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**Experienced and Anticipated Stigma among People with Mental Illness when Interacting
with Healthcare Workers**

A Thesis Presented in Partial Fulfillment of the Requirements for the Degree of
Master of Arts in Forensic Psychology
John Jay College of Criminal Justice

Shaindel Feuer

June 2023

Experienced and Anticipated Stigma among People with Mental Illness when Interacting with Healthcare Workers

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This Thesis has been presented to and accepted by the Office of Graduate Studies, John Jay College of Criminal Justice in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Forensic Psychology

Thesis Committee

Thesis Advisor: Philip T. Yanos, PhD

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Abstract

Research has found that most people have negative attitudes towards those with mental illnesses, and the resulting stigma and discrimination can be dangerous. Unfortunately, mental health stigma and discrimination are also seen in healthcare providers, with potentially fatal consequences, given that people with mental illnesses have shorter lifespans and are more likely to become ill than members of the general population. This study explored anticipatory and experienced mental health stigma from the patient's perspective in a sample of 275 people with self-reported mental illness recruited from the online panel Prolific. Between 30.3% (Everyday Discrimination Scale) and 44.1% (Stigma Scale) of participants reported substantial levels of stigma from healthcare providers. Results also found that over forty percent of participants avoid healthcare providers on some level out of fear of stigma. Findings have important implications for improving the health of people diagnosed with mental illnesses.

Experiences of Stigma and Anticipated Stigma among People with Mental Illness when Interacting with Healthcare Workers

Stigma is defined as negative attitudes or beliefs held by some in society about a group of people who differ in some way from the general population. These beliefs may in turn lead to behavioral expressions, including social distance and discrimination. Stigma against those with mental illnesses appears to be widespread and manifests itself in many forms. Some examples include microaggressions, discrimination, hate speech, legal discrimination, hate crimes, and media bias (Yanos, 2018). Despite the anti-stigma work that has been done, research shows that stigma against those with serious mental illnesses has actually increased in the United States (Yanos et al., 2020). A study by Pescosolido and colleagues (Pescosolido et al., 2019), looking at a sample that was nationally representative of the United States population, found that roughly 70% of people believed those who met diagnostic criteria for schizophrenia were dangerous, despite research showing the contrary. Stigma also persists in other countries. Crisp and colleagues (2018) assessed mental health stigma towards people with depression, panic attacks, schizophrenia, dementia, eating disorders, alcohol addiction, and drug addiction in the general British population. Seventy percent of respondents believed that people with schizophrenia or substance use disorders were dangerous and 80% believed they were unpredictable. Over 50% of respondents thought people with depression, panic attacks, schizophrenia, dementia, alcohol addiction, and drug addiction were hard to talk to and over 20% of respondents believed that those with these conditions could never recover.

People suffering from mental illnesses often experience stigma at the hands of healthcare providers (Riffel, 2020). According to the Substance Abuse and Mental Health Services Administration (2022), 22.8% of Americans suffer from a mental illness, and 5.5% suffer from a

serious mental illness, defined as a mental illness that “results in serious functional impairment” (p. A-30). A survey done by the Mental Health Foundation found that 44% of people who have a mental illness say they have been dismissed, ignored, or discriminated against by a doctor (Chadda, 2000). This is particularly concerning given that people with mental illness are disproportionately likely to experience physical health issues.

Health Issues Among People with Mental Illness

Poor physical health is common among people with mental illnesses, and mental health stigma was found to be a contributing factor (Lawrence et al, 2010). Patients with severe mental illnesses have shorter life expectancies compared to the general population, living on average 13 to 30 years less, and these shortened lifespans are most commonly caused by physical illness (De Hert, 2011).

Roshanaei-Moghaddam and Katon (2009) reviewed the existing literature on premature deaths in people with bipolar spectrum disorders due to medical illness. They found that the mortality rates for certain illnesses, like cardiovascular, respiratory, cerebrovascular, and endocrine disorders, were much higher for people with bipolar spectrum disorders than the general population. Beyer et al. (2005) looked at the medical records of 1,379 patients treated for bipolar disorder and found high comorbidity rates of medical conditions such as endocrine, circulatory, and nervous system diseases. Relatedly, Leucht and colleagues (2007) conducted a review of the literature on physical health and schizophrenia and found that many illnesses are more common in people with schizophrenia, including HIV, hepatitis, diabetes, and cardiovascular disease. Another study found that people with schizophrenia or related psychosis

are more likely than those without to have between one and three physical illnesses. The most common were viral hepatitis, constipation, and Parkinson's disease (Smith et al., 2013).

Data from a German mental health survey found that migraine headaches and respiratory diseases were more common in people with obsessive-compulsive disorder (OCD) or subthreshold obsessive-compulsive disorder as compared to people without. Thyroid disorders and allergies were more common among people with subthreshold obsessive-compulsive disorder (Witthauer et al., 2014). Drummond and colleagues (2011) found that severe OCD can, at times, cause the sufferer to be unable to perform basic self-care activities, resulting in high rates of urinary incontinence, severe dehydration, and even renal failure.

More recently, research found that people with serious mental illnesses are more likely to have more severe symptoms of and are at higher risk of dying of COVID-19 than the general population (Barcella et al., 2021). Another study found that adults with mental illnesses were more likely to be hospitalized for and die from COVID-19 (Egede et al., 2021).

In conclusion, it is clear that physical health issues are common in patients with mental health issues, suggesting that the experience of stigma in the context of encounters with healthcare providers could have potentially significant consequences.

Attitudes of Healthcare Providers Towards People with Mental Illness

Research indicates that healthcare providers have high rates of mental health stigma and negative attitudes toward people with mental illness. Rao and colleagues (2009) administered the Attitude to Mental Illness Questionnaire to 108 health professionals. They found high levels of stigma, particularly toward patients in forensic mental health settings, patients with schizophrenia, and patients with active substance use disorders. Three hundred and fifty-two

medical and nursing staff were given a survey assessing attitudes about patients with eating disorders. Fleming and colleagues (1992) found that patients with eating disorders are often blamed for their illness by medical and nursing staff and are also often disliked by them.

Janoušková and colleagues (2017) wanted to examine stigma levels in medical students and faculty. They also wanted to see if and how medical school curriculums affect stigma levels in medical students and faculty. They found that faculty were more likely to have stronger stigmatizing attitudes than students. Additionally, students' stigma levels were even lower after taking courses in psychiatry (Janoušková et al, 2017). This suggests that education about mental health and mental illness reduces stigmatizing attitudes in medical professionals.

A study examining how prior psychiatric history affects diagnosis by a non-mental health healthcare professional found that doctors were less likely to believe that those with a serious mental illness were ill, as compared to other patients (Graber, 2000). Noblett and colleagues (1999) surveyed the attitudes of 52 doctors in UK hospitals toward people diagnosed with comorbid mental illness in addition to the physical illness they were being hospitalized for. They found highly stigmatized attitudes towards patients with a mental illness, with the strongest stigma towards patients with schizophrenia, personality disorders, and patients classified as “criminals.” These stigmatizing attitudes towards people with mental illnesses from healthcare providers are seen across the globe, from India to Sri Lanka, to Nigeria, to Turkey (Kumar et al, 2019; Mayanthi Fernando et al, 2010; Adewuya et al, 2007; Seda et al, 2021).

Healthcare Stigma from the Perspective of People with Mental Illness

A small body of research has examined the experience of stigma from healthcare providers among people with mental illness. Harangozo and colleagues (2013) were interested in

the experiences of people diagnosed with schizophrenia with healthcare-related stigma. They interviewed 777 people diagnosed with schizophrenia and found that 17% of them felt discriminated against in healthcare settings and 38% felt a lack of respect from mental health care workers. Additionally, 71% did not feel comfortable disclosing their mental illness (Harangozo et al, 2013).

Brondani and colleagues (2017) interviewed 25 patients with mental illnesses from community treatment centers. They analyzed the interviews for specific themes and found that being labeled as “unworthy”, “different”, and being discriminated against made the patients feel stigmatized. Another study surveyed patients at 12 Behavioral Integration Clinics. 26.81% of respondents reported experiencing stigma. The most common issues reported were unmet health needs, issues getting care, and poor communication from healthcare providers (Kenton et al., 2019).

Effects of Stigma from Healthcare Providers on Patients with Mental Illness

Given that people with mental illness are more likely to experience physical health issues, it is plausible that stigmatizing attitudes among healthcare providers may have damaging consequences. It has been documented that the life expectancy of people with mental illness in the US is 25 years younger, on average, than the general population life expectancy (Jones et al., 2008). One theory to explain this disheartening trend blames diagnostic overshadowing, a phenomenon that is seen in doctors, “by which physical symptoms are misattributed to mental illness” (Jones et al., 2008, p. 1). Diagnostic overshadowing can cause doctors to delay testing or treatment for an illness, which can result in grave consequences (Shefer et al., 2014). Druss and colleagues (2000) found that having a mental illness lowered patients’ chances of having

important cardiac procedures after an acute myocardial infarction. Similarly, Kisely and colleagues (2007) found that - even when controlling for differences in socioeconomic status and comorbidity - psychiatric patients were less likely than non-psychiatric patients to have specialized or important treatments for circulatory diseases. A study that looked at cancer in patients with mental illnesses found that they were less likely to be screened for cancer and more likely to die from it than patients without mental illnesses (Howard et al., 2010). A study by Mai and colleagues (2011) that examined disparities in diabetes diagnoses found that diabetes is more common in patients with mental health issues, and hospitalization and fatality rates are higher in this population. This is despite the fact that people with mental health issues are not tested for diabetes as often as people without.

Shefer and colleagues (2014) conducted a study to examine the scope and causes of doctors misattributing physical symptoms to mental illness. They found that having a mental illness raises the chances of misdiagnosis in emergency departments of hospitals (Shefer et al., 2014). Graber and colleagues (2000) studied whether a prior psychiatric diagnosis affected doctors' beliefs that a patient was ill. They found that patients with a history of depression or somatic complaints had a much lower chance of being sent for further testing than the general population (2000).

Current Study

The existing research clearly shows that there is a problem with stigma in healthcare. Studies have shown high levels of stigma in healthcare providers around the globe as well as dangerous and even fatal effects. However, there is a dearth of data and a lack of research on patients' experiences with stigma when interacting with healthcare providers. Harangozo and

colleagues (2013) study was limited to patients with schizophrenia. Brondani and colleagues (2017) study had a very small, non-nationally representative sample or generalizable sample. Kenton and colleagues (2019) only looked at patients in a specific type of clinic. However, their results show that more research is needed here. Additionally, there is little information on anticipated stigma and whether this causes people with mental illnesses to avoid healthcare providers.

Speaking to and surveying those whom this stigma affects is vital in creating a fuller understanding of the breadth and depth of the issue and in creating interventions to reduce this stigma and its impact. This study explores if and how stigma impacts patients with different mental illnesses by examining differences in anticipated stigma and experienced stigma from healthcare providers by diagnosis, gender, sexual identity, race, socioeconomic class, and medication usage. It is hypothesized that there will be more experienced and anticipated in this population, that there will be increased stigma in participants who are part of another marginalized identity, that medication use will increase stigma, and that stigma will be more severe for participants with a severe mental illness.

Methods

Participants

275 participants were recruited through Prolific, an online platform for survey recruitment tool that pre-vets and provides participants for online research studies. Prolific claims to curate a participant pool researchers can trust by requiring participants to answer many screening questions and to upload a copy of a government ID. Additionally, they do not allow participants to have more than one account and have measures in place to close down bot run

accounts. The participants were screened through Prolific, and the survey was built on and hosted through Qualtrics. All participants were required to have a diagnosis of a mental illness, to be above the age of 18, and to live in the United States. Additionally, the sample was split evenly by gender by Prolific. The sample was made up of primarily white participants under the age of 35 who identify as heterosexual, who have a diagnosis of anxiety and/or depression and was evenly divided by gender (aside from a few gender-expansive participants). The initial sample was almost completely white, so another 75 BIPOC participants were sampled. Prolific offered an option to only sample BIPOC participants through their prescreening process. It is unclear why most of the initial sample were white, perhaps the majority of Prolific participants are not BIPOC. In order to minimize the chances of participants clicking through without responding thoughtfully to content, two attention checks were used and every participant passed both. Demographic characteristics of participants are summarized in Table 1.

Table 1: Participant Demographics

Race/Ethnicity*	N	%
White	193	70.2
Black/African American	38	13.8
Indigenous	12	4.4
Asian	36	13.1
Bi-/Multiracial	22	8
Other	12	4.4
Gender		
Male	130	47.3
Female	120	43.6
Trans or Gender Queer	25	9.1
Age		
18-24	93	33.8
25-34	116	42.2
35-44	39	14.2
45-54	20	7.3
55-64	6	2.2
65-74	1	.4
Education		
High School	50	18.2
Some College	84	30.5
Associate Degree	25	9.1
Bachelor's Degree	96	34.9
Master's Degree	14	5.1
Doctoral Degree	5	1.8
Trade School	0	0
Sexuality*		
Heterosexual	157	57.1
Gay	14	5.15
Lesbian	7	2.5
Bisexual	60	21.8
Queer	14	5.1
Pansexual	18	6.5
Asexual	14	5.1
Other	6	2.2
Self-Reported Diagnoses*		
Depression	209	76
Anxiety	226	82.2
OCD	31	11.3
Psychotic Disorder	8	2.9

Personality Disorder	18	6.5
Substance Use Disorder	15	5.5
Eating Disorder	25	9.1
PTSD	55	20
Other	38	13.8
Total Sample	275	-

Note. (*) Denotes variables where percentages do not sum to 100% as participants chose multiple responses.

Measures

The survey used to collect the data for this study was made up of three sections: a demographic section with general and mental health specific questions; a scale created for this survey that measures experienced and anticipated stigma in patients regarding healthcare providers; and an adjusted version of the Everyday Discrimination Scale.

Demographic Questions

This survey began with five general demographic questions to get a better understanding of the participants. These were Age, Gender, Sexual Orientation, Education Level, and Race/Ethnicity.

Mental Health Specific Demographic Questions

Additionally, this survey contains six demographic questions specifically about the participants mental health. These were used to set a baseline for the study and to provide information for use when analyzing the data from the two stigma measures.

- 1. Please indicate which mental illness or illnesses you have been diagnosed with*
- 2. Do you take medication to treat your mental illness or illnesses?*
- 3. Do you have any diagnosed physical illnesses?*

Stigma Scale

The stigma scale was made up of close-ended questions to gain general knowledge about how stigmatized people with mental illnesses are treated by their healthcare providers. This scale specifically measured mental health stigma in healthcare settings. These questions were answered using a 5-point Likert scale and scored to get an understanding of the severity of the stigma ($\alpha = .895$).

- 1. Do you disclose your mental illness or illnesses to your healthcare providers?*

2. *Do you ever avoid going to see a healthcare provider because of fear of stigma?*
3. *Do you feel that you are not taken seriously by your healthcare providers because of your mental illness?*
4. *Have healthcare providers ever blamed your physical symptoms on your mental illness?*
5. *Have you been discriminated against by healthcare providers because of your mental illness?*
6. *Has a healthcare provider ever told you your symptoms were all in your head without doing further testing?*
7. *Is medical testing not offered or been delayed because a healthcare provider did not believe you?*
8. *Have you been treated differently when taking psychiatric medications by a healthcare provider?*
9. *If you have been diagnosed with a disease or illness, do you believe your diagnosis was delayed in some way because your doctor did not believe your symptoms?*
10. *Do you feel as though healthcare providers are equipped to handle mental health emergencies?*

Medical Malpractice

Participants were asked to self-report if they have been victims of medical malpractice.

1. *Have you experienced medical malpractice because of your mental illness?*

Everyday Discrimination Scale

Additionally, an adapted version of the Everyday Discrimination Scale was used. This scale was created by Williams and colleagues (1997) and the validity and reliability of the original

measure has been tested (Krieger et al, 2005; Taylor et al., 2004). The adjustments include adding the term “healthcare provider” in place of “people” in the statement where needed and using different response categories (Always, Very Frequently, Occasionally, Rarely, Very Rarely, Never) ($\alpha=.921$). This scale measured general stigma from healthcare providers, it is not specific to mental health stigma.

1. *You are treated with less courtesy by healthcare providers than other people are.*
2. *You are treated with less respect by healthcare providers than other people are.*
3. *You receive poorer service than other people at doctors' offices, hospitals, and clinics.*
4. *Healthcare providers act as if they think you are not smart.*
5. *Healthcare providers act as if they are afraid of you.*
6. *Healthcare providers act as if they think you are dishonest.*
7. *Healthcare providers act as if they're better than you are.*
8. *You are called names or insulted by healthcare providers.*
9. *You are threatened or harassed by healthcare providers.*

Analysis Plan

An analysis of variance statistical test and correlation matrix were used to examine differences in experienced and anticipated mental health stigma from healthcare providers based on diagnosis, race, education, sexuality, gender, and age. All the results can be found in the tables below.

Results

Overall Findings

Between 30.3% (Everyday Discrimination Scale) and 44.1% (Stigma Scale) of participants reported moderate to high levels of stigma from healthcare providers (median split). Medical malpractice was reported by 5.8% of participants, and 22.9% of participants said they may have been victims of medical malpractice. Anticipatory stigma and avoidance of healthcare providers was reported by 41.2% of the sample.

Table 2: Scale Results

Scales	M	SD	Range
Everyday Discrimination Scale, Adjusted	20.08	8.93	9-46
You are treated with less courtesy by healthcare providers than other people are.	2.54	1.29	1-6
You are treated with less respect by healthcare providers than other people are.	2.51	1.32	1-5
You receive poorer service than other people at doctors' offices, hospitals, and clinics.	2.44	1.31	1-6
Healthcare providers act as if they think you are not smart.	2.78	1.5	1-6
Healthcare providers act as if they are afraid of you.	1.7	1.06	1-6
Healthcare providers act as if they think you are dishonest.	2.59	1.46	1-6
Healthcare providers act as if they're better than you are.	2.72	1.54	1-6
You are called names or insulted by healthcare providers.	1.45	.916	1-5
You are threatened or harassed by healthcare providers.	1.34	.814	1-5
Stigma Scale	25.49	10.15	10-46
Do you disclose your mental illness or illnesses to your healthcare providers?	2.07	1.18	1-5
Do you ever avoid going to see a healthcare provider because of fear of stigma?	2.61	1.5	1-5

Do you feel that you are not taken seriously by your healthcare providers because of your mental illness?	2.6	1.44	1-5
Have healthcare providers ever blamed your physical symptoms on your mental illness?	2.82	1.54	1-5
Have you been discriminated against by healthcare providers because of your mental illness?	2.12	1.22	1-5
Has a healthcare provider ever told you your symptoms were all in your head without doing further testing?	2.58	1.53	1-5
Is medical testing not offered or been delayed because a healthcare provider did not believe you?	2.59	1.59	1-5
Have you been treated differently when taking psychiatric medications by a healthcare provider?	2.28	1.27	1-5
If you have been diagnosed with a disease or illness, do you believe your diagnosis was delayed in some way because your doctor did not believe your symptoms?	2.62	1.53	1-5
Do you feel as though healthcare providers are equipped to handle mental health emergencies?	3.24	1.27	1-5
Medical Malpractice	1.35	.586	1-3

Predictors of Stigma Experiences

ANOVA tests were conducted for both measures (Everyday Discrimination Scale and Stigma Scale), and several factors and disorders were correlated with worse experienced and anticipated stigma. Results summarized in Tables 3 and 4.

Gender did significantly predict stigma from healthcare providers from both the Everyday Discrimination Scale ($f=4.85$, $p=.009$) and Stigma Scale ($f=9.157$, $p<.001$). On average, female and gender queer participants had higher scores on both scales than men. Education did not predict stigma in this study. While race and ethnicity did not predict stigma overall, Asian participants did report lower rates of stigma than other groups ($f=3.89$, $p=.05$). LGBTQIA+ participants reported significantly worse stigma than heterosexual participants on both the Everyday Discrimination Scale ($f=9.573$, $p=.002$) and the Stigma Scale ($f=15.775$,

$p < .001$). Participants with comorbid physical illness(es) had significantly higher scores on the Everyday Discrimination Scale ($f = 6.56$, $p = .011$) and the Stigma Scale ($f = 10.23$, $p = .002$). Age, education, and race/ethnicity did not significantly predict stigma.

Mental Health Related Predictors

Having a diagnosis of obsessive-compulsive disorder (OCD) significantly predicted stigma from healthcare providers according to responses to the Everyday Discrimination Scale ($f = 7.438$, $p = .007$) and Stigma Scale ($f = 8.471$, $p = .004$). Individuals with personality disorders had higher stigma scores on both scales, ($f = 6.216$, $p = .013$), ($f = 4.741$, $p = .03$). Having an eating disorder diagnosis predicted stigma from healthcare providers according to the Everyday Discrimination Scale ($f = 9.359$, $p = .002$) and the Stigma Scale ($f = 6.915$, $p = .009$). A diagnosis of post-traumatic stress disorder (PTSD) significantly predicted stigma according to both scales ($f = 12.025$, $p < .001$), ($f = 6.915$, $p = .009$). Finally, having three or more diagnosed mental illnesses significantly predicted stigma from healthcare providers ($M = .35$, $f = 1.633$, $p = .019$) per the Everyday Discrimination Scale. Taking psychiatric medication, having a diagnosis of depression, anxiety, psychosis, substance use disorder, or other did not predict stigma in this study.

Anticipatory Stigma

This study assessed anticipatory stigma from healthcare providers by asking if patients avoid seeing healthcare providers for fear of stigma. Of the 274 people who responded to this question, 83 said somewhat agree and 30 said strongly agree. Gender significantly predicted anticipatory stigma ($f = 9.657$, $p < .001$), with gender queer people being much more likely to experience this form of stigma. Sexuality also predicted this form of stigma ($f = 6.129$, $p = .014$).

LGBTQIA+ participants were more likely than the heterosexual ones to avoid healthcare providers for fear of stigma. Additionally, personality disorders ($f=12.431$, $p<.001$), eating disorders ($f=8.715$, $p=.003$), and PTSD ($f=4.313$, $p=.039$) all predicted anticipatory stigma. Having a comorbid physical diagnosis predicted anticipatory stigma and avoidance of healthcare providers ($f=5.116$, $p=.024$). See Tables 3 and 5 for more details.

Medical Malpractice

Participants were asked to report on experiences of medical malpractice. Gender predicted this, with gender queer and female participants having higher reported rates of medical malpractice ($f=4.424$, $p=.013$). Medical malpractice was found to be more common among Indigenous individuals ($f=15.526$, $p<.001$), but not any other race or ethnicity. LGBTQIA+ participants reported medical malpractice at higher rates than heterosexual participants ($f=6.129$, $p=.014$). Comorbid physical illness also predicted medical malpractice ($f=6.718$, $p=.01$), as did having a personality disorder ($f=5.885$, $p=.016$) and having PTSD ($f=11.607$, $p<.001$).

Table 3: Association Between Demographics and Stigma Measures

Predictor Variables	Scales							
	EDS		Stigma		Malpractice		Anticipatory	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Age								
18-24	19.65	8.26	25.01	9.17	1.3	.506	2.66	1.471
25-34	19.79	9.23	26.17	10.55	1.37	.583	2.7	1.545
35-44	22.2	9.53	25.05	11.13	1.46	.756	2.31	1.417
45-54	21	9.54	24.7	10.65	1.2	.523	2.65	1.531
55-64	17.17	7.11	28	10.41	1.33	.816	2.17	1.472
65-74	11	n/a	12	n/a	1	n/a	1	n/a
Total	20.08	8.93	25.49	10.15	1.35	.586	2.61	1.496
F	.88		.603		.768		.764	
P-value	.492		.697		.573		.577	
η^2	.016		.011		.014		.014	
Gender								
Male	18.77	8.78	23.19	9.72	1.25	.575	2.22	1.43
Female	20.57	8.8	26.65	9.92	1.39	.598	2.89	1.488
Gender Queer	24.56	9.06	31.64	10.24	1.6	.5	3.28	1.37
Total	20.08	8.93	25.49	10.15	1.35	.586	2.61	1.496
F	4.85		9.157		4.424		9.657	
P-value	.009*		<.001*		.013*		<.001*	
η^2	.035		.064		.012		.067	
Education								
High School	20.42	9.08	26.59	10.24	1.38	.602	2.55	1.555
Some College	20.84	8.75	25.65	10.22	1.38	.599	2.68	1.498
Associates Degree	17.8	9.33	24.6	10.13	1.24	.523	2.56	1.53
Bachelor's Degree	19.96	9.12	25.18	10.08	1.33	.610	2.65	1.465
Master's Degree	21.43	8.53	26.23	11.89	1.36	.497	2.57	1.697
Doctoral Degree	16	6.2	21.8	10.16	1.2	.447	1.8	1.304
Total	20.12	8.93	25.52	10.16	1.35	.587	2.61	1.499
F	.733		.317		.324		.357	
P-value	.599		.902		.898		.878	
η^2								
Psychiatric Meds								
Yes	19.81	8.88	24.8	10.19	1.34	.573	2.5	1.453
No	20.55	9.05	26.66	10.03	1.36	.61	2.8	1.556
Total	20.08	8.93	25.49	10.15	1.35	.586	2.61	1.496
F	.44		2.146		.141		2.664	
P-value	.508		.144		.708		.104	
η^2	.014		.006		.006		.007	
Physical Illness								
Yes	22.18	8.23	28.41	9.33	1.48	.666	2.92	1.424

No	19.21	9.09	24.24	10.23	1.29	.539	2.48	1.511
Total	20.12	8.93	25.55	10.12	1.35	.587	2.62	1.496
F	6.56		10.23		6.718		5.116	
P-value	.011*		.002*		.01*		.024*	
η^2	.024		.037		.024		.019	

Note. (*) denotes correlation is significant at the .05 level (2-tailed)

Table 4: Association Between Demographics and Stigma Measures

Predictor Variables	Scales									
	EDS					Stigma				
	<i>M</i>	<i>SD</i>	<i>F</i>	<i>P</i>	η^2	<i>M</i>	<i>SD</i>	<i>F</i>	<i>P</i>	η^2
Race/Ethnicity										
White	20.4	9.46	.148	.701	.001	25.17	10.27	.114	.736	.00
Black	21	9.5	.463	.497	.002	24.42	9.37	.491	.484	.002
Asian	17.36	7.76	3.89	.05*	.014	23.47	9.54	1.648	.2	.006
Indigenous	24.25	10.26	2.746	.099	.010	28.81	9.98	1.232	.268	.005
Biracial	20.14	9.33	.001	.977	.000	26.77	11.02	.38	.538	.001
Other	23.92	7.34	2.321	.129	.008	10.4	28.58	1.165	.281	.004
Total	20.08	8.93				25.49	10.15			
Sexuality										
Heterosexual	18.65	8.97				23.4	9.8			
LGBTQIA+	21.97	8.97	9.573	.002*	.034	28.21	9.99	15.775	<.001*	.055
Gay	19.79	8.15	.016	.898	.000	26.43	9.46	.125	.724	.000
Lesbian	24.86	11	2.058	.153	.008	32.43	11.94	3.385	.067	.012
Bisexual	22.43	9.47	5.398	.021*	.019	27.77	9.51	3.906	.049*	.014
Queer	21.71	9.75	.49	.484	.002	29.86	11.07	2.747	.099	.010
Pansexual	24.67	7.89	5.146	.24*	.019	32.33	10.81	9.015	.003*	.032
Asexual	21.07	8.4	.180	.672	.001	28.29	11.34	1.118	.291	.004
Other	23	11.51	.653	.42	.002	25.67	12.04	.002	.966	.000
Total	20.08	8.93				25.49	10.15			
Mental Illness Disorder										
Depression	20.25	8.89	.298	.586	.001	25.52	10.17	.008	.928	.000
Anxiety	19.99	9	.152	.697	.001	25.52	10.18	.006	.936	.000
OCD	24.23	8.8	7.438	.007	.027	30.42	10.06	8.471	.004*	.030
Psychosis	24.88	9.93	2.382	.124	.009	25.38	10.95	.001	.974	.000
Personality Disorder	25.11	9.96	6.216	.013*	.022	30.65	9.16	4.741	.03*	.017

EXPERIENCES OF STIGMA AND ANTICIPATED STIGMA

Substance Use Disorder	21.47	8.43	.379	.539	.001	25.87	10.86	.021	.884	.000
Eating Disorder	25.33	8.2	9.359	.002*	.033	30.2	9.27	6.032	.015*	.022
PTSD	23.74	9.2	12.025	<.001*	.042	28.67	10.96	6.915	.009*	.025
Other	20.92	9.9	.386	.535	.001	26.21	11.17	.220	.639	.001
Total	20.08	8.93				25.49	10.15			

Table 5: Association Between Demographics and Anticipatory Anxiety and Medical Malpractice

Predictor Variables	Anticipatory					Malpractice				
	<i>M</i>	<i>SD</i>	<i>F</i>	<i>P</i>	η^2	<i>M</i>	<i>SD</i>	<i>F</i>	<i>P</i>	η^2
Race/Ethnicity										
White	2.58	1.46	.343	.558	.001	1.35	.585	.005	.942	.000
Black	2.66	1.547	.046	.83	.000	1.29	.515	.410	.527	.001
Asian	2.5	1.54	.221	.638	.001	1.31	.624	.191	.662	.001
Indigenous	3	1.612	.78	.378	.003	2	.853	15.526	<.001*	.057
Biracial	2.73	1.609	.148	.701	.001	1.36	.492	.023	.88	.000
Other	2.92	1.564	.528	.468	.002	1.5	.522	.871	.351	.003
Total	2.61	1.496				1.35	.586			
Sexuality										
Heterosexual	2.42	1.481				1.24	.545			
LGBTQIA+	2.86	1.484	6.129	.014*	.022	1.49	.61	13.411	<.001*	.047
Gay	2.14	1.46	1.437	.232	.005	1.21	.579	.738	.391	.002
Lesbian	3.14	1.773	.912	.34	.003	1.57	.535	1.067	.302	.004
Bisexual	2.85	1.424	1.992	.159	.007	1.5	.624	5.419	.021*	.019
Queer	3.21	1.626	2.423	.121	.009	1.43	.514	.296	.587	.001
Pansexual	3.44	1.504	6.111	.014*	.022	1.78	.548	10.85	.001*	.038
Asexual	3	1.414	1.005	.317	.004	1.5	.519	1.025	.312	.004
Other	2.83	1.722	.137	.712	.001	1.5	.837	.425	.515	.002
Total	2.61	1.496				1.35	.586			
Mental Illness										
Depression	2.61	1.483	0	.983	.000	1.35	.586	.037	.848	.000
Anxiety	2.6	1.506	.05	.822	.000	1.36	.582	1.115	.292	.004
OCD	2.97	1.402	2.011	.157	.007	1.52	.677	2.982	.085	.011
Psychosis	2.25	1.753	.475	.491	.002	1.63	.916	1.879	.172	.007
Personality Disorder	3.82	1.237	12.431	<.001*	.044	1.67	.686	5.885	.016*	.021
Substance Use Disorder	2.4	1.549	.31	.578	.001	1.47	.64	.677	.411	.002

Eating Disorder	3.44	1.474	8.715	.03*	.031	1.48	.653	1.451	.229	.005
PTSD	2.98	1.557	4.313	.039*	.016	1.58	.658	11.607	<.001*	.041
Other	2.61	1.516	0	.985	.000	1.45	.686	1.334	.249	.005
Total	2.61	1.496				1.35	.586			

Table 6: Correlation Between Study Scales

		EDS	Stigma	Malpractice	# of Mental Illnesses
EDS	Pearson				
	Correlation				
	N	274			
Stigma	Pearson	.770**			
	Correlation				
	Sig. (2-tailed)	<.001			
	N	271	272		
Malpractice	Pearson	.520**	.594**		
	Correlation				
	Sig. (2-tailed)	<.001	<.001		
	N	274	272	275	
# of Mental Illnesses	Pearson	.264**	.214**	.247**	
	Correlation				
	Sig. (2-tailed)	<.001	<.001	<.001	
	N	273	271	274	274

Note. (*) denotes correlation is significant at the .05 level (2-tailed)

Note. (**) denotes correlation is significant at the .01 level (2-tailed)

Correlations

Table 6 reports correlations between study scales and experiences of medical malpractice. As can be seen in Table 6, the Everyday Discrimination Scale and the Stigma Scale were highly correlated with each other and with reported experiences of medical malpractice ($p < .001$). Stigma and medical malpractice were associated with the number of mental illnesses reported by participants ($p < .001$). More diagnoses also correlated with more reported stigma.

Discussion

The previous research in this area supported that mental health stigma exists in healthcare by examining healthcare providers' attitudes towards those diagnosed with mental illness and by looking at the effects of these attitudes. Only a few very limited studies explored this issue from the perspective of those being stigmatized and how this impacts their feelings and interactions with healthcare and healthcare providers. As with any issue of stigma, discrimination, and oppression, it is important to listen to those who are being hurt by an issue and not just those perpetuating the hurt. This study attempted to begin expanding the literature in this area to shed more light on these issues in the hopes that this expansion will one day lead to change.

This study found that, overall, those with mental illness report experiencing higher than average levels of stigma from healthcare providers. Every patient deserves equal access to healthcare, and it is clear that this stigma is negatively impacting these patients and preventing them from accessing the healthcare they deserve. These results suggest that the significant health disparities experienced by people with diagnosed mental illnesses may in fact be caused by stigma, with healthcare providers not giving these patients the attention they need because of the assumption that their symptoms are mental - not physical. Additionally, several health conditions

either cause or mimic psychiatric symptoms. Hall and colleagues (1978) examined a group of 658 psychiatric patients, and they found missed physical illnesses in 9.1% of them. Patients had infectious, hepatic, pulmonary, central nervous system, diabetic, thyroid, and hematopoietic diseases. Some examples of specific illnesses that can present with psychiatric symptoms are: limbic encephalitis which can present as a psychotic disorder; hypothyroidism can cause depression and psychosis in some cases; Parkinson's disease can present with hallucinations; and lupus can present with depression, cognitive dysfunction, and anxiety (Meszaros et al., 2012; McKee et al., 2016; Welch et al., 2018). If healthcare providers treat these patients with discrimination because of stigma, they are very likely missing diagnoses. Future research should examine if stigma explains these disparities completely, or if there is a potential physiological cause of mental illness that somehow contributes to this population being more likely to develop certain health conditions.

This study did not find that education predicted higher or lower levels of stigma or medical malpractice. This was an unexpected finding. This finding may be because of the demographic of the sample, in which the majority of participants have at least some college education, 50.9% have a college degree and none of the participants went to a trade school. It is also possible that education is not a predictor of mental health stigma from healthcare providers. There is evidence that education level correlates with health, that those with more education live longer and healthier lives than those without (Zajacova et al., 2018). Stigma may play a role in this, but more research is needed before any statements on this can be made.

Gender predicted stigma experiences with healthcare providers. This is not a surprising finding, as gender is considered an important social determinant of health (Marmot, 2005). Women experience worse stigma from the general population than men as well as discrimination

within the healthcare system. Khan and colleagues (2015) looked at gender differences in discrimination and stigma towards people with depression from the general population and found that women experienced worse stigma and discrimination than men. There is a robust body of research that explores gender bias in healthcare. A qualitative study by Van Den Tillart and colleagues (2009) looked at the healthcare experiences of women with mental health diagnoses. The participants reported that healthcare providers silenced their concerns and made them feel powerless in their own care and that mental health stigma played a role. Additionally, some health conditions, such as cardiovascular diseases, present with different symptoms in women and men. This highlights a systemic issue regarding gender and healthcare (Ketepe-Arachi & Sharma, 2017). In this study, female and gender queer identifying participants reported higher levels of stigma, suggesting that non-men are at risk for experiencing stigma related issues and discrimination from healthcare providers. This shows that sexism and transphobia combine with mental health stigma to create a dangerous and damaging culture in healthcare that puts lives at risk.

Transgender and gender-diverse individuals are already an incredibly stigmatized and discriminated against community (Velasco, 2022). In healthcare, they are not only more stigmatized than other individuals, their right to access healthcare is constantly being debated in legislative chambers, with many states currently debating whether trans people, especially trans children, should be able to access affirming healthcare. The American Civil Liberties Union is currently tracking 122 anti trans healthcare bills (ACLU, 2023). The stigma this community experiences from healthcare providers is correlated with negative health outcomes across the board (Garcia et al., 2022). It is not surprising that this community experiences higher levels of mental health stigma from healthcare providers as well, as this study found.

Overall, race and ethnicity did not predict stigma or medical malpractice in this study. This finding was unexpected as racism in healthcare is a well-documented phenomenon. The American Medical Association states “Racism is one of the major causes of health problems in the United States” (White Coats for Black Lives, 2015, p. 1). Interestingly, Asian participants reported lower stigma, suggesting that perhaps Asian individuals with mental illness are less likely than individuals of other races and ethnicities to experience this form of stigma. Indigenous participants reported more medical malpractice than other racial and ethnic groups, suggesting that they are at a higher risk for being victims of medical malpractice. These findings were not unexpected as discrimination towards Indigenous peoples in healthcare settings has been studied in the past. Wylie and colleagues (2018) claim that healthcare discrimination is one of the main causes of health inequities seen in this population. Additionally, Indigenous people often use healing traditions outside of western medicine, but many allopathic doctors hold negative attitudes towards alternative medicine (Koithan et al., Li, 2017; 2010; Maha et al., 2007). Perhaps this view explains, at least in part, the elevated risk of medical malpractice for Indigenous individuals.

Sexual orientation appeared to be a significant predictor of stigma from healthcare providers and medical malpractice, with LGBTQIA+ identifying individuals reporting significantly worse stigma than heterosexual participants. This was not a surprising result. Members of the LGBTQIA+ have worse health outcomes than heterosexual people (Medina-Martinez et al., 2021). Additionally, this population has a more challenging time accessing proper healthcare and homophobia is considered to be a contributing factor (Alencar Albuquerque et al., 2016).

An important implication of this study relates to the theory of intersectionality, “the critical insight that race, class, gender, sexuality, ethnicity, nationality, ability, and age operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape complex social inequalities” (Collins, 2015, p. 2) because those with more than one stigmatized identity reported higher levels of stigma. Intersectional stigma, “a concept that has emerged to characterize the convergence of multiple stigmatized identities within a person or group, and to address their joint effects on health and wellbeing” (Turan et al., 2019, p. 1) has been used to understand the impact of stigma on other stigmatized individuals, such as those with HIV/AIDS and autism (Doyle et al., 2022; Norcini Pala et al., 2022). Intersectional stigma should be further explored in future studies in regard to mental illness as a stigmatized identity, as this paper suggests that it is.

This study found that while taking psychiatric medication did not predict overall stigma, it did decrease the likelihood of individuals disclosing mental illness to their healthcare providers and increase the chances of a healthcare provider treating them differently when they do find out. This is dangerous for a number of reasons. Healthcare providers need to have as complete a picture as possible of their patients’ health in order to treat them safely, especially when it comes to pharmaceuticals since medication interactions are common and potentially harmful. A study that looked at patients' non-disclosures lists stigma as a common reason for patients to withhold information from a doctor and that non-disclosure leads to poorer clinical outcomes (Alrasheed et al., 2021).

Having a diagnosed physical illness in addition to being diagnosed with a mental illness does predict stigma from healthcare providers. Additionally, it predicts medical malpractice. It also predicts anticipatory stigma and avoidance of healthcare providers, which can be

detrimental to health and contribute worse outcomes. Research has already shed some light on this, with studies finding that people with mental illnesses receive worse medical care than those without (Abbey et al., 2011; Thornicroft et al., 2007).

While participants in this study overall reported high stigma from healthcare providers, only certain diagnoses predicted stigma at a significant level. These are OCD, personality disorders, eating disorders, and PTSD. Additionally, a diagnosis of PTSD or a personality disorder appears to predict medical malpractice.

OCD is a poorly understood disorder, but one thing that seems to be clear in research is that the severity of OCD stigma is related to the content of the intrusive thoughts. Generally, those with contamination or symmetry related obsessions are not viewed as negatively as those who have violent or taboo obsessions (Homonoff et al., 2019). Perhaps this is the case with healthcare providers as well where those patients with obsessive or intrusive thoughts related to health and contamination are perceived negatively or are not believed when reporting symptoms because it is assumed that it is “just anxiety.”

Personality disorders are highly stigmatized, particularly borderline personality disorder (BPD) and because of the lack of understanding that most people have about personality disorders, some commonly held beliefs about individuals who suffer from them are: that they are acting out or misbehaving, that they just want attention, or that they are being manipulative (Sheehan et al., 2016). People with borderline personality disorder, like other stigmatized groups, struggle to access healthcare and have poor health outcomes (Klein et al., 2022).

A common form of stigma towards those with eating disorders is blame for causing their own illness (Brelet et al., 2021). Healthcare providers may inadvertently cause eating disorders

by encouraging intentional weight loss without considering their patients mental health. Attempted weight loss multiple times is a big risk factor for developing an eating disorder (Westby et al., 2021). Eating disorder stigma is related to another form of stigma: fat phobia. Obesity can be caused by or can contribute to eating disorders and those who are obese experience stigma in healthcare which contributes to poorer health outcomes (da Luz et al., 2018; Phelan et al., 2015). The finding in this study that having an eating disorder predicts stigma from healthcare providers fits with the previous research and literature on this topic. A diagnosis of PTSD elevated an individual's chances of experiencing stigma in a healthcare setting and of being a victim of medical malpractice. Much of the stigma around PTSD relates to perceived danger and violence, however, PTSD is not seen as a highly stigmatized disorder compared to others (Mittal et al., 2013). However, chronic PTSD, an official ICD diagnosis that is not in the DSM, can present in a similar way to BPD, which is highly stigmatized both in general and specifically within the healthcare framework as discussed above (Ford & Courtois, 2021). No previous literature could be found on stigma and healthcare related to PTSD or chronic PTSD. This is an interesting finding that should be explored further.

The more mental illnesses one is diagnosed with, the more likely it was that they would report experiencing stigma from healthcare providers. Those diagnosed with three or more mental illnesses also reported significantly higher stigma levels. While no literature on stigma and multiple mental illnesses could be found, it makes sense that if one mental illness can result in debilitating stigma, then more diagnoses can increase stigma further.

Stigma in healthcare is clearly prevalent and is deleteriously impacting millions of people's lives. Thankfully, there are stigma interventions that are empirically researched such as: social contact which involves speaking with and listening to people with mental illnesses who

are trained as educators; education to correct misconceptions and untrue beliefs that healthcare providers may hold; emphasizing recovery which focuses on recovery and the important role that healthcare providers play in it; skills-based trainings; and workshops (Knaak et al., 2017).

This study has a number of implications. Firstly, anti-stigma measures need to be put in place in all healthcare settings. These should be empirically proven stigma interventions that are regularly reevaluated and updated. Second, medical schools, physician assistant programs, nurse practitioner programs, and any other educational institutions for healthcare providers need to create and institute classes that educate future providers on mental illnesses and stigma. Third, education is needed to make healthcare providers aware of the unique medical needs of this community and of what medical conditions can mimic psychiatric illnesses. It is important that both points two and three are seen as at least of equal importance to other areas of education and training and afforded the appropriate amount of coverage within educational materials and curricula in relation to other topics of concern, rather than being seen and addressed as an afterthought or “PC motion.” Fourth, more research is desperately needed to discover how best to serve this underserved and discriminated-against community. Finally, more attention needs to be given to the issue of untreated physical illness in this population, especially chronic illness, which carries its own additional stigma (Earnshaw & Quinn, 2022). There are many initiatives and programs for untreated mental illness. Similar programs should be created for untreated physical illness.

Limitations

This study has a number of limitations. There was no control group of people without mental illnesses so the data can only be analyzed in relation to itself. Data was not collected on

which physical diagnosis participants were diagnosed with or who diagnosed them. Data was also not collected on what psychiatric medications participants were taking or who made their mental illness diagnoses. The sample size is on the smaller end, especially because so many factors were analyzed. Additionally, participants were recruited using Prolific which does attract a certain demographic, although the sample does generally match current population data percentages for race/ethnicity and gender. Another potential issue with Prolific is that while Prolific does screen participants, it is an online platform, and it is possible for people to be distracted while providing responses or not provide sincere responses. This study was limited to the United States and to English speakers. Additionally, it was only accessible online, so internet access was required in order to participate. These things limit the participants who can be reached and reduce the chances of a truly representative sample. Also, of the two measures used, one is the Everyday Discrimination Scale which is a previously validated scale that was adjusted for this study, while the other was created for this study. However, it should be noted that they both demonstrated good internal consistency and were highly correlated with each other, suggesting that they are valid measures of the construct of stigma in healthcare. While the stigma scale created for this study did specifically measure mental health stigma in healthcare, the adjusted Everyday Discrimination Scale measured general stigma in healthcare. It is possible that the discrimination faced by some is caused more by gender or race discrimination than mental health stigma.

Conclusion

Every patient deserves equal access to healthcare regardless of diagnosis, and this study hopes to contribute to that goal by shedding light on this issue. This study added vital information to an area of research that is still quite limited despite its impact on millions of

people's lives. It shows, from the patients' perspective, that mental health stigma is in fact an issue in healthcare and that the limited education that most healthcare providers receive is inadequate, and that this stigma is potentially contributing to the negative healthcare experiences and outcomes discussed in the introduction above. Additionally, mental illness should be considered a factor when discussing intersectionality and discrimination in healthcare settings.

References

- Abbey, S., Charbonneau, M., Tranulis, C., Moss, P., Baici, W., Dabby, L., Gautam, M., & Paré, M. (2011). Stigma and discrimination. *Canadian journal of psychiatry*, *56*(10), 1–9.
<https://pubmed.ncbi.nlm.nih.gov/22014688/>
- Adewuya, A. O., & Oguntade, A. A. (2007). Doctors' attitude towards people with mental illness in Western Nigeria. *Social Psychiatry and Psychiatric Epidemiology*, *42*(11), 931–936.
<https://doi.org/10.1007/s00127-007-0246-4>
- ACLU. (2023). *Mapping Attacks on LGBTQ Rights in U.S. State Legislatures*. American Civil Liberties Union. <https://www.aclu.org/legislative-attacks-on-lgbtq-rights?impact=health#categories>
- Alencar Albuquerque, G., de Lima Garcia, C., da Silva Quirino, G., Alves, M. J., Belém, J. M., dos Santos Figueiredo, F. W., da Silva Paiva, L., do Nascimento, V. B., da Silva Maciel, É., Valenti, V. E., de Abreu, L. C., & Adami, F. (2016). Access to health services by lesbian, gay, bisexual, and transgender persons: systematic literature review. *BMC international health and human rights*, *16*, 2. <https://doi.org/10.1186/s12914-015-0072-9>
- Alrasheed, A. A., Alharbi, A. H., Alotaibi, A. F., Alqarni, A. H., Alshahrani, A. M., Almigbal, T. H., & Batais, M. A. (2022). Prevalence, Reasons and Determinants of Patients' Nondisclosure to Their Doctors in Saudi Arabia: A Community-Based Study. *Patient preference and adherence*, *16*, 245–253. <https://doi.org/10.2147/PPA.S347796>
- Brelet, L., Flaudias, V., Désert, M., Guillaume, S., Llorca, P. M., & Boirie, Y. (2021). Stigmatization toward People with Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder: A Scoping Review. *Nutrients*, *13*(8), 2834.
<https://doi.org/10.3390/nu13082834>

- Chadda, D. (2000). Discrimination “rife” against mental health patients. *BMJ*, *320*(7243), 1163–1163. <https://doi.org/10.1136/bmj.320.7243.1163/a>
- Collins, P. H. (2015). Intersectionality’s definitional dilemmas. *Annu. Rev. Sociol.* *41*, 1–20. doi: 10.1146/annurev-soc-073014-112142
- Barcella, C.A., Polcwiartek, C., Mohr, G.H., Hodges, G., Søndergaard, K., Niels Bang, C., Andersen, M.P., Fosbøl, E., Køber, L., Schou, M., Torp-Pedersen, C., Kessing, L.V., Gislason, G. and Kragholm, K. (2021), Severe mental illness is associated with increased mortality and severe course of COVID-19. *Acta Psychiatr. Scand.*, *144*, 82-91. <https://doi-org.ez.lib.jjay.cuny.edu/10.1111/acps.13309>
- Beyer, J., Kuchibhatla, M., Gersing, K., & Krishnan, K. R. (2005). Medical comorbidity in a bipolar outpatient clinical population. *Neuropsychopharmacology: official publication of the American College of Neuropsychopharmacology*, *30*(2), 401–404. <https://doi.org/10.1038/sj.npp.1300608>
- Brondani, M. A., Alan, R., Donnelly, L. (2017) Stigma of addiction and mental illness in healthcare: The case of patients’ experiences in dental settings. *PLOS ONE*, *12*(5). <https://doi.org/10.1371/journal.pone.0177388>
- Crisp, A., Gelder, M., Rix, S., Meltzer, H., & Rowlands, O. (2000). Stigmatization of people with mental illnesses. *British Journal of Psychiatry*, *177*(1), 4-7. Doi:10.1192/bjp.177.1.4
- da Luz, F. Q., Hay, P., Touyz, S., & Sainsbury, A. (2018). Obesity with Comorbid Eating Disorders: Associated Health Risks and Treatment Approaches. *Nutrients*, *10*(7), 829. <https://doi.org/10.3390/nu10070829>

- De Hert. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry, 10*(1), 52–77.
<https://doi.org/info:doi/>
- Drummond, L. M., Kham Hameed, A., & Ion, R. (2011). Physical complications of severe enduring obsessive-compulsive disorder. *World psychiatry: official journal of the World Psychiatric Association (WPA), 10*(2), 154. <https://doi.org/10.1002/j.2051-5545.2011.tb00039.x>
- Druss, B. G., Bradford, D. W., Rosenheck, R. A., Radford, M. J., & Krumholz, H. M. (2000). Mental disorders and use of cardiovascular procedures after myocardial infarction. *JAMA, 283*(4), 506–511. <https://doi.org/10.1001/jama.283.4.506>
- Earnshaw, V. A., & Quinn, D. M. (2012). The impact of stigma in healthcare on people living with chronic illnesses. *Journal of health psychology, 17*(2), 157–168.
<https://doi.org/10.1177/1359105311414952>
- Egede, C., Dawson, A. Z., Walker, R. J., Garacci, E., Campbell, J. A., & Egede, L. E. (2021). Relationship between mental health diagnoses and COVID-19 test positivity, hospitalization, and mortality in Southeast Wisconsin. *Psychological medicine, 1*–9.
<https://doi.org/10.1017/S0033291721002312>
- Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods, 39*(2), 175–191. <https://doi.org/10.3758/BF03193146>
- Fleming, J., & Szumukler, G. I. (1992). Attitudes of medical professionals towards patients with eating disorders. *The Australian and New Zealand journal of psychiatry, 26*(3), 436–443.
<https://doi.org/10.3109/00048679209072067>

Ford, J. D. & Courtois, C. A. (2021) Complex PTSD and borderline personality disorder.

Borderline Personality Disorder and Emotion Dysregulation, 8(16).

<https://bpd.biomedcentral.com/articles/10.1186/s40479-021-00155-9>

Garcia, A. D., & Lopez, X. (2022). How Cisgender Clinicians Can Help Prevent Harm During Encounters with Transgender Patients. *AMA journal of ethics*, 24(8), E753–E761.

<https://doi.org/10.1001/amajethics.2022.753>

Graber, M. A., Bergus, G., Dawson, J. D., Wood, G. B., Levy, B. T., & Levin, I. (2000). Effect of a patient's psychiatric history on physicians' estimation of probability of disease. *Journal of General Internal Medicine*, 15(3), 204–206.

<https://doi.org/10.1046/j.1525-1497.2000.04399.x>

Hall, R. C., Popkin, M. K., Devaul, R. A., Faillace, L. A., & Stickney, S. K. (1978). Physical illness presenting as psychiatric disease. *Archives of general psychiatry*, 35(11), 1315–1320. <https://doi.org/10.1001/archpsyc.1978.01770350041003>

Harangozo, J., Reneses, B., Brohan, E., Sebes, J., Csukly, G., López-Ibor, J., Sartorius, N., Rose, D., & Thornicroft, G. (2014). Stigma and discrimination against people with schizophrenia related to medical services. *International Journal of Social Psychiatry*, 60(4), 359–366. <https://doi.org/10.1177/0020764013490263>

Howard, L. M., Barley, E. A., Davies, E., Rigg, A., Lempp, H., Rose, D., Taylor, D., & Thornicroft, G. (2010). Cancer diagnosis in people with severe mental illness: practical and ethical issues. *The Lancet. Oncology*, 11(8), 797–804. [https://doi.org/10.1016/S1470-2045\(10\)70085-1](https://doi.org/10.1016/S1470-2045(10)70085-1)

- Janoušková, M., Weisssová, A., Formánek, T., Pasz, J., & Bankovská Motlová, L. (2017). Mental illness stigma among medical students and teachers. *The International Journal of Social Psychiatry*, 63(8), 744–751. <https://doi.org/10.1177/0020764017735347>
- Jones, S., Howard, L., & Thornicroft, G. (2008). 'Diagnostic overshadowing': worse physical health care for people with mental illness. *Acta Psychiatrica Scandinavica*, 118(3), 169–171. <https://doi.org/10.1111/j.1600-0447.2008.01211.x>
- Kenton, N.R., Broffman, L., Jones, K., Albrecht-Mcmenamin, K., Weller, M., Brown, K., Currier, J. & Wright, B. (2019). Patient experiences in behavioral health integrated primary care settings: the role of stigma in shaping patient outcomes over time, *Psychology, Health & Medicine*, 24(10), 1182-1197.
DOI: 10.1080/13548506.2019.1595685
- Ketepe-Arachi, T., & Sharma, S. (2017). Cardiovascular Disease in Women: Understanding Symptoms and Risk Factors. *European cardiology*, 12(1), 10–13.
<https://doi.org/10.15420/ecr.2016:32:1>
- Khan, N., Kausar, R., Khalid, A., & Farooq, A. (2015). Gender differences among discrimination & stigma experienced by depressive patients in Pakistan. *Pakistan journal of medical sciences*, 31(6), 1432–1436. <https://doi.org/10.12669/pjms.316.8454>
- Klein, P., Fairweather, A. K., Lawn, S., Stallman, H. M., & Cammell, P. (2021). Structural stigma and its impact on healthcare for consumers with borderline personality disorder: protocol for a scoping review. *Systematic reviews*, 10(1), 23.
<https://doi.org/10.1186/s13643-021-01580-1>
- Kisely, S., Smith, M., Lawrence, D., Cox, M., Campbell, L. A., & Maaten, S. (2007). Inequitable access for mentally ill patients to some medically necessary procedures. *CMAJ*:

Canadian Medical Association journal, 176(6), 779–784.

<https://doi.org/10.1503/cmaj.060482>

Krieger, N., Smith, K., Naishadham, D., Hartman, C., & Barbeau, E. M. (2005). Experiences of discrimination: validity and reliability of a self-report measure for population health research on racism and health. *Social science & medicine* (1982), 61(7), 1576–1596.

Kumar, M., Macharapu, R., Reddy, P., & Babu, S. (2019). Attitude toward mental illness among medical students and nonpsychiatric doctors. *Archives of Mental Health*, 20(1), 9–13.

https://doi.org/10.4103/AMH.AMH_36_18

Pescosolido, B. A., Manago, B., & Monahan, J. (2019). Evolving Public Views on The Likelihood of Violence from People with Mental Illness: Stigma and Its Consequences. *Health Affairs (Project Hope)*, 38(10), 1735–1743.

<https://doi.org/10.1377/hlthaff.2019.00702>

Riffel, T., & Chen, S. P. (2020). Stigma in Healthcare? Exploring the Knowledge, Attitudes, and Behavioural Responses of Healthcare Professionals and Students toward Individuals with Mental Illnesses. *The Psychiatric Quarterly*, 91(4), 1103–1119.

<https://doi.org/10.1007/s11126-020-09809-3>

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare management forum*, 30(2), 111–116. <https://doi.org/10.1177/0840470416679413>

Lawrence, D., & Kisely, S. (2010). Inequalities in healthcare provision for people with severe mental illness. *Journal of Psychopharmacology (Oxford)*, 24(4), 61–68.

<https://doi.org/10.1177/1359786810382058>

- Leucht, S., Burkard, T., Henderson, J., Maj, M., & Sartorius, N. (2007). Physical illness and schizophrenia: a review of the literature. *Acta psychiatrica Scandinavica*, 116(5), 317–333. <https://doi.org/10.1111/j.1600-0447.2007.01095.x>
- Li, R. (2017). Indigenous identity and traditional medicine: Pharmacy at the crossroads. *Canadian pharmacists journal: CPJ = Revue des pharmaciens du Canada: RPC*, 150(5), 279–281. <https://doi.org/10.1177/1715163517725020>
- Marmot M. (2005). Social determinants of health inequalities. *Lancet (London, England)*, 365(9464), 1099–1104. [https://doi.org/10.1016/S0140-6736\(05\)71146-6](https://doi.org/10.1016/S0140-6736(05)71146-6)
- Mai, Q., Holman, C. D., Sanfilippo, F. M., Emery, J. D., & Preen, D. B. (2011). Mental illness related disparities in diabetes prevalence, quality of care and outcomes: a population-based longitudinal study. *BMC Medicine*, 9, 118. <https://doi.org/10.1186/1741-7015-9-118>
- Mayanthi Fernando, S., Deane, F. P., & Mcleod, H. J. (2010). Sri Lankan doctors' and medical undergraduates' attitudes towards mental illness. *Social Psychiatry and Psychiatric Epidemiology*, 45(7), 733–739. <https://doi.org/10.1007/s00127-009-0113-6>
- Medina-Martínez, J., Saus-Ortega, C., Sánchez-Lorente, M. M., Sosa-Palanca, E. M., García-Martínez, P., & Mármol-López, M. I. (2021). Health Inequities in LGBT People and Nursing Interventions to Reduce Them: A Systematic Review. *International journal of environmental research and public health*, 18(22), 11801. <https://doi.org/10.3390/ijerph182211801>
- Meszaros, Z. S., Perl, A., & Faraone, S. V. (2012). Psychiatric symptoms in systemic lupus erythematosus: a systematic review. *The Journal of clinical psychiatry*, 73(7), 993–1001. <https://doi.org/10.4088/JCP.11r07425>

- Mittal, D., Drummond, K. L., Blevins, D., Curran, G., Corrigan, P., & Sullivan, G. (2013). Stigma associated with PTSD: perceptions of treatment seeking combat veterans. *Psychiatric rehabilitation journal*, *36*(2), 86–92. <https://doi.org/10.1037/h0094976>
- Noblett, J. E., Lawrence, R., & Smith, J. G. (2015). The attitudes of general hospital doctors toward patients with comorbid mental illness. *International Journal of Psychiatry in Medicine*, *50*(4), 370–382. <https://doi.org/10.1177/0091217415612721>
- Norcini Pala, A., Kempf, M. C., Konkle-Parker, D., Wilson, T. E., Tien, P. C., Wingood, G., Neilands, T. B., Johnson, M. O., Weiser, S. D., Logie, C. H., Turan, J. M., & Turan, B. (2022). Intersectional stigmas are associated with lower viral suppression rates and antiretroviral therapy adherence among women living with HIV. *AIDS (London, England)*, *36*(13), 1769–1776. <https://doi.org/10.1097/QAD.0000000000003342>
- Phelan, S. M., Burgess, D. J., Yeazel, M. W., Hellerstedt, W. L., Griffin, J. M., & van Ryn, M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity reviews: an official journal of the International Association for the Study of Obesity*, *16*(4), 319–326. <https://doi.org/10.1111/obr.12266>
- Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A. & Luty, J. (2009). A study of stigmatized attitudes towards people with mental health problems among health professionals. *Journal of Psychiatric and Mental Health Nursing*, *16*, 279–284. <https://doi-org.ez.lib.jjay.cuny.edu/10.1111/j.1365-2850.2008.01369.x>
- Roshanaei-Moghaddam, B., & Katon, W. (2009). Premature mortality from general medical illnesses among persons with bipolar disorder: a review. *Psychiatric services (Washington, D.C.)*, *60*(2), 147–156. <https://doi.org/10.1176/ps.2009.60.2.147>

- Samra, R., Griffiths, A., Cox, T., Conroy, S., Gordon, A., & Gladman, J. R. (2015). Medical students' and doctors' attitudes towards older patients and their care in hospital settings: a conceptualization. *Age and ageing, 44*(5), 776–783.
<https://doi.org/10.1093/ageing/afv082>
- Shefer, G., Henderson, C., Howard, L. M., Murray, J., & Thornicroft, G. (2014). Diagnostic overshadowing and other challenges involved in the diagnostic process of patients with mental illness who present in emergency departments with physical symptoms--a qualitative study. *PloS one, 9*(11), e111682.
<https://doi.org/10.1371/journal.pone.0111682>
- Smith, D. J., Langan, J., McLean, G., Guthrie, B., & Mercer, S. W. (2013). Schizophrenia is associated with excess multiple physical-health comorbidities but low levels of recorded cardiovascular disease in primary care: cross-sectional study. *BMJ open, 3*(4), e002808.
<https://doi.org/10.1136/bmjopen-2013-002808>
- Seda, K. E. & Dursun, D. H. (2021). Stigmatizing Attitudes and The Use of Stigmatizing Language Towards Mental Illness Among Doctors and Nurses in Turkey. *Sanamed, 16*(2), 123–130. <https://doi.org/10.24125/sanamed.v16i2.479>
- Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). *Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration*. <https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report>.

- Taylor, T. R., Kamarck, T. W., & Shiffman, S. (2004). Validation of the Detroit Area Study Discrimination Scale in a community sample of older African American adults: the Pittsburgh healthy heart project. *International journal of behavioral medicine, 11*(2), 88–94. https://doi.org/10.1207/s15327558ijbm1102_4
- Thornicroft, G., Rose, D., & Kassam, A. (2007). Discrimination in health care against people with mental illness. *International review of psychiatry (Abingdon, England), 19*(2), 113–122. <https://doi.org/10.1080/09540260701278937>
- Turan, J. M., Elafros, M. A., Logie, C. H., Banik, S., Turan, B., Crockett, K. B., Pescosolido, B., & Murray, S. M. (2019). Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC medicine, 17*(1), 7. <https://doi.org/10.1186/s12916-018-1246-9>
- van Boekel, L. C., Brouwers, E. P., van Weeghel, J., & Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. *Drug and alcohol dependence, 131*(1-2), 23–35. <https://doi.org/10.1016/j.drugalcdep.2013.02.018>
- Van Den Tillaart, S., Kurtz, D., & Cash, P. (2009). Powerlessness, marginalized identity, and silencing of health concerns: voiced realities of women living with a mental health diagnosis. *International journal of mental health nursing, 18*(3), 153–163. <https://doi.org/10.1111/j.1447-0349.2009.00599.x>
- Velasco R. A. F. (2022). Stigma among transgender and gender-diverse people accessing healthcare: A concept analysis. *Journal of advanced nursing, 78*(3), 698–708. <https://doi.org/10.1111/jan.15040>

- Welch, K. A., & Carson, A. J. (2018). When psychiatric symptoms reflect medical conditions. *Clinical medicine (London, England)*, *18*(1), 80–87.
<https://doi.org/10.7861/clinmedicine.18-1-80>
- Westby, A., Jones, C. M., & Loth, K. A. (2021). The Role of Weight Stigma in the Development of Eating Disorders. *American family physician*, *104*(1), 7–9.
- Westberg, K. H., Nyholm, M., Nygren, J. M., & Svedberg, P. (2022). Mental Health Problems among Young People-A Scoping Review of Help-Seeking. *International journal of environmental research and public health*, *19*(3), 1430.
<https://doi.org/10.3390/ijerph19031430>
- White Coats for Black Lives (WC4BL) National Working Group (2015). #BlackLivesMatter: physicians must stand for racial justice. *AMA journal of ethics*, *17*(10), 978–982.
<https://doi.org/10.1001/journalofethics.2015.17.10.sect1-1510>
- Williams, D.R., Yu, Y., Jackson, J.S., & Anderson, N.B. (1997). Racial Differences in Physical and Mental Health: Socioeconomic Status, Stress, and Discrimination. *Journal of Health Psychology*, *2*(3):335-351.
- Witthauer, C., Gloster, T. A., Meyer, A. H., & Lieb, R. (2014). Physical diseases among persons with obsessive compulsive symptoms and disorder: a general population study. *Social psychiatry and psychiatric epidemiology*, *49*(12), 2013–2022.
<https://doi.org/10.1007/s00127-014-0895-z>
- Wylie, L., McConkey, S. (2019). Insiders' Insight: Discrimination against Indigenous Peoples through the Eyes of Health Care Professionals. *J. Racial and Ethnic Health Disparities*, *6*, 37–45. <https://doi.org/10.1007/s40615-018-0495-9>

- Yang, L. H., Wong, L. Y., Grivel, M. M., & Hasin, D. S. (2017). Stigma and substance use disorders: an international phenomenon. *Current opinion in psychiatry*, *30*(5), 378–388. <https://doi.org/10.1097/YCO.0000000000000351>
- Yanos, P. (2018). *Written Off: Mental Health Stigma and the Loss of Human Potential*. New York: Cambridge University Press.
- Yanos, P. T., DeLuca, J. S., & Gonzales, L. (2020). Commentary: The United States has a national pro-stigma campaign. It needs a national, evidence-based anti-stigma campaign to counter it. *Stigma and Health*, *5*, 497–498.
- Zajacova, A., & Lawrence, E. M. (2018). The Relationship Between Education and Health: Reducing Disparities Through a Contextual Approach. *Annual review of public health*, *39*, 273–289. <https://doi.org/10.1146/annurev-publhealth-031816-044628>