation to each other in society to enable and constrain the actions of individual and institutional agents in different ways. As Iris Marion Young notes, individual and institutional agents occupy various social-structural positions that give them different ranges of opportunities and limitations on their action (Young 2011, 45). People experience structural injustices when they are positioned in ways that subject them to systematic burdens and harms based on how they are situated socially, while other people are positioned in ways that allow them to experience systematic benefits (Young 2011, 52). People who are vulnerable to various social inequities and harms, including those with mental illness, are subject to more systematic burdens as they face more limitations and experience more constraints on their action due to how they are socially situated. Systemic discrimination sets limitations on vulnerable people's actions, in part by preventing them from having access to the basic goods they need to function in society, so they have less agency.

In addition to putting more limitations and obstacles on some people's actions compared to others', unjust social structures unfairly subordinate some groups of people to others based on a perception that the subordinated group has less moral worth than nonsubordinated groups (Moreau 2020, 124–151). This unfair subordination results in those groups with perceived greater moral worth having power and authority over those groups with perceived lesser moral worth. This power and authority allows them to create systems within social structures that benefit them, and that encourage those with less power and authority to collude in them, thinking these systems benefit them as well, even though they do not. Discrimination maintains status quo power relations and can lead those who are discriminated against

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to feel resigned to their lot in life, believing that their situation is inevitable or even good for them.

The negative treatment that people who are discriminated against typically experience consists of denying or preventing them from being able to access resources and opportunities that others are able to access, or that they would be able to access if they were not treated in this way. Employment, housing, education, and healthcare are some of the resources and opportunities that are available to many but that certain people may be denied on account of their having or being seen to have a culturally undesirable trait that is the basis for discrimination. Discrimination can occur in many different areas of a person's life and can lead to social outcasting and shunning, decreased capabilities, diminished agency and autonomy, and poorer quality of life.

Epistemic Injustice

People who are stigmatized against experience various forms of injustice, including the distributive and structural injustices that stem from discrimination. A distinct form of injustice that stigmatized people face is epistemic injustice, or injustices in their capacity as a knower. Epistemic injustice stems from and is related to all of the other components of stigma, including labeling, stereotyping, prejudice, moral distancing, social exclusion, status loss, dehumanization, microaggressions, and discrimination. As already noted, the two primary forms of epistemic injustice, originally identified by Miranda Fricker, are testimonial injustice and hermeneutical injustice (Fricker 2007). In testimonial injustice, a person's testimony is not taken seriously due to prejudice against their social identity, while in hermeneutical injustice, a person is denied the hermeneutical resources that allow them to make sense of their experience, again due to prejudice against their social identity.

Epistemic injustice can be transactional, institutional, or structural. Transactional epistemic injustice occurs when individual agents interact with each other in ways that prevent certain groups of people from being seen as equal participants in epistemic practices. Institutional epistemic injustice consists of institutions preventing certain groups of people from being able to participate in epistemic activities through policies and practices that preclude them from being recognized as credible epistemic participants.[11]

[11] Elizabeth Anderson notes that social institutions can be epistemically unjust (Anderson 2012). She conflates institutional epistemic injustice with structural epistemic injustice, but these can be distinguished from each other.

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Structural epistemic injustice exists when social structures unfairly and disproportionately burden some groups of people by putting unintentional yet systematic epistemic constraints on their epistemic behavior. People who are stigmatized against can experience epistemic injustices at all of these levels.

As we see, stigma involves several mental and behavioral processes (McCullock and Scrivano 2023). Marking people as different, labeling them, and forming stereotypes about people based on traits that they share are cognitive processes. Judging people for being different and assessing them as inferior are evaluative processes. Prejudice against people who share the stigmatized trait, where one has negative associations, emotions, and reactive attitudes toward stigmatized people, is an affective process. Treating stigmatized people as different, in unequal and negative ways, and thereby discriminating against them or committing microaggressions against them, is a behavioral process. Other behavioral processes involve subjecting people to distributive, structural, and epistemic injustices. These different components of stigma connect with each other to create an experience of devaluing a person on account of them having a culturally undesirable trait such as having mental illness. In Chapter 1, I examine what these components of stigma look like specifically for people who have mental illness.

The Contours of This Book

The general aim of this book is to examine what mental illness stigma consists of, and to develop an account of what makes it harmful and thus wrongful, as well as to use this account of resultant harms to make a positive proposal of how mental illness stigma can and should be addressed. In making this analysis, the book explores several aspects of mental illness stigma, including the process of stereotyping, the expressive harm of stereotypes, the role of social norms embedded within stereotypes in creating adaptive preferences and shaping behavior, the moral distancing and status loss involved with social exclusion and dehumanization, and the harm of discrimination. The book shows how mental illness stigma creates a variety of harms for those who are stigmatized against, in part because it has a cultural power that persists despite more attention and resources than ever being directed toward mental illness treatment and destigmatization. As a result, addressing stigma requires lessening its cultural power and changing the social norms that mental illness is perceived as violating.

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The main argument in this book is that mental illness stigma has lasting power to control the thoughts, feelings, behavior, and social interactions of people in ways that gravely harm those who are stigmatized; as a result, it is paramount that mental illness stigma be challenged. I start by analyzing what stigma is, drawing on two leading models of stigma, and argue that both public stigma (stigma that is imposed on people with mental illness by others) and internalized stigma (stigma that is projected by the person with mental illness onto themselves) are pervasive in a mental illness context. The book is organized around several aspects of mental illness stigma that it focuses on: the process of stereotyping and the kinds of judgments made while stereotyping; the way stereotypes cause harm to self and identity (primarily through internalizing oppressive social scripts and stereotype threat); the role of social norms embedded within stereotypes in creating adaptive preferences that unduly restrict options and damage self-concept; threats to the relational self, including the moral distancing and status loss involved with social exclusion and dehumanization, and the precariousness of identity and autonomous agency involved with belonging uncertainty; the diminishment of epistemic credibility and agency; and the various material and agential/identity harms and distributive and structural injustices that result from discrimination. Public stigma creates some of these harms, while internalized stigma causes others (and some harms result from both).

I situate my project in relation to the philosophical literature on stereotyping, prejudice, discrimination, dehumanization, relational autonomy, and adaptive preferences, drawing on many philosophical concepts and theories in these areas to develop my own account of mental illness stigma. I also engage with the social psychology and sociology research on the experience and perpetuation of mental illness stigma. With this engagement, I aim to offer a robust philosophical account of what mental illness stigma consists of, how it harms people who are stigmatized against, and how it can and ought to be challenged.

Scope

The scope of this book covers people who have or who are regarded as having mental illness in twenty-first-century Western culture, and the general public who interact with them. The book analyzes the process of stigmatization in the twenty-first century in Western culture, especially but not exclusively in the United States. It looks at how people who have or are seen as having mental illness are viewed and treated by others and how

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stigma colors this perception and treatment. The book also examines how people who have mental illness regard and behave toward themselves, and the role that internalized stigma plays in that treatment. Social norms of twenty-first-century Western culture greatly affect how people with mental illness or who are presumed to have mental illness are seen and treated, and cultural stereotypes that persist even as cultural attitudes have changed influence how the public interacts with people with mental illness. This book examines the social norms, cultural trends, and persisting stereotypes that affect the treatment of people with mental illness in twenty-first-century Western culture.

Methodology

This book proceeds through analytical argumentation to offer a framework for understanding stigma, particularly mental illness stigma, and for accounting for the harms that stigma causes to people who have mental illness, as well as to develop a positive proposal for how stigma can and should be challenged. Philosophical theories of stigma, stereotyping, dehumanization, discrimination, autonomy, and adaptive preferences are explained and examined in the process of putting forth an account of mental illness stigma. While the book mainly engages with philosophical literature related to stigma and its harms, it also reviews psychology and sociology research on mental illness stigma to give empirical information about how stigma is experienced and perpetuated. The book is written in a clear analytical style that explains terminology and theory in an accessible way. The chief project of the book is to analyze stigma, assess its harms, and provide a positive proposal for what can be done to reduce stigma.

Chapter Outline

The book proceeds as follows. Chapter 1 starts by analyzing the components of mental illness stigma to show how people with mental illness experience stigma in their daily lives. Drawing from Link and Phelan's model of stigma (Link and Phelan 2001, 367) and Corrigan and Kleinlein's model of stigma (Corrigan and Kleinlein 2005, 16–17), I develop my own account of the components of mental illness stigma. These include labeling, stereotyping, prejudice, moral distancing, social exclusion, status loss, dehumanization, microaggressions, discrimination, and epistemic injustice. Using stigma theory and empirical evidence from the social psychology literature, I show how these components of stigma manifest in (public)

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mental illness stigma and in internalized stigma. The chapter proceeds with an overview of the social psychology literature that demonstrates some of the factors that impact mental illness stigma, including beliefs, political values, cultural values, socioeconomic status, education, and gender. The chapter concludes with an examination of how many people experience compounding stigmas when they are subject to other kinds of stigma besides mental illness stigma.

Chapter 2 assesses what stereotypes are and explains what makes them both wrongful and harmful. The chapter begins by defining stereotypes, explaining their relationship to prejudice and implicit bias, and showing how they are maintained due to cognitive biases. Three sorts of judgments are made in the process of stereotyping, including a judgment about whether a stereotype is true or not, a judgment about whether a person conforms to the stereotype, and a judgment about whether a person is good or bad for fitting the stereotype; various factors go into making these judgments. What makes stereotypes wrongful is their rigidity, their frequent falsity, and the way they overgeneralize about a person's experience so as to erase its nuance and complexity. The chapter ends by looking at descriptive and normative components of stereotypes and showing that negative stereotypes always make a normative judgment about the badness and inferiority of a person who fits the stereotype.

Chapter 3 analyzes some of the ways that stereotypes harm people's sense of self and identity. One way is through what Elizabeth Anderson calls "expressive harm," which is the harm that results from the unwitting and inevitable perpetuation of stereotypes regardless of whether people endorse these stereotypes (Anderson 2010, 44–66). When someone interacts with a person who has a stereotyped social trait, the negative stereotype associated with that trait always hovers in the atmosphere and controls people's thoughts, feelings, behavior, and social interactions, even when people actively disavow the stereotype. Other ways that stereotypes harm people's sense of self and identity are through the internalization of what Natalie Stoljar calls "oppressive social scripts" (Stoljar 2015) and through the phenomenon of stereotype threat. In addition, expressive harm, internalization of oppressive social scripts, and stereotype threat all diminish a person's autonomy. Through these mechanisms, people with mental illness incorporate negative stereotypes into aspects of their experience and identity in harmful ways.

Chapter 4 shows how internalized stigma often results in adaptive preferences that harm a person. When people incorporate aspects of negative stereotypes into their identity, they sometimes develop adaptive preferences by internalizing harmful social norms and beliefs embedded within these

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stereotypes. I show how people with mental illness often develop goals and desires that are shaped by these beliefs and social norms, which limits what they believe they are capable of, thus reducing their options for action and truncating their agency and autonomy. While adapting desires to one's circumstances can be positive, as in positive adaptation, it is negative when it is harmful to a person. The adaptive preferences that result from this can be seen as rationality deficits that are oppressive and nonautonomous and that damage well-being and flourishing. Internalizing harmful social norms that are nested within negative stereotypes unduly restricts a person's life in a way that inhibits their flourishing and prevents them from exercising full autonomous agency.

Chapter 5 assesses harms that people with mental illness experience which are related to how their self is constituted, in particular harms of social exclusion and dehumanization that result from status loss and moral distancing. Having a sense of belonging and being accepted as an equal member of a moral/epistemic/social community are important parts of being viewed as (and viewing oneself as) a full human being; these are also critical for developing and exercising autonomous agency as well as for well-being and flourishing. People with mental illness are often excluded from these communities as a result of public stigma, shunning, avoidance, social exclusion, microaggressions, and discrimination. Through the process of stigmatization, they are often marked as bad and inferior and viewed as lesser compared to others, which dehumanizes them. This chapter shows how a sense of belonging and being accepted as an equal member of a community is essential for the expression of the relational self, as well as for being an autonomous agent, and how the status loss and moral distancing of both public stigma and internalized stigma threaten these. Both outright social rejection and belonging uncertainty are examined in this context.

Chapter 6 examines what makes moral and behavioral discrimination (expressions of public stigma) wrongful. Discrimination, as I am using the concept, involves differential treatment where some people are treated in different, unequal, and worse ways compared to others, and where that differential treatment is based on possessing a socially undesirable trait that marks a person as bad and inferior. Discrimination is wrongful because it harms people in a variety of ways, impacting their circumstances, resources and opportunities, options, agency, autonomy, and well-being. Discrimination causes material disadvantage, and it constitutes a distributive injustice that denies people access to resources and opportunities others have access to, for no morally salient reason (a comparative distributive injustice), as well as a distributive injustice

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that prevents people from having the basic goods necessary for equal participation in society (a baseline distributive injustice). It also demeans a person by degrading them; it unfairly subordinates a person through social structures that disregard their needs and interests; and it causes agential harms, including a loss of deliberative freedom and decreased autonomy. This chapter reviews the philosophical literature on discrimination to provide a pluralistic account of the many harms discrimination causes to people with mental illness, which altogether make discrimination wrongful.

After several chapters explaining the harms and wrongfulness caused by stigmatization of mental illness, including both public stigma and internalized stigma, Chapter 7 looks at various sorts of interventions that can be implemented to address stigma. These include individual actions that the person who is stigmatized can engage in to help them cope with or resist stigma, and actions that other people are obligated to perform in order to decrease stigma they may endorse or perpetuate unwittingly. These also include structural changes that social institutions and systems must undergo to make social structures less stigmatizing and more supportive of people with mental illness, and social and cultural interventions that increase the belongingness and acceptance of people with mental illness into the community as well as transform social norms to be more supportive of people with mental illness. In addition to using philosophical argumentation, this chapter draws on empirical literature in social psychology that examines what works to reduce and resist stigma.

Mental illness stigma is pervasive despite great strides we have made toward increasing awareness of mental health problems and the stigma that has always accompanied them. In examining what mental illness stigma consists of and how it is harmful to those who are stigmatized against, this book explores why it is so widespread and how it can be addressed. Although deeply rooted within our culture, mental illness stigma can be resisted and challenged. But first we need to understand it. To do that, let us turn to Chapter 1.

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