

ATTITUDINAL ABLEISM:
A THREE-STUDY EXPLORATION INTO ATTITUDINAL BARRIERS
ENCOUNTERED BY PEOPLE WITH MENTAL ILLNESS, SUBSTANCE USE,
AND PHYSICAL DISABILITIES

by

Jayci Lynn Robb

Copyright © Jayci Lynn Robb 2015

A Dissertation Submitted to the Faculty of the

DEPARTMENT OF DISABILITY AND PSYCHOEDUCATIONAL STUDIES

In Partial Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOSOPHY

WITH A MAJOR IN REHABILITATION

In the Graduate College

THE UNIVERSITY OF ARIZONA

2015

THE UNIVERSITY OF ARIZONA
GRADUATE COLLEGE

As members of the Dissertation Committee, we certify that we have read the dissertation prepared by Jayci Lynn Robb, titled "Attitudinal Ableism: A Three-Study Exploration into Attitudinal Barriers Encountered by People with Mental Illness, Substance Use, and Physical Disabilities," and recommend that it be accepted as fulfilling the dissertation requirement for the Degree of Doctor of Philosophy.

Date: 11/20/2015
Michael Hartley

Date: 11/20/2015
Phillip Johnson

Date: 11/20/2015
Jeffery Stone

Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copies of the dissertation to the Graduate College.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

Date: 11/20/2015
Dissertation Director: Michael Hartley

STATEMENT BY AUTHOR

This dissertation has been submitted in partial fulfillment of the requirements for an advanced degree at the University of Arizona and is deposited in the University Library to be made available to borrowers under rules of the Library.

Brief quotations from this dissertation are allowable without special permission, provided that an accurate acknowledgement of the source is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the copyright holder.

SIGNED: Jayci Lynn Robb

ACKNOWLEDGEMENTS

As Sandra Day O'Connor once said, "we never accomplish anything in this world alone... and whatever happens is the result of the whole tapestry of one's life and all the weavings of individual threads from one to another that creates something." Indeed, this dissertation and doctoral degree represent the influence and support of many people. I would like to thank the following people for their invaluable role in this journey:

Thank you to my dissertation chair, Dr. Michael Hartley; to my committee members, Dr. Philip Johnson, Dr. Sue Kroeger, and Dr. Jeffery Stone; and to my former chair, Dr. Chih Chin Chou, for their time, support, and guidance. Thank you also to all the faculty and staff of the Department of Disability and Psychoeducational Studies at the University of Arizona for their support and assistance during my years as a master's and doctoral student. Thank you to the faculty of the departments of Psychology, Educational Leadership, and Educational Psychology for the wisdom they shared in their courses. Finally, thank you to my fellow students for the mutual support and encouragement.

Thank you to my family; words cannot express my love and gratitude. I would not be where I am today if not for you. Thank you for always believing in me and supporting me in all my endeavors. I love you so much.

Thank you to my friends, both near and far, for their support and encouragement. I feel so blessed to have each of you in my life.

Thank you to the Westminster College Ronald E. McNair Post-Baccalaureate Scholars Program and to Dr. Jo Hinsdale, Dr. Cathleen Power, and Dr. Laura Bennett-Murphy for their continued support, mentorship, and friendship.

Thank you to the many scholarship sponsors who have provided financial assistance through my undergraduate and graduate studies. Without your financial support, my pursuit of a bachelor's, master's, and doctoral degree would not have been possible.

Thank you to the agencies that granted me permission to recruit participants and to the individuals who took part in my studies. Thank you also to Dr. Hsin-Ya Lao for consulting on the statistical analyses for study two.

Above all, thank you to Jesus for supplying me with the endurance and wisdom to complete this dissertation and degree, and for placing so many individuals in my life to support, encourage, and guide me along the way. To Him be the glory and honor.

Proverbs 21:31

DEDICATION

To my family

TABLE OF CONTENTS

	Page
LIST OF FIGURES.....	8
LIST OF TABLES.....	9
ABSTRACT.....	10
CHAPTER	
I. INTRODUCTION.....	12
II. IMPLICIT BIAS TOWARD PEOPLE WITH MENTAL ILLNESS: A SYSTEMATIC LITERATURE REVIEW.....	21
III. STIGMA AND SUBSTANCE USE: AN INVESTIGATION INTO THE MEDIATING EFFECTS OF PERSONALITY, SOCIAL SUPPORT, AND COPING IN THE PATHWAY BETWEEN PERCEIVED AND INTERNALIZED STIGMA.....	67
IV. A NARRATIVE INQUIRY OF AMBIVALENT ABLEISM: UNDERSTANDING HOW PHYSICALLY DISABLED ADULTS PERCEIVE MICROAGGRESSIONS.....	93
V. CONCLUSIONS.....	129
REFERENCES.....	154

LIST OF FIGURES

	Page
Figure 3.1	Proposed pathway between perceived stigma and internalized stigma.....75
Figure 3.2	The mediating effects of social support, coping behaviors, and personality characteristics84
Figure 3.3	The mediating effects of maladaptive coping and adaptive coping.....86
Figure 3.4	The mediating effects of affectionate support, emotional/informational support, and tangible support.....87

LIST OF TABLES

	Page
Table 2.1	Summary of participant characteristics and measurement tools used in studies on implicit biases toward mental illness.....31
Table 2.2	Summary of target and comparison categories used in implicit measures.....52
Table 3.1	Summary of participant demographics for study two.....76
Table 4.1	Summary of participant demographics for study three.....103

ABSTRACT

The three studies presented in this dissertation generated new insight about the attitudinal ableism experienced by people with mental illness, substance use, and physical disabilities. First, the purpose of study one was to synthesize existing evidence about the implicit (unconscious) biases toward people with mental illness. Extensive academic database searches were performed and 19 articles were selected for review. Main findings from the review indicated that 63% of the participant samples showed an implicit bias against people with mental illness. Further, the implicit biases were positively correlated with explicit desires for social distance in two studies and were not improved by interventions or prior contact in six studies.

Second, the purpose of study two was to investigate potential mediators in the pathway between perceived stigma and internalized stigma among people with substance use disorders. A total of 125 individuals completed the survey packet. Results indicated that overall social support (particularly affectionate social support) and maladaptive coping behaviors were significant mediators of the pathway. Personality characteristics, overall coping behaviors, adaptive coping behaviors, emotional/informational social support, and tangible social support were not significant mediators.

Third, the purpose of study three was to validate and expand upon existing research on the microaggressions perceived by people with physical disabilities. The third study was also an initial exploration into the applicability of Glick and Fiske's (1996) theory of ambivalent sexism in conceptualizing ableist microaggressions. Specifically, Glick and Fiske's (1996) theory was used as a framework for conceptualizing ableist

microaggressions as examples of ambivalent ableism, characterized by hostility and benevolence toward people with disabilities. Twelve individuals with visible, physical disabilities were interviewed about their microaggressive experiences and the personal impacts of being targets of ableism. Participants' experiences were coded and categorized as representing hostile ableism, benevolent ableism, or impact on the target. Hostile microaggressive experiences included othering, victimizing, and desexualizing; benevolent microaggressive experiences included helping and infantilizing; and impacts on the target included passing/covering and internalizing.

Finally, implications related to research, education, and practice for each of the three studies were discussed in the concluding chapter of this dissertation.

CHAPTER I

INTRODUCTION

In 2010, approximately 56.7 million people in the United States were considered disabled (Brault, 2012). Unfortunately, these individuals continue to represent a marginalized group due to an array of barriers. Evidence of this marginalization can be observed by data indicating that people with disabilities (PWD) have been approximately twice as likely to be unemployed (Bureau of Labor Force Statistics, U.S. Department of Labor, 2015), twice as likely to live in poverty (Annual Disability Statistics Compendium, 2013), and half as likely to obtain a postsecondary degree than people without disabilities (PWOD) (Bureau of Labor Force Statistics, U.S. Department of Labor, 2014). Consequently, the expense of supporting PWD in the United States each year has been in the billions with the cost of Medicaid reaching nearly \$450 billion in 2013 (Centers for Medicare & Medicaid Services, 2015) and the cost of Social Security payments hitting nearly \$4.7 billion in 2013 (Social Security Administration, 2014).

In an attempt to lessen the marginalization of PWD, legislators have written many laws to protect the rights of such individuals in the United States. The Rehabilitation Act of 1973, the American's with Disabilities Act (ADA) of 1990, and the Individuals with Disabilities Education Act (IDEA) have been among the most widely recognized disability rights laws. Each of these laws has prohibited discrimination against PWD and mandated accessibility of the environment (Rubin & Roessler, 2008). Although such laws can be used to force professionals to provide architectural accessibility, appropriate learning environments, nondiscriminatory hiring practices, etc., these mandates have

targeted macro level changes in the United States. Legislators cannot be present to moderate the prejudice encountered by PWD in daily interactions nor can they force changes in attitude regarding such individuals.

Because held beliefs can influence behavior (Perugini, Richetin, & Zogmaister, 2010), the attitudes toward PWD warrant special attention. Therefore, even though environmental and political barriers are worthy of investigation and in need of ameliorating efforts, the focus of the current dissertation is on attitudinal barriers encountered by PWD. More specifically, the current dissertation represents the compilation of research on attitudinal ableism that was conducted throughout the author's five years of graduate study. Unlike the traditional one-study dissertation format, the current dissertation contains three separate studies with each emphasizing a different facet of attitudinal ableism and each employing a different methodology. Namely, quantitative and qualitative methodologies were used to examine attitudinal barriers as experienced by people with mental illness, substance use, and physical disabilities. Although the three studies were not initially intended to be compiled into a single dissertation, when presented together, they offer a unique perspective on attitudinal barriers by easing the comparability of attitudes toward people with different types of disabilities. Further, because different methodologies were used in each study, the sequential presentation of all three studies helps to facilitate comparison of the methods and their potential influence on the resulting attitudes.

Overview and Significance of the Three Studies

This section contains a brief summary of the purpose, relevant literature, and research questions for each study. A more extensive discussion of each study can be found in chapters II, III, and IV of this dissertation.

Study one. The purpose of the first study (Chapter II), “Implicit Bias toward People with Mental Illness: A Systematic Literature Review,” was to synthesize the implicit (unconscious) attitudes toward individuals with mental illness. As Amodio and Mendoza (2010) explained, exploration of implicit biases has been significant because participants have less opportunity to manipulate their answers than when their explicit biases are being tested. In turn, implicit measures may be more likely to accurately capture a participant’s biases than explicit measures (Stier & Hindshaw, 2007). The Implicit Association Test (IAT), developed by Greenwald, McGhee, and Schwartz (1998), has been one of the most widely used implicit measures. In completing the IAT, the strength of participants’ unconscious biases is determined by the speed at which participants correctly categorize stimuli (Teige-Mocigemba, Klauer, & Sherman, 2010).

Researchers have begun to use implicit measures, such as the IAT, to explore participants’ unconscious biases about PWD. Several of these findings were discussed by Wilson and Scior (2014) in their systemic review of 17 authors. Namely, Wilson and Scior (2014) reviewed studies that explored participant’s implicit attitudes toward people with physical disabilities, intellectual disabilities, and unspecified disabilities. The authors concluded that, overall, participants demonstrated negative implicit attitudes toward the disabled targets.

Because people with mental illness were not represented in the articles reviewed by Wilson and Scior (2014), the purpose of the first study was to examine existing evidence regarding implicit bias toward such individuals. A comprehensive understanding of implicit attitudes toward people with mental illness could have many benefits, such as helping to facilitate the identification of patterns and gaps in attitudes across diverse participant samples and cultures. This information could, in turn, assist researchers in formulating new hypotheses for study and could aid in the implementation of more effective methodologies for studying implicit biases toward PWD. Therefore, an extensive search of existing research was performed and 19 articles were selected for review. Three research questions were explored in the systematic review of the articles: (1) How was implicit bias toward people with mental illness represented in the articles?; (2) What factors influenced the valence of implicit associations toward people with mental illness?; and (3) How did implicit biases compare to explicit attitudes toward people with mental illness?

Study two. The second study (Chapter III) has been titled “Stigma and Substance Use: An Investigation into the Mediating Effects of Personality, Social Support, and Coping in the Pathway between Perceived and Internalized Stigma.” As the title implies, the purpose of the second study was to explore potential mediators along the pathway between perceived and internalized stigma among people with substance use disorders. According to Luoma et al. (2007), *perceived stigma* has been defined as the stigmatized individual’s awareness of the existence and prevalence of the public attitudes toward the stigmatized group of which he or she belongs. *Self or internalized stigma*, on the other

hand, has been defined as the individual's personal identification with the public attitudes related to his or her stigmatized status and the negative thoughts, emotions, and behaviors that result from this identification (Luoma et al., 2007).

No doubt, being the target of stigma comes at a cost. Numerous researchers have documented the impact of stigma on the target and have concluded that perceptions of stigma have negatively correlated with willingness to seek treatment for physiological (e.g., Cunningham, Kerrigan, Jennings, & Ellen, 2009) or psychological concerns (e.g., Keyes et al., 2010; Komiya, Good, & Sherrod, 2000), have led to an increase in depressive symptoms (e.g., Norman, Windell, Lynch, & Manchanda, 2011), and have resulted in a decrease in self-esteem and coping behaviors (e.g., Kleim et al., 2008). Similarly, consequences of internalized stigma have been noted as poorer social functioning (Cerit, Filizer, Tural, & Tufan, 2012; Lysaker, Roe, & Yanos, 2007), worsening depression (Cerit et al., 2012), unemployment (Corrigan, Powell, & Rusch, 2012), lower recovery orientation (Drapalski et al., 2013), diminished hope (Lysaker et al., 2007), and poorer quality of life (Tang & Wu, 2012; Park, Bennett, Couture, & Blanchard, 2013).

Although multiple researchers have examined perceived and internalized stigma among people with mental illness (Bathje & Pryor, 2011; Cerit et al., 2012; Corrigan et al., 2012; Corrigan, Watson, & Barr, 2006; Norman, Windell, Lynch, & Manchanda, 2011), fewer have examined these as they pertain to individuals with substance use (e.g., Luoma et al., 2007; Luoma et al., 2010; Schomerus et al., 2011; Smith, Dawson, Goldstein, & Grant, 2010). Further still, researchers have not considered mediating

factors in the pathway between perceived and internalized stigma. Even though both forms of stigma can negatively impact targeted individuals, the effects of internalized stigma have been more severe (Corrigan et al., 2006; Norman et al., 2011). Therefore, identification of factors that prevent perceptions of stigma from becoming internalized would be critical. This information would be particularly beneficial for rehabilitation counselors as they support consumers in reaching their goals. Hence, the guiding research question of the study was as follows: How, if at all, do personality characteristics, social support, and coping behaviors mediate the pathway between perceived and internalized stigma among people with substance use concerns?

Study three. The third study (Chapter IV), “A Narrative Inquiry of Ambivalent Ableism: Understanding how Physically Disabled Adults Perceive Microaggressions,” involved interviewing people with physical disabilities about the microaggressions they encounter from others. More specifically, the purpose of the third study was to validate existing research on ableist microaggressions and to understand the impact of microaggressions on the disabled targets. Additionally, the purpose of study three was to investigate if ableist microaggressions could be conceptualized in terms of ambivalent ableism.

Although the overtly negative attitudes and behaviors toward PWD have long been documented, only in recent years have researchers begun to investigate the subtleties of ableism that reside within daily interactions, otherwise known as microaggressions. According to Sue (2010), microaggressions have been defined as “the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether

intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely on their marginalized group membership” (p. 3).

Microaggressions can occur in three forms: microassaults (e.g., bullying), microinsults (e.g., providing PWD with unsolicited assistance), and microvalidations (e.g., denying that disability is part of a person’s identity) (Sue, 2010). To date, only Keller and Galgay (2010) and Bell (2015) have investigated the microaggressions toward individuals with physical disabilities. Examples of microaggressions identified by their participants included infantilization, perceived helplessness, spread, patronization, and desexualization.

In an attempt to propose a new lens for conceptualizing ableist microaggressions, study three was used to explore the applicability of Glick and Fiske’s (1996) theory of ambivalent sexism in understanding microaggressive experiences of PWD. Namely, Glick and Fiske (1996) posited that sexism occurs in both hostile and benevolent forms. Specifically, hostile sexism has been defined as the overtly negative attitudes and behaviors toward women while benevolent ableism has been defined as the well-intentioned but implicitly negative attitudes or behaviors toward women. In applying these concepts to PWD, hostile ableism could be exemplified by microassaults such as bullying and discrimination while benevolent ableism could be exemplified microinsults or microinvalidations such as inspiration porn or failing to recognize the marginalization experienced by PWD.

Due to the dearth of research investigating ableist microaggressions, study three was significant because the findings contributed additional insight into the nature of

microaggressions experienced by PWD. Further, study three served as an initial investigation into a new framework for conceptualizing ableist microaggressive experiences. Finally, the qualitative methodology used in the study created a space for the voices of PWD to be heard. As Linton (1998) discussed, within research, participants with disabilities tend to be studied “only in their particularity” and as “deviation from the norm.” Questioning participants in semi-structured interviews, therefore, allowed participants to be more active in the research and to select what they discussed. In study three, participant narratives were analyzed in terms of three research questions: (1) How do people with physical disabilities narrate their experiences with microaggressions and ambivalent ableism?; (2) How, if at all, do the microaggressions reported by people with physical disabilities resemble the categories of hostile ableism and benevolent ableism?; and (3) How do people with physical disabilities believe that microaggressions and ambivalent ableism have impacted their lives?

Researcher Positionality

The author of this dissertation and principal researcher of the three studies identifies as a Caucasian female in her late 20’s who has a congenital physical disability. She has a master’s degree in Rehabilitation Counseling and has counseled consumers with psychiatric disabilities, substance use disorders, and individuals experiencing homelessness. Influenced by her education, personal experience as a disabled person, and work with disabled consumers, the author subscribes to both the Rehabilitation and Disability Studies conceptualizations of disability. Through the lens of Rehabilitation, the author recognizes the importance of working with PWD on a personal level to assess,

treat, and empower them in reaching their goals (Commission on Rehabilitation Counselor Certification, 2015). However, in order for PWD to be fully integrated into society, change must occur on a macro level. Therefore, through the lens of Disability Studies, this author agrees that disability is a social phenomenon caused by the attitudinal, environmental, and political barriers within society (Berger, 2013; Linton, 1998).

Organization of the Dissertation

The dissertation contains five chapters. The current chapter (Chapter I) has included an introduction to the problem of ableist attitudinal barriers and to the three studies that were conducted to offer new insight into this problem. The three studies are then presented in chapters II, III, and IV. Each chapter includes a review of literature relevant to the particular study; a description of the methods, data analysis, and results; and a discussion of implications, limitations, and directions for future research. Finally, the concluding chapter of the dissertation, chapter V, contains a summary of each study and a discussion of implications for research, education, and practice.

CHAPTER II
IMPLICIT BIAS TOWARD PEOPLE WITH MENTAL ILLNESS:
A SYSTEMATIC LITERATURE REVIEW

For rehabilitation counselors to be most effective in working with consumers who have psychiatric disabilities, counselors must be aware of barriers that could prevent these consumers from achieving their goals. The societal stigma regarding mental illness serves as one such barrier for the nearly 43.7 million people in the United States who have been diagnosed with a mental illness (Corrigan & Kosyluk, 2014; National Institute of Mental Health, 2012). Indeed, numerous researchers have noted an array of stigmatizing beliefs toward people with mental illness (Parcesepe & Cabassa, 2013). Three of the most common stereotypes about people with mental illness have included beliefs that they are dangerous (e.g., Corrigan et al., 2002), incompetent (e.g., Sadler, Meagor, & Kaye, 2012), and responsible for the onset and offset of their condition (e.g., Corrigan et al., 2002; Ebnetter & Latner, 2013). Consequently, individuals who endorse these stereotypical beliefs may experience emotions such as fear, pity, and anger (Corrigan et al., 2002; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). These emotions, in turn, could lead to the avoidance, segregation, and coercive treatment of people with mental illness (Corrigan et al., 2002; Corrigan et al., 2003).

Although most of the research on bias toward people with mental illness has focused on explicit, consciously reported negative attitudes and beliefs (e.g., Angermeyer & Dietrich, 2006), recent research in social psychology indicates that people also hold implicit, unconscious prejudices and stereotypes toward people with mental illness (e.g.,

Brener, Rose, von Hippel, & Wilson, 2013; Cheon & Chiao, 2012; Kopera et al., 2014; Lincoln, Arens, Berger, & Rief, 2008). Understanding the implicit form of bias is critical because in some contexts, implicit biases have greater impact on discrimination toward people with mental illness than explicit biases. The purpose of the current paper was to review the literature on implicit bias toward people with mental illness, with an eye toward recommendations for future research on the interventions that may prove effective for reducing the implicit negative attitudes and beliefs that exist toward these individuals.

Explicit vs. Implicit Prejudice toward People with Mental Illness

Broadly speaking, prejudice toward mental illness has important consequences for individuals with psychiatric diagnoses. For instance, exposure to and knowledge of negative attitudes about mental illness can lead to self-stigma (Corrigan & Kosyluk, 2014). According to Corrigan and Kosyluk (2014), self-stigma occurs when “people internalize the prejudice and discriminate against themselves” (p. 40). As a result, people with mental illness have reported delaying or failing to seek treatment for their symptoms because they fear being stigmatized (Franz et al., 2010; Ienciu, Romoşan, Bredicean, & Romoşan, 2010; Jennings et al., 2015; Substance Abuse and Mental Health Services Administration, 2007). The presence of self-stigma can further interfere with the work between the consumer and rehabilitation counselor by causing lower self-esteem and self-efficacy (Drapalski et al., 2013), poor medication adherence (Uhlmann et al., 2014), worsening symptoms (Cerit, Filizer, Tural, & Tufan, 2012), and suicidal ideation (Sharaf, Ossman, & Lachine, 2012).

Held beliefs can also influence behavior toward people with mental illness (Perugini, Richetin, & Zogmaister, 2010). As the findings from Marie and Miles (2008) exemplified, participants who perceive people with mental illness as dangerous may be more likely to increase social distance from such individuals. Similar results have been reported across various participant samples such as high school students (Economou et al., 2012), college students (Economou, Peppou, Louki, & Stefanis, 2012), healthcare providers (Mittal et al., 2014), and the general public (Loch et al., 2014). As Corrigan and Kosyluk (2014) explained, fear and avoidance of people with mental illness can lead to specific acts of discrimination such as landlords failing to approve someone for housing and employers choosing not to hire an applicant upon learning of his or her diagnosis.

In an attempt to change the stigma toward people with mental illness, researchers have developed and tested intervention strategies (e.g., Corrigan et al., 2001; Corrigan & O'Shaughnessy, 2007; Corrigan & Penn, 2015). Three main approaches have emerged over the years: (1) protest interventions, (2) education interventions, and (3) contact interventions (Corrigan & O'Shaughnessy, 2007; Corrigan & Penn, 2015). During protest interventions, individuals are told that their beliefs about mental illness are incorrect but are not provided with information to contradict their beliefs. Education interventions, on the other hand, have been characterized by the presentation of facts about mental illness and/or mental health treatments. The primary objective of education interventions has been to increase participants' knowledge about mental health related topics. Finally, during contact interventions, participants have the opportunity to interact with someone who has a mental illness. This final approach reflects Allport's (1954) interpersonal

contact theory which posits that positive contact with out-group members improves attitudes toward such individuals. However, in order for the contact to lead to positive change, it must occur under optimal circumstances. For instance, the contact should occur naturally with both the in-group and out-group member holding equal positions of power and working toward a common goal (Smart, 2001). The contact should also lead to the biased person to individualizing the stigmatized person (Smart, 2001). Of the three approaches to changing attitudes toward people with mental illness, the education and contact interventions have shown the greatest effectiveness in reducing mental health stigma (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012).

Although researchers have extensively studied and sought to change attitudes toward people with mental illness on an explicit level (i.e., self-reported attitudes within participants' awareness; Payne & Gawronski, 2010), less emphasis has been placed on nonconscious, or implicit attitudes toward these individuals (Payne & Gawronski, 2010). By using explicit measures, participants may choose to alter their responses to what they believe will be more acceptable (Dunton & Fazio, 1997). The limitation to relying exclusively on explicit measures of bias against people with mental illness is that when participants are aware that it is not socially acceptable to express prejudice toward out-group members, they may be dishonest and alter their responses when reporting their attitudes or beliefs. Therefore, as is the case in racial and ethnic prejudice, implicit measures may offer a more accurate understanding of the level of prejudice, and prevalence of stereotyping toward individuals with mental health concerns (Stier & Hindshaw, 2007).

A full understanding of the implicit biases people hold about individuals with mental illness would also offer valuable contributions to the field of rehabilitation counseling. By identifying the unconscious beliefs that students hold about people with mental illness, rehabilitation professors could better tailor their courses to deepen students' understanding in the areas of implicit bias. Similarly, exploring the implicit associations held by non-student samples such as employers, healthcare professionals, and the general public would provide rehabilitation counselors with better insight into the barriers encountered by their consumers. This insight, in turn, could lead to more effective in-service trainings that encourage open discussion about common implicit beliefs. Further still, identifying and improving implicit associations is vital given that unconscious biases can influence behavior (e.g., Perugini et al., 2010), which may lead to discrimination.

Measuring Implicit Attitudes

The Implicit Association Test (IAT) has been one of the most widely used measures for studying implicit social cognition. Developed by Greenwald, McGhee, and Schwartz (1998), the IAT is an indirect, response-time measure used to examine the strength of participant implicit associations (Teige-Mocigemba, Klauer, & Sherman, 2010). The IAT consists of two types of categories: target categories and attribute categories. Target categories represent the objects toward which attitudes are being measured or compared while attribute categories represent characteristics being paired with the target(s). Multiple trials of the IAT are administered to participants during which participants pair stimuli with the appropriate target and attribute categories in both

compatible and incompatible blocks. The assumption is that participants will categorize stimuli faster when the target and attribute categories are compatible with participants' personally held associations than when the target and attribute categories are incompatible.

For example, to explore implicit racial attitudes, the researcher may use the target words of "White" and "Black" and the attribute words of "Good" and "Bad." For the compatible blocks, participants complete a series of tasks in which they place images or words that represent "White" or "Good" in one category and "Black" or "Bad" in another category. Following, participants complete incompatible blocks over a series of tasks in which they place images or words that represent "White" or "Bad" in one category and "Black" or "Good" in another category. The speed at which participants make the correct categorization in the compatible blocks as compared to the incompatible blocks is indicative of the strength of the associations and of a preference for one target more than another.

Over the years, variations of the IAT have emerged. For instance, whereas the standard IAT requires two target categories, the Single Category Implicit Association Test (SC-IAT; Karpinski & Steinman, 2006) and the Single Target Implicit Association Test (ST-IAT; Wigboldus, Holland, & van Knippenberg, 2005) require only one target category. The testing procedures are similar to the IAT with the exception that, during each trial, one attribute category exists independently and is not paired with an attitude object. Another variation of the IAT, the Brief Implicit Association Test (BIAT; Sriram & Greenwald, 2009), serves as a bridge between IATs that contain two target categories

and those that contain one target category. Like the standard IAT, the BIAT presents two target categories; however, one of the categories is labeled as “anything else” (Teige-Mocigemba et al., 2010). Thus, similar to the SC-IAT and ST-IAT, participants are able to focus their efforts on only one target. Because two target categories may not be appropriate for certain research questions, by limiting the measure to a single target, the researchers make the test more precise and obtain more relevant results (Karpinski & Steinman, 2006).

Differences in Attitude-Related Terms

When reviewing research on attitudes toward members of minority groups, terms such as attitude, bias, stereotype, prejudice, discrimination, and stigma often become lumped together. However, to fully grasp the application of what is being studied with implicit and explicit attitude measures, understanding the distinction between these terms is important. Hence, a brief discussion of the differences between these terms is provided.

First, according to Eagly and Chaiken (1993), an attitude is “a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor.” In other words, an attitude is a person’s judgment or appraisal of a person or object. Allport (1935) proposed that such attitudes develop as a result of past experiences and can influence future behavior toward given objects or situations (as cited by Fazio, 2007). Further, bias (intergroup bias in particular) occurs when a person holds a preference and more positive evaluation of his or her own in-group than members of an out-group (Dovidio, Hewstone, Glick, & Esses, 2010). In studying attitudes toward people with mental illness, participants may show an implicit bias against people with

mental illness by having slower response times during the incompatible tasks than during the compatible blocks.

A stereotype, on the other hand, has been defined as “an inference made about individuals based on their assignment to a particular group or category” (Jones & Corrigan, 2014, p. 12). An example of a stereotype toward people with mental illness would be the belief that such individuals are dangerous. Prejudice then adds another layer when a person agrees with a stereotype and experiences an emotional reaction to the target (Jones & Corrigan, 2014). For instance, someone who believes the stereotype that people with mental illness are dangerous may experience fear when in contact with such individuals. As a result of stereotyping and prejudice, a person may engage in acts of discrimination, that is, engage in negative behaviors toward the target (Jones & Corrigan, 2014). Dovidio et al. (2010) elaborated that discrimination “creates, maintains, or reinforces advantage for some groups and their members over other groups and their members” (p. 10). An example of discrimination toward people with mental illness would include landlords failing to approve someone for housing upon learning of his or her psychiatric diagnosis.

Finally, stigma refers to “an attribute that is deeply discrediting” and causes a stigmatized individual to be perceived as “not quite human,” as inferior, and as having blemishes of character (Goffman, 1963). Link and Phelan (2001) expanded Goffman’s (1963) definition by positing that stigma contains five components. Namely, Link and Phelan (2001) proposed that “stigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows

them.” Considering Goffman’s (1963) and Link and Phelan’s (2001) definitions of stigma in combination, stigma encompasses elements of the previously defined terms of attitudes, biases, stereotypes, prejudice, and discrimination.

Purpose

Although various authors have written reviews focused on explicit attitudes toward people with mental illness (e.g., Parcesepe & Cabassa, 2013), a review has not been written with a focus on implicit bias toward such individuals. Therefore, the purpose of the current paper was to compare and critique available research that included the component of implicit bias regarding people with mental illness. Given that people with mental illness continue to be a stigmatized group (Corrigan & Kosyluk, 2014), gaining a collective understanding of implicit bias toward these individuals would be valuable.

Three research questions were explored in writing this review paper: (1) How was implicit bias toward people with mental illness represented in the articles? (2) What factors influenced the valence of implicit associations toward people with mental illness? and (3) How did implicit biases compare to explicit attitudes toward people with mental illness?

Method

Articles were chosen for review if the following criteria were met: (1) the researchers’ primary focus of the study was on implicit prejudice or stereotyping toward people with mental illness; (2) the researchers used a version of the IAT (e.g., IAT, BIAT, GNAT, SC-IAT, ST-IAT) in their methodology; (3) individuals who identified as having a mental illness were not included in the participant sample; (4) the article was

written in English; (5) the article was published between 1998 and June 2015; and (6) the article was peer-reviewed. To locate all relevant articles, an extensive search was conducted in the academic databases of Academic Search Complete, MEDLINE, PsychArticles, and PsychINFO. The keywords of *Mental Illness* were entered into the databases in combination with the following terms: *attitude, bias, discrimination, EMA, Go No Go, IAT, IAP, implicit, indirect, prejudice, provider attitude, provider discrimination, provider stereotype, provider stigma, SPF, stigma, and unconscious*. A review of reference lists was also conducted for each article that met the inclusion criteria.

Results

Nineteen articles met the inclusion criteria for this review. The selected articles were analyzed in terms of participant characteristics, implicit versus explicit participant responses, implicit measure designs, and moderators of implicit bias. For a summary of the participant characteristics, methods, instruments, and implicit-explicit correlations noted in each study, refer to Table 2.1.

Table 2.1

Summary of Participant Characteristics and Measurement Tools used in Studies on Implicit Biases toward Mental Illness

Author(s)	Participants		Method	Implicit Measure			Explicit Measure(s)	Implicit-Explicit Correlations
	Sample	Country		Type	Target Categories	Attribute Categories		
Brener et al. (2013)	Mental health workers	Australia	<ul style="list-style-type: none"> • Participants completed implicit and explicit measures. 	Single category IAT	<ul style="list-style-type: none"> • People with mental illness 	<ul style="list-style-type: none"> • Wonderful vs. Awful 	<ul style="list-style-type: none"> • Feeling Thermometer Scale • Helping intent measure • Emotions measure 	<ul style="list-style-type: none"> • Implicit biases positively correlated with explicit attitudes and emotions. • Implicit biases negatively correlated with willingness to help someone with a mental illness.
Cheon & Chiao (2012)	Undergraduate students	United States	<ul style="list-style-type: none"> • Participants completed implicit and explicit measures. • Researchers compared responses of Asian American participants and Caucasian American participants. 	GNAT	<ul style="list-style-type: none"> • Mental illness vs. Physical illness 	<ul style="list-style-type: none"> • Good vs. Bad 	<ul style="list-style-type: none"> • Social Distance Scale 	<ul style="list-style-type: none"> • Implicit biases did not significantly correlate with desire for social distance.

(continued)

Table 2.1

Summary of Participant Characteristics and Measurement Tools used in Studies on Implicit Attitudes toward Mental Illness (continued)

Author(s)	Participants		Method	Implicit Measure			Explicit Measure(s)	Implicit-Explicit Correlations
	Sample	Country		Type	Target Categories	Attribute Categories		
Kopera et al. (2014)	Mental health professionals and nonprofessionals	Poland	<ul style="list-style-type: none"> • Participants completed implicit and explicit measures. 	GNAT	<ul style="list-style-type: none"> • Mentally ill vs. Various unrelated professions 	<ul style="list-style-type: none"> • Pleasant vs. Unpleasant 	<ul style="list-style-type: none"> • Emotion Scale • Opinions about Mental Illness Scale 	<ul style="list-style-type: none"> • Statistical implicit-explicit correlations were not reported.
Lincoln et al. (2008)	Psychology and medical students	Germany	<ul style="list-style-type: none"> • Participants completed implicit and explicit measures. • Participants were randomly assigned to a condition to learn about the etiology of schizophrenia or water (control condition). • Participants completed implicit measure a second time. • Participants completed explicit measure a second time. 	IAT	<ul style="list-style-type: none"> • Schizophrenia vs. Depression 	<ul style="list-style-type: none"> • Dangerous vs. Safe • Culprit vs. Victim • Cureless vs. Healable 	<ul style="list-style-type: none"> • Causes of schizophrenia measure • Stereotype measure • Social Distance Scale 	<ul style="list-style-type: none"> • Statistical implicit-explicit correlations were not reported.

(continued)

Table 2.1

Summary of Participant Characteristics and Measurement Tools used in Studies on Implicit Attitudes toward Mental Illness (continued)

Author(s)	Participants		Method	Implicit Measure			Explicit Measure(s)	Implicit-Explicit Correlations
	Sample	Country		Type	Target Categories	Attribute Categories		
Lund & Boggero (2014)	Undergraduate students	United States	Study 1: <ul style="list-style-type: none"> • Participants completed implicit and explicit measures. Study 2: <ul style="list-style-type: none"> • Participants were primed with articles about disease, crime, or job loss. • Participants completed same implicit measure as Study 1. 	Study 1 and 2: Single target IAT	Study 1 and 2: <ul style="list-style-type: none"> • Mentally ill 	Study 1 and 2: <ul style="list-style-type: none"> • Danger vs. Sick 	Study 1: <ul style="list-style-type: none"> • Illness recency 	Study 1: <ul style="list-style-type: none"> • Implicit associations had a significant positive correlation with illness recency for male participants. • Implicit associations had a positive but non-significant correlation with illness recency for female participants. Study 2: <ul style="list-style-type: none"> • N/A
Mannarini & Boffo (2014)	Undergraduate students	Italy	<ul style="list-style-type: none"> • Participants completed implicit measure. 	IAT	<ul style="list-style-type: none"> • Mental illness vs. Physical illness 	<ul style="list-style-type: none"> • Psychological vs. Biological 	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • N/A

(continued)

Table 2.1

Summary of Participant Characteristics and Measurement Tools used in Studies on Implicit Attitudes toward Mental Illness (continued)

Author(s)	Participants		Method	Implicit Measure			Explicit Measure(s)	Implicit-Explicit Correlations
	Sample	Country		Type	Target Categories	Attribute Categories		
Monteith and Pettit (2011)	Undergraduate students	United States	<ul style="list-style-type: none"> • Participants completed implicit and explicit measures. 	IAT	<ul style="list-style-type: none"> • Depressed vs. Physically ill 	<ul style="list-style-type: none"> • Permanent vs. Temporary • Controllable vs. Uncontrollable • Psychological vs. Biological • Good vs. Bad 	<ul style="list-style-type: none"> • Semantic differential scale 	<ul style="list-style-type: none"> • Implicit associations did not significantly correlate with explicit responses.

(continued)

Table 2.1

Summary of Participant Characteristics and Measurement Tools used in Studies on Implicit Attitudes toward Mental Illness (continued)

Author(s)	Participants		Method	Implicit Measure			Explicit Measure(s)	Implicit-Explicit Correlations
	Sample	Country		Type	Target Categories	Attribute Categories		
Norman et al. (2010)	Undergraduate students	Canada	<ul style="list-style-type: none"> • Participants pre-study seating distance were assessed. • Participants provided saliva sample. • Participants completed implicit measure. • Participants completed explicit measures. • Participants went into a room and were told they would meet someone with schizophrenia. • Participants seating distance from the person's chair was assessed. • Participants provided second saliva sample. 	Concept Association Task	<ul style="list-style-type: none"> • Schizophrenia vs. Health • Schizophrenic vs. Healthy 	<ul style="list-style-type: none"> • Dangerous vs. Safe • Friendly vs. Hostile • Pleasant vs. Unpleasant • Nasty vs. Nice 	<ul style="list-style-type: none"> • Semantic differential scale • Level of previous mental health experience 	<ul style="list-style-type: none"> • Statistical implicit-explicit correlations were not reported.

(continued)

Table 2.1

Summary of Participant Characteristics and Measurement Tools used in Studies on Implicit Attitudes toward Mental Illness (continued)

Author(s)	Participants		Method	Implicit Measure	Explicit Measure(s)	Implicit-Explicit Correlations		
	Sample	Country					Type	Target Categories
O'Driscoll et al. (2012)	Children (10-11 years old) Adolescents (15-16 years old)	Ireland	<ul style="list-style-type: none"> • Participants were randomly assigned to an ADHD or Depression condition. • Participants read vignettes about peers with and without mental health disorders. • Participants completed implicit and explicit measures. 	IAT	<ul style="list-style-type: none"> • ADHD vs. Normal Issues • Depression vs. Normal Issues 	<ul style="list-style-type: none"> • Good vs. Bad 	<ul style="list-style-type: none"> • Strengths and difficulties questionnaire (SDQ) • Vignettes • Revised Attribution Questionnaire (r-AQ) • Shared Activity Questionnaire (SAQ) • Name-behaviour training (NBT) procedure 	<ul style="list-style-type: none"> • Statistical implicit-explicit correlations were not reported.
Omori et al. (2012)	Clinical medical residents	Japan	<ul style="list-style-type: none"> • Participants completed implicit and explicit measures. 	IAT	<ul style="list-style-type: none"> • Schizophrenia (old vs. new term) vs. Hypertension 	<ul style="list-style-type: none"> • Victim vs. Criminal 	<ul style="list-style-type: none"> • Devaluation-discrimination scale 	<ul style="list-style-type: none"> • Implicit associations did not significantly correlate with explicit responses.

(continued)

Table 2.1

Summary of Participant Characteristics and Measurement Tools used in Studies on Implicit Attitudes toward Mental Illness (continued)

Author(s)	Participants		Method	Implicit Measure			Explicit Measure(s)	Implicit-Explicit Correlations
	Sample	Country		Type	Target Categories	Attribute Categories		
Peris et al. (2008)	Clinical psychology graduate students; Professional mental health clinicians; Undergraduate students; General public; Other health/social service workers	United States	<ul style="list-style-type: none"> Participants completed implicit and explicit measures. 	IAT	<ul style="list-style-type: none"> Mentally ill people vs. Welfare recipients 	<ul style="list-style-type: none"> Good vs. Bad 	<ul style="list-style-type: none"> Semantic differential scale Vignettes 	<ul style="list-style-type: none"> Implicit good-bad associations had a significant positive correlation with explicit good-bad responses. Implicit blameworthy-innocent associations had a positive but non-significant correlation with explicit blameworthy-innocent responses. Implicit helpless-competent associations had a positive but non-significant correlation with explicit helpless-competent responses.

(correlation)

Table 2.1

Summary of Participant Characteristics and Measurement Tools used in Studies on Implicit Attitudes toward Mental Illness (continued)

Author(s)	Participants		Method	Implicit Measure			Explicit Measure(s)	Implicit-Explicit Correlations
	Sample	Country		Type	Target Categories	Attribute Categories		
Saporito et al. (2011)	High school students	United States	<ul style="list-style-type: none"> • Participants completed explicit measures. • Participants were randomly assigned to an experimental or control condition. • Participants completed implicit measure. • Participants completed additional explicit measures. 	Paper and pencil Brief IAT	<ul style="list-style-type: none"> • Mental health treatment • Mentally ill people 	<ul style="list-style-type: none"> • Respectable vs. Shameful • Good vs. Bad 	<ul style="list-style-type: none"> • Attitudes toward Seeking Professional Psychological Help – short form • Positive and Negative Affect Scale • Social Restrictiveness subscale from Community Attitudes toward the Mentally Ill scale • Semantic differential scale; Perceptions of stigma • Willingness to seek treatment 	<ul style="list-style-type: none"> • Statistical implicit-explicit correlations were not reported.
Stull et al. (2013)	Mental health workers	United States	<ul style="list-style-type: none"> • Participants completed implicit and explicit measures. 	IAT	<ul style="list-style-type: none"> • Mental illness vs. Physical illness 	<ul style="list-style-type: none"> • Good vs. Bad • Blameworthy vs. Innocent • Helpless vs. Competent 	<ul style="list-style-type: none"> • Semantic differential scales • Vignette 	<ul style="list-style-type: none"> • Implicit associations did not significantly correlate with explicit responses.

(continued)

Table 2.1

Summary of Participant Characteristics and Measurement Tools used in Studies on Implicit Attitudes toward Mental Illness (continued)

Author(s)	Participants		Method	Implicit Measure			Explicit Measure(s)	Implicit-Explicit Correlations
	Sample	Country		Type	Target Categories	Attribute Categories		
Takahashi et al. (2009)	Undergraduate students	Japan	<ul style="list-style-type: none"> Participants completed implicit and explicit measures. 	IAT	<ul style="list-style-type: none"> Schizophrenia (old vs. new term) vs. Diabetes 	<ul style="list-style-type: none"> Criminal vs. Victim 	<ul style="list-style-type: none"> Devaluation-Discrimination Scale 	<ul style="list-style-type: none"> Implicit associations had a significant negative correlation with explicit attitudes.
Teachman et al. (2006); Study I	Study 1: Undergraduate students Study 2: Did not meet selection criteria.	United States	Study 1: <ul style="list-style-type: none"> Participants completed implicit and explicit measures. Study 2: <ul style="list-style-type: none"> N/A 	IAT	<ul style="list-style-type: none"> Mental illness vs. Physical illness 	<ul style="list-style-type: none"> Good vs. Bad Blameworthy vs. Innocent Helpless vs. Competent 	<ul style="list-style-type: none"> Semantic differential scales Perceived Dangerousness Scale 	<ul style="list-style-type: none"> Implicit associations did not significantly correlate with explicit responses. Study 2: <ul style="list-style-type: none"> N/A

(continued)

Table 2.1

Summary of Participant Characteristics and Measurement Tools used in Studies on Implicit Attitudes toward Mental Illness (continued)

Author(s)	Participants		Method	Implicit Measure			Explicit Measure(s)	Implicit-Explicit Correlations
	Sample	Country		Type	Target Categories	Attribute Categories		
Thomas et al. (2007)	Undergraduate students	United States	Study 1: <ul style="list-style-type: none"> • Participants completed implicit measures. Study 2: <ul style="list-style-type: none"> • Participants completed implicit and explicit measures. 	IAT	<ul style="list-style-type: none"> • Paraplegic vs. Non-paraplegic • Alcoholic vs. Non-alcoholic • Cancer vs. Cancer free • Mental illness vs. No mental illness 	<ul style="list-style-type: none"> • Pleasant vs. Unpleasant 	<ul style="list-style-type: none"> • Interactions with Disabled Persons Scale • Marlowe-Crowne Social Desirability Scale 	<ul style="list-style-type: none"> • Overall implicit associations had a significant positive correlation with explicit attitudes toward disability. • Overall implicit associations had a significant positive correlation with explicit social discomfort toward disability. • Overall implicit associations had a negative non-significant correlation with explicit empathy toward disability.

(continued)

Table 2.1

Summary of Participant Characteristics and Measurement Tools used in Studies on Implicit Attitudes toward Mental Illness (continued)

Author(s)	Participants		Method	Implicit Measure			Explicit Measure(s)	Implicit-Explicit Correlations
	Sample	Country		Type	Target Categories	Attribute Categories		
Vertilo & Gibson (2014)	Undergraduate students	United States	<ul style="list-style-type: none"> • Participants completed implicit and explicit measures. 	IAT	<ul style="list-style-type: none"> • Mental health vs. Mental illness 	<ul style="list-style-type: none"> • Good vs. Bad 	<ul style="list-style-type: none"> • Participant characteristics scales • Sentence evaluation task • Social distance task 	<ul style="list-style-type: none"> • Implicit associations had a significant negative correlation with helping intent. • Implicit associations did not correlate with participant character strengths.
Wang et al. (2012)	Undergraduate students	China	<ul style="list-style-type: none"> • Participants completed implicit and explicit measures. 	Single category IAT	<ul style="list-style-type: none"> • Mental illness 	<ul style="list-style-type: none"> • Positive words vs. Negative words 	<ul style="list-style-type: none"> • Social Distance Scale • Feeling Thermometer Scale 	<ul style="list-style-type: none"> • Implicit associations did not significantly correlate with explicit responses.

(continued)

Table 2.1

Summary of Participant Characteristics and Measurement Tools used in Studies on Implicit Attitudes toward Mental Illness (continued)

Author(s)	Participants		Method	Implicit Measure			Explicit Measure(s)	Implicit-Explicit Correlations
	Sample	Country		Type	Target Categories	Attribute Categories		
Zvonkovic & Lucas-Thompson (2015)	Undergraduate students	United States	<ul style="list-style-type: none"> • Participants completed implicit measure. • Participants were randomly assigned to an experimental or control condition. • Participants completed an additional implicit measure. • Participants completed explicit measure. 	IAT	<ul style="list-style-type: none"> • Schizophrenia vs. Mental health 	<ul style="list-style-type: none"> • Violence vs. Peacefulness 	<ul style="list-style-type: none"> • Social Distance Scale 	<ul style="list-style-type: none"> • Implicit associations did not significantly correlate with explicit responses.

Participant Characteristics

Ethnic differences among participants are important to note given that some authors have posited that a person's implicit attitudes and beliefs are influenced by the cultural environment (Payne & Gawronski, 2010). Cheon and Chiao (2012) provided support for this claim in their findings that Caucasian American participants showed a positive implicit bias toward people with mental illness while Asian American participants showed a negative implicit bias against people with mental illness. Although participants were recruited from the United States in 53% of the studies (Cheon & Chiao, 2012; Lund & Boggero, 2014; Monteith & Pettit, 2011; Peris, Teachman, & Nosek, 2008; Saporito, Ryan, & Teachman, 2011; Stull, McGrew, Salyers, Ashburn-Nardo, 2013; Teachman, Wilson, & Komarovskaya, 2006; Thomas, Vaughn, & Doyle, 2007; Vertilo & Gibson, 2014; Zvonkovic & Lucas-Thompson, 2015), a variety of other countries were also represented across the participant samples including Australia (Brenner et al., 2013), Canada (Norman et al., 2010), China (Wang, Huang, Jackson, & Chen, 2012), Germany (Lincoln et al., 2008), Ireland (O'Driscoll, Heary, Hennessy, & McKeague, 2012), Italy (Mannarini & Boffo, 2014), Japan (Omori et al., 2012; Takahashi et al., 2009), and Poland (Kopera et al., 2014).

Among the samples, gender representation was nearly equal in 42% of the studies (Cheon & Chiao, 2012; Kopera et al., 2014; O'Driscoll et al., 2013; Omori et al., 2012; Takahashi et al., 2009; Teachman et al., 2006; Vertilo & Gibson, 2014; Wang et al., 2012) and was not noted for 5% of the studies (Mannarini & Boffo, 2014). Women represented 60% or more of the participants in remaining studies. Undergraduate students

were the target sample in 63% of the studies. Only O'Driscoll et al. (2012) and Saporito et al. (2011) explored implicit attitudes toward mental illness among participants under the age of 18.

Implicit versus Explicit Participant Responses

With the exception of two papers (Lund & Boggero, 2014; Mannarini & Boffo, 2014), researchers in all studies explored both participants' implicit and explicit attitudes toward people with mental illnesses. However, statistical correlations between participants' implicit and explicit attitudes were reported in only 65% of the papers that included both measures (Brener et al., 2013; Cheon & Chiao, 2012; Monteith and Pettit, 2011; Omori et al., 2012; Peris et al., 2008; Stull et al., 2013; Takahashi et al., 2009; Teachman et al., 2006; Thomas et al., 2007; Vertilo & Gibson, 2014; Wang et al., 2012). The most frequent implicit-explicit correlation explored was the relationship between participants' implicit associations and their desired social distance from people with mental illness. Of the four researchers who examined this relationship, half reported significant negative correlations between participants' implicit bias and their willingness to help someone with a mental illness (Brener et al., 2013; Vertilo & Gibson, 2014). In other words, the more implicit bias participants held toward people with mental illness, the less likely they predicted they would be to offer assistance to such individuals. These findings support the claim that implicit biases can influence behavior (e.g., Perugini et al., 2010). Researchers of the remaining two studies, Cheon and Chiao (2012) and Wang et al. (2012), did not report significant correlations between participants' implicit associations and desired social distance.

Twenty-four percent of the researchers examined the relationship between participants' implicit associations and explicit responses on semantic differential scales (Monteith & Pettit, 2011; Peris et al., 2008; Stull et al., 2013; Teachman et al., 2006). Of these, only Peris et al. (2008) reported a significant correlation between participants' responses on the implicit and explicit measures. Namely, a significant positive correlation occurred with regards to the implicit and explicit Bad-Good categories wherein participants were more likely to perceive people with mental illness as more good than bad on both measures. Although results were not statistically significant, semantic differential scales were used in the remaining studies to explore the implicit and explicit stereotypes of controllability, blameworthiness, and incompetency of people with mental illness.

Participants' implicit and explicit belief that people with mental illness are dangerous was also examined in studies. In particular, Omori et al. (2012) and Takahashi et al. (2009) explored if word choice in reference to schizophrenia (i.e., "Seishin-Bunretsu-Byo" or "Mind-Split Disease" vs. "Togo-Shitcho-Sho" or "Integration Disorder") influenced implicit associations between schizophrenia and criminal vs. victim. In addition, Omori et al. (2012) and Takahashi et al. (2009) examined the data for correlations between participants' implicit associations on the IAT and explicit responses on the Devaluation-Discrimination Scale. Omori et al. (2012) reported participants showed stronger implicit associations between "Mind Split Disease" and "criminal" prior to working with patients who have schizophrenia but stronger implicit associations between "Integration Disorder" and "criminal" after working with such individuals.

When these results were compared to participants' explicit responses, however, Omori et al. (2012) concluded that participants' implicit and explicit responses were not significantly correlated. Takahashi et al. (2009), on the other hand, found that participants showed the strongest implicit associations between "Mind Split Disease" and "criminal." The researchers also reported a significant, negative correlation between participants' implicit and explicit responses.

Finally, 18% of researchers reported on miscellaneous implicit-explicit correlations. Brener et al. (2013), for example, concluded that participants who had negative implicit associations toward people with mental illness were also more likely to explicitly express negative emotions toward such individuals. Thomas et al. (2007) also examined participants' implicit and explicit attitudes toward people with mental illness in addition to exploring the same attitudes toward people with alcoholism, cancer, and paraplegia. Because Thomas et al. (2007) combined participant scores regarding all four conditions when calculating potential implicit-explicit correlations, understanding the correlations specific to mental illness was not possible. However, results from the combined analyses indicated that participants' overall implicit associations had significant positive correlations with their explicit attitudes toward people with disabilities. In particular, implicit bias toward people with disabilities had a significant positive correlation with social discomfort around such individuals.

Participant self-reports of personal characteristics was a final factor that was examined in terms of its relationship with implicit bias toward people with mental illness (Vertilo & Gibson, 2014). Vertilo and Gibson (2014) concluded that statistically

significant correlations did not occur between participants' implicit bias and personal characteristics. However, main effects were observed in that participants who had slower reaction times on the IAT also showed lower levels of pity and avoidance.

Implicit Measure Design

Target categories. Sixty-three percent of the studies examined bias toward mental illness as a whole rather than toward individuals with certain types of psychiatric diagnoses. Namely, the terms '*people with mental illness*' (Brener et al., 2013), '*mental illness*' (Cheon & Chiao, 2012; Mannarini & Boffo, 2014; Stull et al., 2013; Teachman et al., 2006; Thomas et al., 2007; Wang et al., 2012), '*mentally ill*' (Kopera et al., 2014; Lund & Boggero, 2014), '*mentally ill people*' (Peris et al., 2008; Saporito et al., 2011), and '*mental health treatment*' (Saporito et al., 2011) were selected as the category target labels. Vertilo and Gibson (2014) chose a slightly different approach by comparing participants' implicit attitudes using the categories '*mental health*' and '*mental illness*.'

As implied by Vertilo and Gibson's (2014) selection of terms, word connotations of the terms selected to represent target categories may have influenced participant responses (i.e., "mental health" holds a more positive connotation than "mental illness"). Indeed, Vertilo and Gibson (2014) concluded that participants' reaction times were slower during the incompatible trials (i.e., mental illness paired with good attributes and mental health paired with bad attributes) than during the compatible trials (i.e., mental illness paired with bad attributes and mental health paired with good attributes). In 37% of the studies, the researchers emphasized attitudes toward people with specific psychiatric diagnoses. For example, 26% of the studies used '*Schizophrenia*' or

'Schizophrenic' as a target category. Omori et al. (2012) and Takahashi et al. (2009) went a step further by presenting participants with two separate IATs. In one version, the target category used the former schizophrenia-related term of "Seishin-Bunretsu-Byo" (Mind-Split Disease) and, in the second version, the current schizophrenia-related term of "Togo-Shitcho-Sho" (Integration Disorder) was used. Takahashi et al. (2009) concluded that participants were more likely to associate people with schizophrenia with criminal stimuli than with victim stimuli and that this association was strongest when presented with the old term instead of the new term. Omori et al.'s (2012) findings paralleled those of Takahashi et al. (2009) when investigating attitudes among clinical medical residents prior to beginning their clinical training. However, when tested following clinical training, Omori et al. (2012) noted that participants associated criminal stimuli easier with the new term than with the old term.

Depression was a second psychiatric diagnosis included as a category in 16% of the studies (Lincoln et al., 2008; Monteith & Pettit, 2011; O'Driscoll et al., 2012). Lincoln et al. (2008) explored the difference in attitudes toward schizophrenia versus depression on an implicit level by presenting them each as categories. As explained by Hengartner et al. (2013), the diagnoses of schizophrenia and depression have been associated with differing levels of stigmatization with schizophrenia perceived more negatively than depression. Results from Lincoln et al.'s (2008) study support this claim in that participants showed a preference for people diagnosed with depression over those diagnosed with schizophrenia. In addition, participants were significantly more likely to categorize people with schizophrenia as dangerous and responsible for their symptoms

than people with depression. Participant implicit associations between depression and attention deficit hyperactivity disorder (ADHD) were also explored (O'Driscoll et al., 2012). O'Driscoll et al. (2012) concluded that participants showed more negative implicit associations toward depression than toward ADHD.

Finally, Zvonkovic and Lucas-Thompson (2015) used a combination of broad and specific terms for their target categories: '*schizophrenia*' vs. '*mental health*.' The results of participants' associations, unfortunately, were not detailed. Rather, the researchers only noted that the interventions were not effective in improving participants' associations.

When comparing the results from studies that used broad terms (e.g., mental illness) versus diagnosis specific terms (e.g., depression) as target categories, 63% reported negative implicit associations toward mental illness (Brener et al., 2013; Cheon & Chiao, 2012; Kopera et al., 2014; Lincoln et al., 2008; Mannarini & Boffo, 2014; Monteith & Pettit, 2011; O'Driscoll et al., 2012; Omori et al., 2012; Takahashi et al., 2009; Teachman et al., 2006; Vertilo & Gibson, 2014; Wang et al., 2012). In other words, participants showed negative implicit associations regardless of whether the target categories were labeled with broad or specific terms. Peris et al. (2008), Stull et al. (2013), and Thomas et al. (2007) were three exceptions with participants' showing implicit preference for '*mentally ill people*' and '*mental illness*' over the comparison categories of '*welfare recipients*,' '*physical illness*,' and '*no mental illness*,' respectively. Norman et al. (2010), Saporito et al. (2011), and Zvonkovic and Lucas-Thompson (2015) did not detail participants' implicit preferences in their articles.

Comparison categories. Terms related to a form of physical illness served as the most common comparison target categories, occurring in 42% of the studies. Similar to the target categories of mental illness, 32% of the researchers referred to physical illness in general rather than a specific diagnosis. Specifically, comparison target categories were labeled as '*physical illness*' (Cheon & Chiao, 2012; Mannarini & Boffo, 2014; Stull et al., 2013; Teachman et al., 2006) and '*physically ill*' (Monteith & Pettit, 2011). Other health-related comparison target categories included '*health/healthy*' (Norman et al., 2010), '*hypertension*' (Omori et al., 2012), and '*diabetes*' (Takahashi et al., 2009).

Additional comparison target categories included '*normal issues*' (O'Driscoll et al., 2012), '*welfare recipients*' (Peris et al., 2008), and '*no mental illness*' (Thomas et al., 2007). Kopera et al. (2014) did not label the comparison category of the GNAT; however, profession-related stimuli (e.g., journalist) were used as distracters from the stimuli related to the target category of mental illness. Saporito et al. (2011) also did not label the comparison category due to their use of the Brief IAT. Further, because Brener et al. (2013), Lund and Boggero (2014), and Wang et al. (2012) used the Single-Target IAT, comparison categories were not included in these studies.

When compared to the target categories related to mental illness, participants showed a preference for physical illness over mental illness in Monteith and Pettit (2011) and Teachman et al. (2006). However, this preference was not unanimous across the studies given that Stull et al. (2013) reported that participants showed a preference for mental illness over physical illness and Peris et al. (2008) reported the same preference over welfare recipients. Further, in examining the role of cultural differences between

participants, Cheon and Chiao (2012) concluded that Caucasian Americans showed a positive bias toward mental illness but a negative bias toward physical illness while Asian Americans showed a negative bias toward mental illness but a slight positive bias toward physical illness.

In addition, participants were able to associate specific types of physical illness (i.e., hypertension and diabetes) with terms related to being a victim easier than with terms related to being a criminal (which were more readily associated with mental illness; Omori et al., 2012; Takahashi et al., 2009). This finding exemplifies the stereotype that people with mental illness are perceived as dangerous and responsible for their condition (e.g., Corrigan et al., 2002). Finally, Mannarini and Boffo (2014) concluded that participants were more efficient when associating '*mental illness*' with '*psychological*' and '*physical illness*' with '*biological*.' Such categorization implies that mental illness is considered to be different from other forms of illness which are beyond the person's control.

For a summary of the target and comparison categories used in the implicit measures, refer to Table 2.2.

Table 2.2

Summary of Target and Comparison Categories used in Implicit Measures

Target and Comparison Categories	Percentage of Studies
Mental illness; Mentally ill; People with mental illness (as used in BIAT, SC-IAT, and ST-IAT)	26%
Mental illness vs. Physical illness	21%
ADHD vs. Normal Issues	5%
Depressed vs. Physically ill	5%
Depression vs. Normal Issues	5%
Mental health vs. Mental illness	5%
Mental health treatment vs. Unrelated category	5%
Mental illness vs. No mental illness	5%
Mentally ill people vs. Welfare recipients	5%
Schizophrenia vs. Depression	5%
Schizophrenia (old vs. new term) vs. Diabetes	5%
Schizophrenia vs. Health; Schizophrenic vs. Healthy	5%
Schizophrenia (old vs. new term) vs. Hypertension	5%
Schizophrenia vs. Mental health	5%

Stimuli. Words related to the target and comparison categories were used as stimuli in all of the studies. Researchers for 26% of the studies did not provide examples of the stimuli used for the categories (Norman et al., 2010; Stull et al., 2013; Teachman et al., 2006; Thomas et al., 2007; Zvonkovic & Lucas-Thompson, 2015). However, for

those who did provide a list of the target stimuli, examples of words related to mental illness included *'bipolar affected,' 'mental problem,' 'schizophrenia,' 'paranoia,' 'diagnosis,' 'hallucination,' 'bizarre,' 'dangerous,'* and *'depression.'* These stimuli tapped into participants' assumptions and stereotypes about what it means to have a mental illness. For example, the stimuli suggest that being diagnosed with a mental illness is a "problem," is something with which people are "affected," and is something that causes people to become "dangerous" and to act "bizarre." In comparison, stimuli related to the comparison categories included words such as *'health problem,' 'heart attack,' 'palpitation,' 'unemployed,' 'diet,'* and *'stable.'*

Attribute categories. The attribute categories were overall effective in exploring not only participant attitudes and biases but also stereotypes concerning people with mental illness. Given that attitudes, biases, and stereotypes each represent slightly different constructs, the attribute categories will be discussed in relation to the terms. Because the definitions of attitude and bias both emphasize an object being evaluated positively or negatively, attribute categories representing either term will be discussed together.

Implicit attitudes and biases. To investigate participants' attitudes and biases about people with mental illnesses, the researchers used the attribute categories of *'good vs. bad'* or *'positive words vs. negative words'* in 47% of the studies (Cheon & Chiao, 2012; Monteith & Pettit, 2011; O'Driscoll et al., 2012; Peris et al., 2008; Saporito et al., 2011; Stull et al., 2013; Teachman et al., 2006; Vertilo & Gibson, 2014; Wang et al., 2012). Attitudes and biases pertaining to people with mental illness were also examined

by using attribute categories such as *'wonderful vs. awful'* (Brener et al., 2013), *'pleasant vs. unpleasant'* (Kopera et al., 2014; Norman et al., 2010; Thomas et al., 2007), and *'nasty vs. nice'* (Norman et al., 2010). Each of these attribute categories exemplify attitudes and biases given that participants were asked to associate stimuli that characterize targets either positively or negatively without relating the association to stereotype content.

Implicit stereotypes. Several attribute categories were also tied to common stereotypes (i.e., beliefs about a person's quality because of group membership; Dovidio et al., 2010) about people with mental illness. Thirty-two percent of the studies targeted the stereotype that people with mental illness are dangerous as was represented by attribute categories such as *'dangerous vs. safe'* (Lincoln et al., 2008; Norman et al., 2010), *'danger vs. sick'* (Lund & Boggero, 2014), *'friendly vs. hostile'* (Norman et al., 2010), *'criminal vs. victim'* (Omori et al., 2012; Takahashi et al., 2009), and *'violence vs. peacefulness'* (Zvonkovic & Lucas-Thompson, 2015). Additional stereotypes represented by the attribute categories included beliefs regarding the controllability, etiology, and stability of mental illness. Stereotypical beliefs about the competency of people with mental illness and shamefulness of seeking mental health treatment were also explored. These stereotypes appeared through the attribute categories of *'culprit vs. victim'* (Lincoln et al., 2008), *'cureless vs. healable'* (Lincoln et al., 2008), *'danger vs. sick'* (Lund & Boggero, 2014), *'psychological vs. biological'* (Mannarini & Boffo, 2014; Monteith & Pettit, 2011), *'permanent vs. temporary'* (Monteith & Pettit, 2011), *'controllable vs. uncontrollable'* (Monteith & Pettit, 2011), *'respectable vs. shameful'*

(Saporito et al., 2011), '*blameworthy vs. innocent*' (Stull et al., 2013; Teachman et al., 2006), and '*helpless vs. competent*' (Stull et al., 2013; Teachman et al., 2006).

Moderators of Implicit Bias

Interventions. Prior research has indicated that education and contact interventions have been effective for improving explicit attitudes toward people with mental illness (Corrigan et al., 2001; Corrigan et al., 2002; Corrigan, Larson, Sells, Niessen, & Watson, 2007). Education interventions entail providing participants with information about mental illness while contact interventions entail participants having the opportunity to interact with and hear the life story of someone who has been diagnosed with having a mental illness (Corrigan & Penn, 1999). Lincoln et al. (2008), Zvonkovic and Lucas-Thompson (2015), and Saporito et al. (2011) developed and implemented similar interventions in an attempt to change attitudes toward people with mental illness on an implicit level.

First, Lincoln et al. (2008) sought to change implicit and explicit attitudes toward people diagnosed with schizophrenia by educating participants about the causes of schizophrenia. To do so, participants were assigned to either a biogenetic intervention, a psychosocial intervention, or to a neutral condition. Participants assigned to the biogenetic intervention were taught that schizophrenia results from abnormality in a person's genes and brain. Participants assigned to the psychosocial intervention, on the other hand, were taught that schizophrenia develops as a result of trauma, stressful life events, and cognitive processes. In both interventions, participants were presented with a vignette of someone with schizophrenia. Participants completed multiple implicit and

explicit measures pre and post receiving the interventions. For the implicit measures, Lincoln et al. (2008) presented participants with one of 12 possible IATs wherein the target categories were schizophrenia and depression and the attribute categories were dangerous vs. safe, culprit vs. victim, and cureless vs. healable. While participants demonstrated some improvements in their explicit attitudes following the interventions, participants' implicit attitudes concerning schizophrenia did not change. One explanation for the absence of change in implicit attitudes could be that, even with interventions, when compared to depression, schizophrenia continues to be more stigmatized.

Zvonkovic and Lucas-Thompson (2015) also sought to improve participants' implicit and explicit attitudes toward people with schizophrenia. In particular, Zvonkovic and Lucas-Thompson (2015) targeted the stereotype that people with schizophrenia are dangerous. Participants were randomly assigned to either an intervention or control condition. Participants assigned to the intervention condition were presented with facts about violence among people with schizophrenia while those assigned to the control condition were presented with facts unrelated to mental illness. IATs were administered both prior to and after participants completed their assigned readings. Namely, when completing the IATs, participants were presented with the target categories of schizophrenia vs. mental illness and the attribute categories of violence vs. peacefulness. In addition, participants completed a social distance scale following the readings.

Zvonkovic and Lucas-Thompson (2015) concluded that participants assigned to the intervention condition showed significantly less desire for distance from people with schizophrenia than participants assigned to the control condition. Participation in the

intervention condition compared to the control condition, however, did not significantly improve implicit stereotypes toward people with schizophrenia.

Finally, Saporito et al. (2011) also followed a pre-post experimental design in attempting to change participants' implicit and explicit attitudes regarding people with mental illness and mental health treatment. Similar to the methodology employed by Lincoln et al. (2008), Saporito et al.'s (2011) intervention involved presenting participants with information about mental illness and mental health treatment before concluding with a video of someone who had been diagnosed with having a mental illness. Prior to and following the intervention, participants completed an explicit measure assessing affect regarding people with mental illness and seeking mental health treatment. Additional explicit measures were administered following the intervention and were used to explore attitudes toward mental illness and willingness to seek to mental health treatment.

Participants also completed two paper-and-pencil BIATs wherein the target categories were "Mental Health Treatment" and "Mental Illness" and the attribute categories were respectable vs. shameful and good vs. bad. Saporito et al. (2011) concluded that, in comparison to the control group, participants who received the intervention reported more positive explicit attitudes toward mental illness and mental health treatment. However, the results indicated that participating in the intervention did not result in more positive implicit associations on the BIATs.

Contact. Another potential moderator of implicit attitudes toward people with mental illness could be direct, positive contact with such individuals. Indeed, Allport

(1954) posited that increased amounts of contact with out-group members improve attitudes toward such members when the contact occurs under optimal conditions. Increased intergroup contact has also been shown to correlate with less bias on an implicit level (Shook & Fazio, 2008). To explore the impact of contact on attitudes toward people with mental illness, researchers of 26% of studies recruited participants with some known level of contact with people with mental illness. Namely, participant samples of these studies included professionals who worked in some capacity with people with mental illness.

Overall, contact with people with mental illness did not result in positive implicit attitudes toward such individuals. This was exemplified by the findings from Brener et al. (2013), Kopera et al. (2014), and Omori et al. (2012) who reported that participants showed negative implicit bias regarding people with mental illness. In fact, Omori et al. (2012), who investigated the implicit and explicit attitudes of clinical medical students prior to and following working with clients with mental illness, concluded that the students' implicit associations were more negative at the follow-up than they were initially. Peris et al. (2008) and Stull et al. (2013) were two exceptions to these findings, both reporting that participants demonstrated a positive preference for people with mental illness. Further, Stull et al. (2013) found that participants implicitly associated people with mental illness with being good, competent, and innocent. The researchers of all five studies reported that participants showed positive explicit attitudes toward people with mental illness.

The participant samples in Kopera et al. (2014) and Peris et al. (2008) allowed for a unique examination of the potential role of direct contact in influencing implicit biases about people with mental illness. Specifically, Kopera et al.'s (2014) sample included a combination of mental health professionals and medical students (who reported no prior contact with people with mental illness) while Peris et al.'s (2008) sample included mental health professionals, undergraduate students, members of the general public, and other health/social service workers. Results from Kopera et al. (2014) indicated that both the professionals and non-professionals showed negative implicit bias regarding people with mental illness. In contrast, Peris et al. (2008) reported that participants showed a positive implicit preference for people with mental illness compared to welfare recipients, with this preference being greatest among the mental health professionals.

Discussion

Three research questions guided the examination of the 19 studies chosen for review in this paper: (1) How was implicit bias toward people with mental illness represented in the articles? (2) What factors influenced the valence of implicit associations toward people with mental illness? and (3) How did implicit attitudes compare to explicit attitudes toward people with mental illness?

On an implicit level, only attitudes, biases, and stereotypes were explored toward people with mental illness. With the exception of reported findings from Peris et al. (2008), Stull et al. (2013), and Thomas et al. (2007), participants were more likely to associate mental illness with negative attributes and stimuli than the comparison categories. The selected comparison target category could have influenced the ease at

which participants made these associations. For example, in several of the studies, the researchers chose physical illness as the comparison category – a condition for which participants showed frequent implicit preference over mental illness. This finding was not surprising given that, according to Tringo's (1970) hierarchy of disability, people with physical disabilities have been placed higher on the hierarchy than people with mental illness. A hierarchy of preference between people with different types of mental illness has also been noted in the literature, with schizophrenia being more stigmatized than other types of psychiatric diagnoses (Hengartner et al., 2013). Again, this hierarchy was supported on an implicit level with Lincoln et al. (2008) reporting that participants showed a preference for people with depression over people with schizophrenia.

Because the majority of the researchers used physical illness as the comparison category, a gap exists in comparing implicit biases between people with mental illness and other stigmatized populations. Peris et al. (2008) demonstrated the importance of this in their comparison of implicit responses to people with mental illness versus welfare recipients, finding a preference for those with mental illness.

More variety was observed in the selection of attributes with several attributes relating to common stereotypes about people with mental illness. For example, many of the attributes related to the stereotypes that people with mental illness were dangerous, incompetent, and responsible for their conditions. Again, because these attributes were linked to stereotypes pertaining to mental illness rather than to physical illness, it was not surprising that participants more easily associated mental illness with negative attributes.

In contrast to Allport's (1954) and Shook and Fazio's (2008) claims that positive contact improves attitudes toward out-group members, three of the five studies that used participant samples of mental health professionals reported that these individuals held negative implicit biases regarding people with mental illness. The mixed results among these participant samples suggested that either (1) contact with people with mental illness does not influence implicit biases regarding such individuals or (2) additional variables existed that moderated the influence of contact on implicit biases. Also important to consider was the valence of the contact and the nature of the relationship. Indeed, for contact to influence positive changes in explicit attitudes toward out-group members, Allport (1954) posited that the contact must occur under optimal conditions and that a power difference must not exist between the two members. The same likely holds true for contact to influence implicit biases. However, Allport's described conditions were not met in the studies reviewed in this paper given that the mental health professionals held positions of power over their clients and may have experienced unpleasant interactions with their clients.

Another possibility regarding the influence of contact on implicit attitudes toward people with mental illness could be that professionals may be highly motivated to control automatic, negative reactions toward such individuals due to the nature of their work. The overall findings reviewed in this paper related to contact, however, did not support this suspicion. In any case, because differences in power exist between professionals and clients, future participant samples comprised of family and friends of someone with a mental illness would be beneficial.

Fifty-eight percent of the studies explored the correlations between participants' responses on the implicit and explicit measures. Significant correlations were reported in 32% of the studies (Brener et al., 2013; Lund & Boggero, 2014; Peris et al., 2008; Takahashi et al., 2009; Vertilo & Gibson, 2014), with 50% of these studies reporting a negative correlation between implicit and explicit biases. Of particular interest were the significant negative correlations between implicit bias and social distance from people with mental illness (Brener et al., 2013; Vertilo & Gibson, 2014). These findings suggest that the implicit biases people hold toward individuals with mental illness could influence acts of discrimination.

Although correlations between implicit-explicit measures were not explored in 32% of the studies, all but one study included both implicit and explicit measures. The valence of participants' responses did not match in the studies conducted by Kopera et al. (2014) and Saporito et al. (2011) wherein participants reported positive explicit attitudes but showed negative implicit associations toward mental illness. This mismatch exemplifies dual-attitudes (Wilson, Lindsey, & Schooler, 2000) and supports assumptions of the motivation and opportunity as determinants (MODE) model in that implicit and explicit attitudes differ because of a person's motivation and opportunity to give desired responses (Fazio & Towles-Schwen, 1999). Namely, when completing the explicit measures, participants were allotted enough time to provide the answer they desired and, if motivation was high, this answer may have represented a more socially desired response. Whereas in completing the IATs, participants had to provide their automatic reaction to the stimuli.

Although participants' explicit biases were generally positive, even on an explicit level, participants frequently perceived people with mental illness as dangerous and desired to have social distance from such individuals. These results speak to the extent to which people with mental illness are stigmatized given that participants had the opportunity to control their negative responses but did not do so in several studies. Needless to say, a need continues to exist for positive changes to occur in the attitudes toward and treatment of people with mental illness.

Future Directions

A review of the 19 studies discussed in this paper highlights many areas where additional research is needed to better understand implicit attitudes associated with mental illness. First, only O'Driscoll et al. (2012) and Saporito et al. (2011) explored the implicit attitudes of participants younger than 18 years old. This gap is concerning because implicit attitudes begin forming in children as young as three years old (Dunham & Banaji, 2009; Dunham, Baron, & Banaji, 2008). By adulthood, beliefs have become more solidified and are, therefore, more difficult to change. Furthermore, individuals begin to experience more mental health concerns during the adolescent years (Berger, 2008, p. 433-435). If these individuals hold negative implicit and explicit attitudes about mental illness and mental health treatment, they may be less likely to reach out for help should they start experiencing symptoms in the future. Further research is thus needed to investigate the implicit attitudes of children toward people with mental health concerns.

On a related note, only Lincoln et al. (2008), Saporito et al. (2011), and Zvonkovic and Lucas-Thompson (2015) conducted interventions in their studies.

Therefore, additional research is needed to examine how interventions may be used in an attempt to change participants' implicit attitudes toward people with mental illness.

Multiple researchers have reported that education and contact interventions can improve participants' explicit attitudes regarding mental illness (Corrigan et al., 2001; Corrigan et al., 2002; Corrigan et al., 2007). However, as the findings from Lincoln et al. (2008), Saporito et al. (2011), and Zvonkovic and Lucas-Thompson (2015) illustrated, such interventions do not significantly improve implicit attitudes. Although participants were presented with factual information about mental illness in the three studies, Petty and Brinol (2010) explained that implicit attitudes change when participants are required to think deeply about a subject. As such, perhaps a more effective approach would be to present participants with multiple success stories of people with mental illness and to instruct participants to write one to two paragraphs about the positive characteristics of the people in the stories. This approach would also align with the claim that implicit attitudes improve when participants are repeatedly presented with positive examples of out-group members (Petty & Brinol, 2010).

Finally, only a handful of research appears to exist regarding implicit self-stigma of people with psychiatric diagnoses. Similar to the effects of explicit self-stigma, the data in this area indicate that implicit self-stigma negatively impact people with mental illness. Indeed, researchers have begun to investigate the link between implicit self-stigma and quality of life (Rusch, Corrigan, Todd, & Bodenhausen, 2010a), depressive symptoms (Rusch, Todd, Bodenhausen, Olschewski, & Corrigan, 2010d), shame (Rusch et al., 2010d), and guilt (Rusch, Todd, Bodenhausen, & Corrigan, 2010b). Research is

needed to confirm these findings, to identify other consequences of implicit self-stigma, and to develop intervention strategies.

Even though the aim of this review was to provide a comprehensive portrayal of implicit bias regarding mental illness, the review is not without limitations. First, because database and reference list searches turned up over 2,600 potentially relevant studies, a detailed review of every study was not feasible. Therefore, due to human error, the possibility exists that studies that should have been included in the review were missed. An additional limitation of the review was the selection of studies that used only versions of the IAT in the methodology, thereby excluding studies that used sequential priming tasks. Further, studies that included participants with mental illness were also excluded from the review. Future research and reviews are needed in order to understand implicit bias toward mental illness from all approaches and perspectives.

Conclusion

People with mental illness continue to be a stigmatized group, encountering negative attitudes and discriminatory behaviors from others. Although numerous researchers have investigated the explicit attitudes toward people with mental illness, limited data is available concerning the implicit biases regarding such individuals. Because past research has suggested that implicit attitudes can influence behaviors (Perugini et al., 2010), understanding and improving the negative implicit attitudes associated with mental illness would be an important step in helping to diminish the societal barriers encountered by these individuals. In turn, diminished attitudinal barriers would aid consumers in achieving their rehabilitation goals. This review has, therefore,

served as a step in conceptualizing the available research on implicit attitudes related to mental illness and in highlighting gaps where additional research is necessary.

CHAPTER III
STIGMA AND SUBSTANCE USE:
AN INVESTIGATION INTO THE MEDIATING EFFECTS OF PERSONALITY,
SOCIAL SUPPORT, AND COPING IN THE PATHWAY BETWEEN PERCEIVED
AND INTERNALIZED STIGMA

The prevalence of substance use disorders has been a growing concern in the United States. As reported by Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), approximately 22.7 million individuals who were 12 years or older needed treatment for substance use concerns in the year 2013. The number of individuals who sought treatment for substance use concerns, however, equated to only 2.1 million people (SAMHSA, 2014). Given the substantial gap in the number of individuals diagnosed with having a substance use disorder and the number who seek treatment for such concerns, identification of barriers to treatment and recovery is paramount. Although multiple factors likely influence a person's reluctance to seek treatment for substance use (Appel, Ellison, Jansky, & Oldak, 2004), in this article we have chosen to focus on the influence of stigma. The role of stigma is important to consider as it can detrimentally impact targeted individuals by causing them to conceal their stigmatized identities (Chronister, Chou, & Liao, 2013), to experience mental health concerns (Smith, Dawson, Goldstein, & Grant, 2010), and to encounter prejudice and discrimination (Schomerus, 2014). Exploration of the impact of stigma on individuals with substance use disorders is particularly valuable because a dearth of research appears to exist in the area.

While research on stigma related to substance use is limited, a considerable number of researchers have examined stigma as it pertains to individuals with mental health concerns (e.g., Bathje & Pryor, 2011; Corrigan et al., 2002; Tang & Wu, 2012). Given that in 2012, more than 40 percent of adults in the United States reported being dually diagnosed with a mental illness and substance use disorder (SAMHSA, 2013), the effects of mental health stigma likely overlap with those related to substance use. Furthermore, several similarities can be noted in the public attitudes toward individuals with substance use disorders and mental illness. For example, individuals belonging to both groups have been perceived as dangerous (Corrigan et al., 2002; Corrigan et al., 2005; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Peluso & Blay, 2008); have been met with increased social distance from the public (Angermeyer & Matschinger, 1996; Corrigan et al., 2002; Link et al., 1999; Schomerus, Matschinger, & Angermeyer, 2006); and have been blamed for their condition (Corrigan et al., 2005; Crisp et al. 2000; Schomerus et al., 2006).

Individuals who have an awareness of the existence and prevalence of the public attitudes toward the stigmatized group of which he or she belongs are said to possess perceived stigma (Luoma et al., 2007). The effects of perceived stigma can be harmful on a person's journey toward recovery from substance use or a mental illness. For instance, the fear of stigmatization has shown to contribute to an individual delaying or resisting treatment for a substance use or mental health disorder (Chandra & Minkovitz, 2006; Cunningham et al. 1993; Komiya, Good, & Sherrod, 2000). In fact, according to Keyes et al. (2010), the more stigma a person perceives to be associated with having a substance use disorder, the less likely he or she is to seek treatment for that disorder. For individuals

with substance use disorders in particular, the average length of delaying treatment has ranged from 5-9 years from the onset of disorder (Wang et al., 2005).

In addition, high levels of perceived stigma have positively correlated with dysfunctional coping behaviors among individuals who have a substance use disorder or mental illness. To hide the diagnosis from others, such individuals may withdraw and resort to secrecy as forms of coping (Kleim et al., 2008; Luoma, O'Hair, Kohlenberg, Hayes, & Fletcher, 2010; Palamar, 2012). Individuals who have high levels of perceived stigma are also less likely to report receiving positive social support (Glass, Kristhansson, & Bucholz, 2013; Mueller et al., 2006). This lack of social support could relate to the finding that perceived stigma increases the person's perception of rejection from others because of his or her disorder (Palamar, 2012; Luoma et al., 2010). Therefore, if a person expects to be rejected, he or she may be less likely to seek support or enter treatment. Additional consequences of perceived stigma for individuals with substance use disorders have included poorer psychological functioning (Smith et al., 2010), and increases in internalized shame, avoidance, and depression (Luoma et al., 2010). Similarly, high levels of perceived stigma in individuals with mental illness have been linked with resistance to emotional openness (Komiya et al., 2000); poor self-esteem (Corrigan, Watson, & Barr, 2006; Norman, Windell, Lynch, & Manchanda, 2011); poor self-efficacy (Kleim et al., 2008; Corrigan et al., 2006); and increases in anxiety, depression, and anger/hostility (Norman et al., 2011).

While perceived stigma can negatively affect a person's journey toward recovery, internalized stigma can also be harmful. According to Luoma et al. (2007), internalized stigma (also known as self-stigma) occurs when the stigmatized individual accepts the

public attitudes as truth for him or herself and develops negative thoughts, emotions, and behaviors due to his or her stigmatized status. The impact of internalized stigma on individuals with substance use disorders has not been widely researched. Among the limited findings, manifestations of internalized stigma in individuals with substance use disorders appear to be similar to those of perceived stigma. For example, higher levels of internalized stigma in these individuals have negatively correlated with psychological functioning, quality of life, and global mental health (Luoma et al., 2007). Internalized stigma has also been shown to negatively influence a person's desire for social distance, severity of depression, and self-efficacy in being able to refuse an alcoholic beverage (Schomerus et al., 2011).

Although a dearth of researchers have explored the presence and impact of internalized stigma among individuals with substance use disorders, researchers have examined internalized stigma as it pertains to people with mental illness more extensively. For people with mental health concerns, internalized stigma has negatively correlated with employment (Corrigan et al., 2012); self-esteem and self-efficacy (Corrigan et al., 2012; Drapalski et al., 2013); quality of life (Tang & Wu, 2012; Park, Bennett, Couture, & Blanchard, 2013); willingness to seek treatment (Bathje & Pryor, 2011); and social functioning (Cerit, Filizer, Tural, & Tufan, 2012). Further still, individuals who have reported high levels of internalized stigma have also reported experiencing an increase in the severity of symptoms (Cerit et al., 2012; Drapalski et al., 2013; Norman et al., 2011; Ritscher & Phelan, 2004) and suicidal ideations (Sharaf, Ossman, & Lachine, 2012) as well as less meaning in life (Ehrlich-Ben Or et al., 2013).

Another gap in the research has been the exploration of the presence of and pathway between perceived and internalized stigma. Luoma et al. (2007) has been one exception in their investigation of the presence and consequences of perceived and internalized stigma. In their study, internalized stigma was negatively correlated with quality of life and global mental health. Perceived stigma, to a lesser extent, was also negatively correlated with quality of life. These findings differed from a later study by Luoma et al. (2010) that examined relationships between perceived stigma, internalized shame, and internalized stigma among people with substance use disorders. They concluded that higher levels of perceived stigma were linked to higher levels of internalized shame and internalized stigma.

In comparison, for people with mental illness, Okhakhume (2012) measured the levels of perceived stigma and internalized stigma along with the variables of self-esteem, self-efficacy, and locus of control. Okhakhume (2012) concluded that high levels of perceived and internalized stigma correlated with low levels of self-efficacy and internal locus of control. High levels of internalized stigma were also significantly related to low levels of self-esteem. Additionally, Norman et al. (2011) reported that internalized stigma led to poorer self-esteem and increased anger/hostility, anxiety, and depression than perceived stigma among people with mental illness. Corrigan et al. (2006) also discovered a difference in the severity of consequences related to perceived and internalized stigma. The researchers concluded that individuals with mental illness who expressed stereotype awareness (perceived stigma) did not necessarily experience stereotype agreement, self-concurrence, or self-esteem decrement (levels of internalized stigma). Furthermore, individuals who had higher levels of internalized stigma also

experienced poorer self-esteem, self-efficacy, and depression than individuals who had only perceived stigma (Corrigan et al., 2006).

Because Luoma et al. (2007), Norman et al. (2011), and Corrigan et al. (2006) indicated that people who developed internalized stigma expressed higher levels of emotional distress than people who expressed only perceived stigma, it seems feasible to hypothesize that mediating factors exist. Therefore, the purpose of this study was to explore the pathway between perceived and internalized stigma among people with substance use disorders and to identify potential mediating factors. Of particular interest were three factors: personality characteristics, social support, and coping behaviors. We first selected personality characteristics as a potential mediator in order to explore the influence of individual differences along the pathway. Social support and coping behaviors were also selected as potential mediators given that previous research has indicated that they can affect a person's experience with internalized stigma (e.g., Cerit et al., 2012; Chronister et al., 2013).

One factor that may influence the development of internalized stigma is individual personality characteristics. Although Margetić, Jakovljević, Ivanec, Margetić, and Tošić (2010) did not measure levels of perceived stigma among participants with mental illness, they did measure levels of internalized stigma in relation to personality. Margetić et al. (2010) concluded that the personality trait of harm avoidance increased the likelihood that a person with schizophrenia would internalize stigma while the personality trait of self-directedness helped to protect against internalized stigma. A person's endorsement of sympathy toward individuals with mental illness has also been suggested as a protective factor against internalized stigma (Bathje & Pryor, 2011). According to Bathje and Pryor

(2011), university students who expressed more sympathy toward individuals with mental illness were more likely to predict that they would be more sympathetic toward themselves and less likely to experience internalized stigma if they developed a mental illness in the future. No research appears to be published regarding the mediating effects of personality characteristics on either individuals with substance use disorders experience of stigma or on the pathway between perceived and internalized stigma. However, considering the findings of Margetić et al. (2010) and Bathje and Pryor (2011), personality characteristics appear to have a role in a person's experience with stigma.

Social support is a second factor that could potentially mediate between perceived and internalized stigma. The positive effects of social support have long been documented and indicate that positive social support not only serves as a buffer against stress (Cohen & Wills, 1985; Skok, Harvey, & Reddihough, 2006; Takizawa et al., 2006) but also enhances overall quality of life (Laudet, Morgan, & White, 2006; Renty & Royers, 2006; Yazicioğlu et al., 2006), psychological well-being (Lee et al., 2006; Skok et al., 2006; Williams & Galliher, 2006), and self-esteem (Williams & Galliher, 2006). For individuals with serious mental illness, positive social support has been shown to help protect against internalized stigma (Cerit et al., 2012; Chronister et al., 2013). Social support has also been an influential factor in a person's recovery from substance use (e.g., Dobkin, De Civika, Paraherakis, & Gill, 2002) For example, Dobkin et al. (2002) concluded that individuals who received higher levels of social support were less depressed, had lower levels of alcohol abuse, and were more likely to complete treatment for their substance use. In addition, researchers have found that positive social support

can increase the time a person remains sober and can help prevent against substance use altogether (Laudet et al., 2006; Wills & Cleary, 1996).

Finally, coping behaviors could influence the pathway between perceived and internalized stigma. Crocker and Major (1989) suggested that, because stigmatized individuals encounter prejudice regularly, these individuals develop strategies to minimize the effects of stigma on their life. Such strategies may include an individual refusing to personalize negative comments about his or her stigmatized group; choosing to not compare him or herself to members of dominant groups; and learning to place more value on areas of strength rather than on areas of weakness. Additionally, Chronister et al.(2013) concluded that individuals who educated others about the truths of their mental illness were less likely to report experiencing internalized stigma. In contrast, individuals who withdrew and resorted to secrecy as coping behaviors were more likely to report higher levels of internalized stigma (Chronister et al., 2013).

To reiterate, the purpose of the current study was to explore and identify mediating factors along the pathway between perceived and internalized stigma for individuals with substance use disorders. Given the limited data regarding the impact of stigma on individuals with substance use disorders, the findings of this research will offer valuable contributions to understanding the role of stigma in a person's journey toward recovery. Furthermore, no research appears to be published about the mediating factors that help prevent perceived stigma from becoming internalized stigma. Because the effects of internalized stigma have been shown to be more detrimental than the effects of perceived stigma (Corrigan et al., 2006; Luoma et al., 2007; Norman et al., 2011), understanding and facilitating the development of mediating factors for individuals with substance use

disorders may enhance a counselor's effectiveness when working with these individuals. Figure 3.1 depicts the proposed pathway wherein an individual's personality, social support, and coping behaviors determine if perceived stigma develops into internalized stigma. In other words, positive personality characteristics, social support, and adaptive coping behaviors were predicted to help prevent internalized stigma for individuals with substance use disorders.

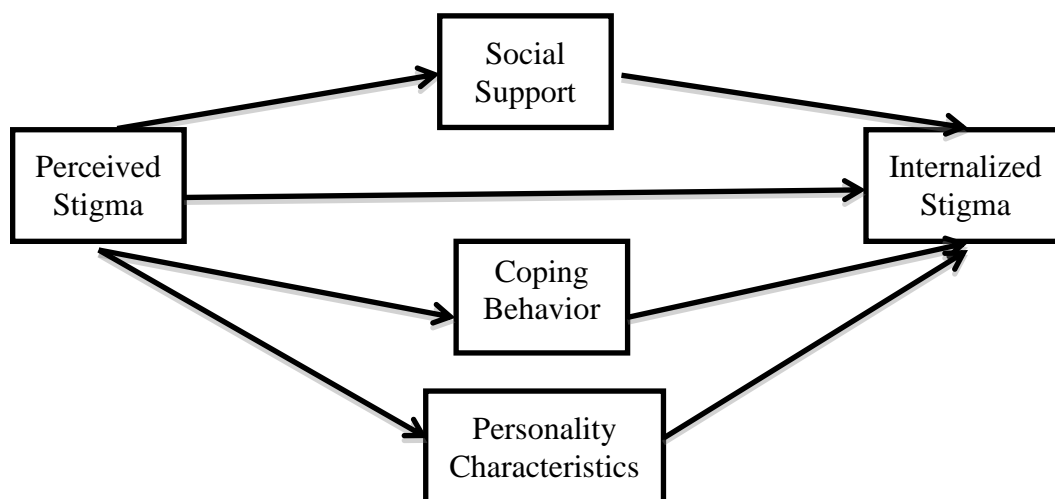


Figure 3.1. Proposed pathway between perceived stigma and internalized stigma.

Method

Participants

Individuals were recruited for the study if they self-identified as having substance use concerns, were consumers of one of the recruitment sites, were at least 18 years old, were able to understand English, and were willing to complete a 30 minute survey.

Participant recruitment occurred via three sites: a local Salvation Army Adult Rehabilitation Center (ARC) and the online support groups of Addiction Recovery Guide (ARG) and SMART Recovery. The Salvation Army ARC offers a residential setting for men to receive treatment for substance use. The program was selected as a recruitment

site because it was located locally and was a well-known agency for individuals to receive treatment for substance use. The online support groups of ARG and SMART Recovery were also selected as recruitment sites because of their popularity. Because the two groups were online and could, therefore, be accessed from any location, this diversified the demographics of the participant sample. A summary of the participant demographics has been provided in Table 3.1.

Table 3.1

Summary of Participant Demographics for Study Two

Variable	<i>n</i> (%)
Gender	
Male	89 (71.2)
Female	35 (28)
Other	1 (0.8)
Age (years)	
20-29	31 (24.8)
30-39	28 (22.4)
40-49	31 (24.8)
50-59	29 (23.2)
60-69	4 (3.2)
70-79	2 (1.6)
Ethnicity	
White	83 (66.4)
Hispanic	21 (16.8)
Mixed Race	7 (5.6)
African American	2 (1.6)
European	2 (1.6)
Irish	2 (1.6)
Native American	1 (0.8)
Other	1 (0.8)
Unknown	5 (4)

(continued)

Table 3.1

Summary of Participant Demographics for Study Two (continued)

Variable	<i>n</i> (%)
Education	
No high school diploma or GED	11 (8.8)
High school diploma or GED	46 (36.8)
Some college	29 (23.2)
Bachelor's degree	16 (12.8)
Has or is working towards graduate degree	19 (15.2)
Marital Status	
Single	57 (45.6)
Married	28 (22.4)
Divorced	28 (22.4)
Separated	7 (5.6)
Civil union	1 (0.8)
Other	2 (1.6)
Substance of Choice	
Alcohol	47 (37.6)
Multiple substances	38 (30.4)
Methamphetamine	14 (11.2)
Pain killers	4 (3.2)
Opiates	6 (4.8)
Heroin	6 (4.8)
Cocaine	3 (2.4)
Marijuana	2 (1.6)
Other	2 (1.6)
Years of Substance Use (Mean)	16.88 years (range = 0-50 years)

A total of 125 participants (male = 89; female = 35; other = 1) completed the survey package. Twenty-three additional participants started but did not complete the entire questionnaire; their responses were excluded from the analysis. Participants had a mean age of 40.83 years (SD = 12.95, range = 20-77). The majority identified as being White (n = 83, 66.4%), followed by Hispanic (n = 21; 16.8%), Mixed Race (n = 7; 5.6%),

African American (n = 2, 1.6%), European (n = 2, 1.6%), Irish (n = 2, 1.6%), Native American (n = 1, 0.8%), and Other (n = 1, 0.8%). Five participants did not disclose their ethnicities. For level of education attainment, 11 (8.8%) reported that they did not graduate from high school or have a GED, 46 (36.8%) reported that they had a high school diploma or GED, 29 (23.2%) reported that they had completed some college, 16 (12.8%) reported that they had a bachelor's degree, and 19 (15.2%) reported that they had or were working toward a graduate degree. Four participants did not disclose their level of educational attainment. The majority reported that they were single (n = 57, 45.6%), followed by those who reported being married (n = 28, 22.4%), divorced (n = 28, 22.4%), separated (n = 7, 5.6%), in a civil union (n = 1, 0.8%), and other (n = 2, 1.6%).

Forty-seven participants (37.6%) stated that alcohol was their substance of choice, followed by multiple substances (n = 38, 30.4%), methamphetamine (n = 14, 11.2%), pain killers (n = 4, 3.2%), opiates (n = 6, 4.8%), heroin (n = 6, 4.8%), cocaine (n = 3, 2.4%), marijuana (n = 2, 1.6%), and other (n = 2, 1.6%). Participants had a mean of 16.88 years of substance use (range = 0-50 years).

Instruments

The survey packet began with demographic questions regarding the participant's age, gender, ethnicity, substance misused, years of misuse, education, income, and marital status. Six scales were included in the remainder of the survey packet:

Values in Action Inventory of Strengths (VIA-IS). The VIA-IS was developed by Peterson, Park, and Seligman (2004) to explore what they considered to be 24 strengths of character. We chose to use the VIA-IS as our personality assessment because it not only taps into an array of character strengths, but has also been tested among

diverse participant samples (e.g., Ruch et al., 2010; Satoshi, Otake, Park, Peterson, & Seligman, 2006). Further, Peterson et al. (2004) concluded that participants' responses on the VIA significantly correlated with reported life satisfaction and that this correlation was stronger than that noted for The Big Five personality assessment. This correlation with life satisfaction is worth noting given that internalized stigma has been associated with lower quality of life (Tang & Wu, 2012; Park et al., 2013).

Peterson et al.'s (2004) VIA-IS contains a total of 240 items that are situated on a 5-point Likert scale ranging from '*Very Much Like Me*' to '*Very Much Unlike Me*.' Example items on the VIA-IS included statements such as "I always keep my promises" and "I always look on the bright side." Because participants need approximately 30 minutes to complete the VIA-IS, we shortened the survey for the purpose of brevity. Namely, our measure contained 24 items with each representing different character strengths. For each item, participants were presented with a character strength (e.g., bravery) and its counterpart (e.g., cowardice). Participants were then asked to mark on a 7-point continuum which of the two characteristics they identified with the strongest.

Substance Abuse Perceived Stigma Scale (SAPSS). The SAPSS was designed by Luoma et al. (2007) based on Link's (1987) "Mental Illness Perceived Stigma Scale" to measure perceived stigma among individuals with substance use behaviors. We included the SAPSS in our survey packet because it has been among the few scales designed to test perceived stigma in people with substance use disorders. Further, the SAPSS was chosen instead of Luoma et al.'s (2010) Perceived Stigma of Addiction Scale (PSAS) because of its higher reliability (.89 for SAPSS compared to .73 for PSAS).

In completing the SAPSS, participants were asked to respond to 12 items regarding their beliefs on how others perceive people with substance use concerns. Each item was answered on a seven-point Likert scale with possible responses ranging from *'Very Strongly Disagree'* to *'Very Strongly Agree'*. Items included statements such as "Most people believe that someone who has been treated for substance use is just as trustworthy as the average citizen," and "Most people feel that entering treatment for substance use is NOT a sign of personal failure."

Stigma Scale. Rosen, Greenberg, Schmeidler, and Shefler (2008) modeled their design of the Stigma Scale based on survey questions posed by Raguram and Weiss (1997). We selected this scale because, although originally written to measure how an individual internalizes the stigmatizing attitudes about mental illness, the questions carried a neutral tone and could be generalized to a variety of groups. Furthermore, Rosen et al. (2008) reported the scale as having a good reliability of .73 (Rosen et al., 2008). Examples of items on the scale included questions as "Do you think less of yourself because of this problem?" and "Do you feel others have avoided you because of this problem?" Participants were asked to respond to 13 items based on a four-point Likert scale. Possible answers were *'No,' 'Uncertain,' 'Possibly,'* and *'Yes.'*

Medical Outcomes Study (MOS) Social Support Survey. The MOS Social Support Survey was selected because of its focus on multiple forms of support and its high reliability. Specifically, Sherbourne and Stewart (1991) developed the MOS Social Support Survey to measure four domains of support: emotional/informational, tangible, affectionate, and positive social interactions. The domains of emotional and informational support were combined into one subscale due to significant overlap between items

following initial testing of the instrument. Participants were asked to indicate on a five-point Likert scale how often someone provided them with various forms of support. Items included statements such as “Someone to confide in or talk to about your problems” and “Someone to help you with daily chores if you were sick.” Possible answers varied from ‘*None of the Time*’ to ‘*All of the Time.*’ Sherbourne and Stewart (1991) reported Cronbach’s alpha overall support index at .97.

The Brief COPE Scale. The survey packet concluded with the Brief COPE scale, a shortened version of the original COPE inventory developed by Carver, Scheier, and Weintraub (1989). We selected the Brief COPE scale because it contained only 28 items that questioned participants about a range of possible coping behaviors (e.g., humor, denial, self-distraction, etc.). Namely, the Brief COPE scale (Carver, 1997) contained 14 subscales of two items each and, for the purpose of this study, were further combined into the subscales of adaptive coping and maladaptive coping. Sample items included statements such as “I’ve been thinking hard about what steps to take” and “I’ve been turning to work or other activities to take my mind off things.” Participants were asked to respond to each item based on a four-point Likert scale with possible answers varying from ‘*I Haven’t Been Doing This At All*’ to ‘*I’ve Been Doing This A Lot.*’ Cronbach’s alpha for the 14 subscales ranged from .50 to .90 (Carver, 1997).

Procedure

Participants were recruited from Salvation Army, SMART Recovery, and Addiction Recovery Guide. For participants located at the Salvation Army, the six instruments were used to create a paper questionnaire that was distributed to participants by a Salvation Army employee during a process group. The same instruments were

entered into Survey Monkey to be accessed online by participants from SMART Recovery and Addiction Recovery Guide. Online participants were notified of the study through a recruitment ad that was distributed via email listservs and posted on the discussion forums. Included in the recruitment ad was a link for participants to click on to be directed to the questionnaire. Participants from all recruitment sites were provided with an informed consent form prior to beginning the questionnaire. To protect confidentiality, however, signed consent forms were not collected. By proceeding to complete the questionnaire, consent was implied.

Analysis

Participant responses were compiled into a data file and SPSS was used to perform analyses. Because personality, social support, and coping behaviors were all predicted to mediate the relationship between perceived and internalized stigma, Preacher and Hayes' (2008) method was adopted to evaluate the mediation (indirect) effects of variables using bootstrap sampling procedure (1,000 bootstrap re-samples). This method of analysis was appropriate for the present study as it allowed for the exploration of several potential mediators at one time.

Prior to beginning analyses, the values assigned to items representing maladaptive coping behaviors were reversed. Because all of the items included on the Brief COPE Scale were situated on a four-point Likert scale with potential answers ranging from *'I Haven't Been Doing This At All'* to *'I've Been Doing This A Lot,'* reversing the values for maladaptive coping allowed for a more accurate reflection of the participants' coping behaviors. For example, in responding to the item "I've been giving up the attempt to cope," someone with healthy coping behaviors would mark *'I Haven't Been Doing This*

At All. Therefore, for this item, the participants who *did not* engage in the maladaptive coping behaviors received the most points.

Next, multiple pathways were analyzed for mediation effects between perceived and internalized stigma. The initial analysis investigated the overall effects of personality, social support, and coping behaviors on the pathway. Because the MOS Social Support Survey and the Brief COPE Scale contained subscales, subsequent analyses were then conducted to examine the independent effects of these subscales.

Results

First, the overall categories of social support, coping behaviors, and personality characteristics were investigated for their mediating roles in the relationship between perceived stigma and internalized stigma. As shown in Figure 3.2, social support significantly mediated the relationship between perceived stigma and internalized stigma, with the bootstrap indirect estimates $c'(SE)$ [95% bias corrected confidence interval] as $-.06 (.03)$ $[-.13, -.02]$, ($p < .05$). Specifically, for every unit that participants' perceived stigma increased, social support increased by $.22$ units, ($p = .006$). In turn, for every unit that participants' social support increased, internalized stigma decreased by $-.29$ units, ($p = .000$). This suggests that participants who had high levels of perceived stigma were less likely to experience internalized stigma when they received high levels of social support.

Participants' coping behaviors and personality characteristics were also included as variables in the mediation model. Overall, coping behaviors did not significantly mediate between perceived stigma and internalized stigma with the bootstrap indirect estimates $c'(SE)$ [95% bias corrected confidence interval] as $.001(.01)$, $[-.01, .02]$, ($p > .05$). Although participants' perceived stigma had a marginal negative correlation with

personality characteristics ($p = .08$), personality characteristics were not significantly related to participants internalized stigma ($p = .62$). Therefore, as evidenced by the bootstrap indirect estimates $c'(SE)$ [95% bias corrected confidence interval] of $-.003$ ($.01$), $[-.03, .01]$, ($p > .05$), personality characteristics did not significantly mediate between perceived stigma and internalized stigma.

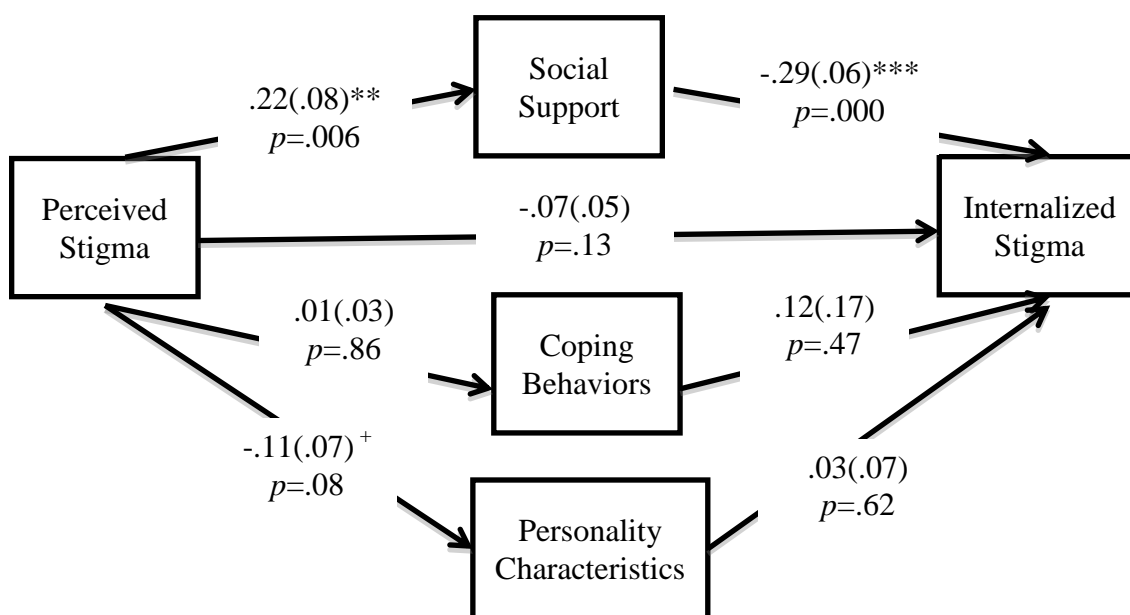


Figure 3.2. The mediating effects of social support, coping behaviors, and personality characteristics. Standard errors appear in parentheses.

⁺ $p = .08$. ** $p < .01$. *** $p < .001$.

Second, the mediating roles of maladaptive coping and adaptive coping (two coping subscales) were explored for the relationship between perceived stigma and internalized stigma. As shown in Figure 3.3, perceived stigma showed a marginally significant positive correlation with maladaptive coping wherein an increase of one unit of perceived stigma resulted in an increase of $.07$ units of maladaptive coping, ($p = .07$). Further, results indicated a significant positive correlation between maladaptive coping

and internalized stigma with an increase of one unit of maladaptive coping correlating with an increase of .32 units of internalized stigma, ($p=.006$). When analyzed as a whole, these results suggest that maladaptive coping behaviors significantly mediated the relationship between perceived stigma and internalized stigma, as evidenced by the bootstrap indirect estimates $c'(SE)$ [95% bias corrected confidence interval] of .03 (.01) [.004, .06], ($p < .05$). In other words, participants with higher levels of perceived stigma were more likely to use maladaptive coping behaviors and, in turn, experience higher levels of internalized stigma.

Although perceived stigma had a significant positive correlation with adaptive coping ($p = .04$), adaptive coping did not significantly correlate with internalized stigma ($p = .97$). Therefore, adaptive coping was not found to significantly mediate the relationship between perceived stigma and internalized stigma, with the bootstrap indirect estimates $c'(SE)$ [95% bias corrected confidence interval] as -.0002(.01), [-.02, .02], ($p > .05$). While adaptive coping behaviors are certainly important, these results suggest that participants' maladaptive coping behaviors have greater influence in perceived stigma developing into internalized stigma.

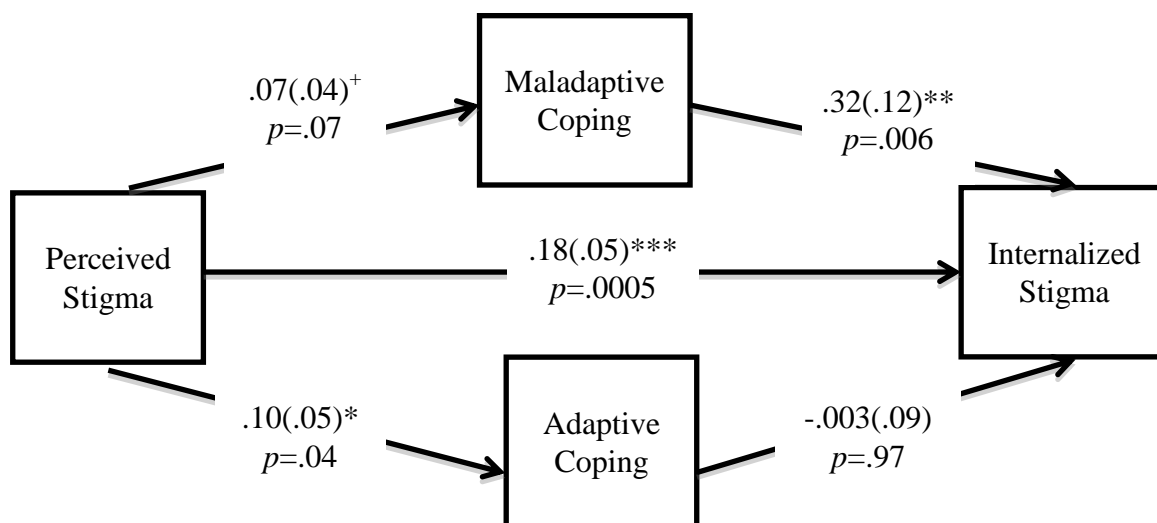


Figure 3.3. The mediating effects of maladaptive coping and adaptive coping. Standard errors appear in parentheses.

⁺ $p = .07$. * $p < .05$. ** $p < .01$. *** $p < .001$.

Finally, the mediating roles of emotional/informational support, tangible support, and affectionate support (three social support subscales) were examined for the relationship between perceived stigma and internalized stigma. As shown in Figure 3.4, affectionate support significantly mediated the relationship between perceived stigma and internalized stigma, with the bootstrap indirect estimates $c'(SE)$ [95% bias corrected confidence interval] as $-.06 (.03)$ $[-.12, -.01]$, ($p < .05$). Specifically, for every unit that participants' perceived stigma increased, affectionate social support increased by .23 units, ($p = .006$). In turn, for every unit that participants' social support increased, internalized stigma decreased by $-.25$ units, ($p = .001$). This suggests that participants who have high levels of perceived stigma are less likely to experience internalized stigma when they receive high levels of affectionate support.

A significant positive correlation was also observed between perceived stigma and emotional/informational support ($p = .03$) and a marginally significant positive correlation between perceived stigma and tangible support, ($p = .06$). However, neither

emotional/informational support nor tangible support significantly correlated with internalized stigma. Therefore, the results showed that emotional/informational support and tangible support did not mediate the relationship between perceived stigma and internalized stigma, with the bootstrap indirect estimates $c'(SE)$ [95% bias corrected confidence interval] as $-.01(.02)$, $[-.05, .01]$, ($p > .05$) (emotional/informational support) and $.01(.01)$, $[-.01, .04]$, ($p > .05$) (tangible support). These results suggest that affectionate forms of support may be more beneficial than emotional/informational and tangible forms of support in preventing perceived stigma from becoming internalized.

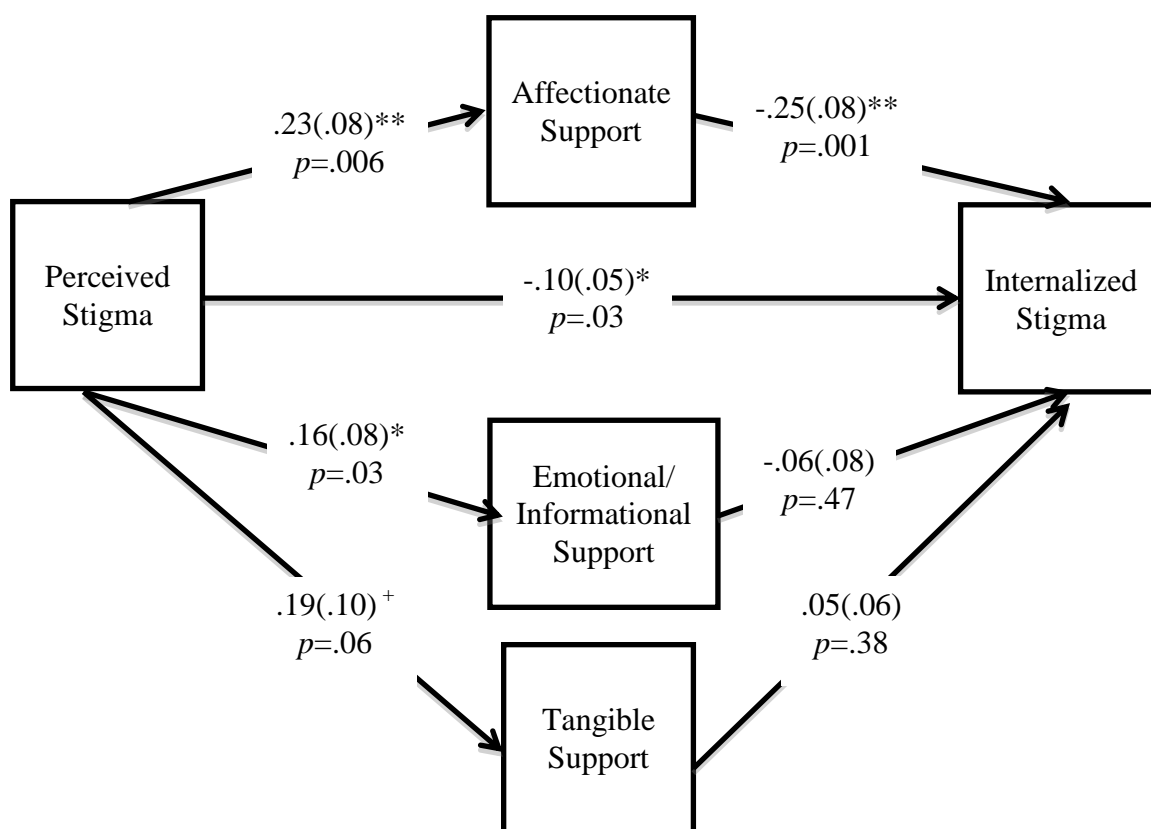


Figure 3.4. The mediating effects of affectionate support, emotional/informational support, and tangible support. Standard errors appear in parentheses.

⁺ $p = .06$. * $p < .05$. ** $p < .01$.

Discussion

The purpose of the current study was to understand the pathway between perceived and internalized stigma among individuals with substance use disorders. Personality characteristics, social support, and coping behaviors were examined for their potential mediating roles along this pathway. Findings indicated that social support was the strongest mediator between the two stigmas in that participants who reported high levels of support were less likely to develop internalized stigma. In particular, affectionate forms of support appeared to buffer participants against internalized stigma. These results confirm the findings of other studies that social support has been a predictor for improved quality of life and positive rehabilitative outcomes (Badoux, 2000; Dobkin et al., 2002; Laudet et al., 2006).

Although participant's overall coping behaviors did not significantly mediate between perceived and internalized stigma, significance was found upon further analysis of the subscales. Specifically, results suggested that participants' maladaptive coping behaviors (e.g., being self-critical, joking about the addiction, using drugs and alcohol, etc.) were significant mediators between perceived and internalized stigma. Participants' adaptive coping behaviors (e.g., seeking advice, praying, turning to work and other activities, etc.), however, did not significantly mediate the pathway. Based on these results, perceived stigma is more likely to develop into internalized stigma among individuals who resort to unhealthy coping behaviors compared to those who rely on healthy coping behaviors. Indeed, evidence exists that individuals who experience higher levels of perceived and internalized stigma have been more likely to use secrecy and withdrawal as coping behaviors (Chronister et al., 2013; Yow & Mehta, 2010). This

finding suggests that, while encouraging consumers to adopt healthy coping behaviors remains necessary, counselors should first direct efforts to help consumers recognize and diminish unhealthy coping behaviors.

Finally, participants' personality characteristics did not significantly mediate between perceived and internalized stigma. The insignificant role of personality along the pathway contradicts Margetić et al.'s (2010) conclusion that traits such as harm avoidance and self-directedness are predictors of internalized stigma. A potential explanation for this insignificance could be that the participants in Margetić et al.'s (2010) study were diagnosed with schizophrenia whereas the participants in the current study self-identified as having substance use concerns. A second explanation of the insignificance could also be attributed to the changes we made to the VIA measure. That is, instead of presenting participants with 240 statements indicative of character strengths, we only presented participants with Peterson et al.'s (2004) 24 character strengths. Further, because SurveyMonkey did not allow for the items to be clearly situated on a continuum or sliding scale, participants may have been confused about how to complete the measure. Because of these concerns, future analyses should be conducted to determine how removing personality characteristics would change the mediation model shown in Figure 3.2.

The findings of this study have many implications for rehabilitation counselors and individuals with substance use disorders. First, although a plethora of research exists on stigma toward people with psychiatric disabilities, fewer studies have been publication on stigma as it relates to individuals with substance use disorders. The findings of the current study offer counselors valuable insight into factors that influence the development

of internalized stigma and potential areas for intervention. Second, the significant mediating role of social support (particularly affectionate support) highlights the benefit of counselors encouraging consumers to seek such support. Educating family members and friends about the positive role that affectionate support can have in their loved one's recovery is also important. Third, the findings extend existing research on coping and stigma by providing evidence that maladaptive coping behaviors serve as mediators between perceived and internalized stigma for individuals with substance use disorders. This result speaks to the need for early intervention to identify and improve consumers' coping behaviors before perceived stigma becomes internalized.

One limitation of the present study was the small sample size of 125 participants. Given that approximately 71% of participants identified as male, 66% identified as White, and 38% listed alcohol as their preferred substance of misuse, the generalizability of the results is limited. Second, participants were recruited from sites that provided support for individuals with substance use disorders during their journey of recovery. Because stigma has been linked to delaying treatment for substance use (Chandra & Minkovitz, 2006; Cunningham et al. 1993; Komiya et al., 2000), the participants in this study may have experienced less perceived and internalized stigma than individuals avoiding treatment. Third, all measures completed by participants were self-report. Therefore, participants could have altered their responses to be more socially desirable. Finally, considering the high co-morbidity between mental illness and substance use, participants' responses could have been reflections of more than one stigmatized identity.

Future research should seek to confirm the findings of the current study across larger, more diverse participant samples. Longitudinal studies would also be beneficial to

determine if emphasis on social support and coping behaviors in counseling significantly impacts participants' perceived stigma and internalized stigma. One approach to testing this could be to survey counselors and their consumers about the topics they most frequently address in their counseling sessions. In the survey packet, consumers would also respond to questions about their perceived social support, coping behaviors, substance use, and experiences with perceived stigma and internalized stigma. Consumers would initially complete the survey packet during the first counseling session and then again at 6 months and 12 months. The goal would be to determine if a correlation exists between how frequently the topics of social support and coping behaviors are discussed in counseling and changes in the consumer's responses over time.

Additionally, researchers should continue to explore the proposed pathway between perceived and internalized stigma. In particular, researchers should explore the interaction between the mediating variables and the impact of the interaction on the pathway. Further, an analysis of the pathway in the opposite direction (i.e., internalized stigma to perceived stigma) could yield significant results. It is possible that individuals who experience high levels of internalized stigma would be more likely to *perceive* higher levels of stigma.

Although a multitude of research exists regarding perceived stigma and internalized stigma related to people with mental illness, less has explored how these affect people with substance use. Because stigma has been one factor that can cause people to delay seeking treatment for substance use (Chandra & Minkovitz, 2006; Cunningham et al. 1993; Komiya, Good, & Sherrod, 2000), identification of variables

that mediate between perceived stigma and internalized stigma is important. The current study served as one step toward better understanding such variables and the potential implications for working with consumers in counseling.

CHAPTER IV
A NARRATIVE INQUIRY OF AMBIVALENT ABLEISM:
UNDERSTANDING HOW PHYSICALLY DISABLED ADULTS PERCEIVE
MICROAGGRESSIONS

Evidence of ableism, or the perceived inferiority of people with disabilities (PWD) (Berger, 2013; Linton, 1998), has existed for centuries. During ancient times, disability was considered to be a sign of demon possession, a punishment for parent misconduct, and a justifiable reason for execution (Berger, 2013). Over the years, the hostile attitudes and behaviors toward PWD have taken on the forms such as bullying (Blake et al., 2012) and job discrimination (U.S. Equal Employment Opportunity Commission, 2014). While these overtly negative forms of ableism remain alive and well, researchers have recently concluded that ableism also exists within the subtleties of daily interactions disguised as well-intentioned comments or behaviors (e.g., Keller & Galgay, 2010). For instance, although providing PWD with unsolicited assistance may be well-intentioned, the underlying message of this behavior is that PWD are perceived as helpless.

As suggested by the above examples, the attitudes and behaviors toward PWD occur both overtly and covertly. These dichotomous experiences with ableism have most recently been conceptualized as representing microaggressions. Namely, Sue (2010) has defined microaggressions as “the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely on their marginalized group membership” (p. 3). To date, only a handful of researchers have examined the

microaggressions toward PWD (e.g., Bell, 2015; Keller & Galgay, 2010), leaving much room for future research.

The dichotomous nature of attitudes and behaviors from others could also be conceptualized as exemplifying ambivalent ableism, a term derived from Glick and Fiske's (1996) theory of ambivalent sexism. As Glick and Fiske (1996) explained, ambivalent sexism (or, in this case, ambivalent ableism) contains both hostile and benevolent components. Hostility, on the one hand, is exemplified by overtly negative experiences (e.g., discrimination) while benevolence is exemplified by seemingly positive attitudes or behaviors that carry negative underlying messages (e.g., providing unsolicited assistance to PWD). Although the co-existence of hostility and benevolence have only been examined in terms of sexism, the concepts also seem to align with the microaggressive experiences of PWD.

Therefore, due to the dearth of research on ableist microaggressions, two objectives guided the current study. First, the primary objective was to collect additional participant narratives about their experiences with microaggressions and to inquire about the personal impact of those experiences. Second, in an attempt to further conceptualize ableist microaggressions, the subsequent objective was to explore if reported microaggressions could be conceptualized as exemplifying ambivalent ableism. Specifically, the current study served as an initial exploration into the applicability of Glick and Fiske's (1996) theory for understanding ableist microaggressive experiences as examples hostility or benevolence.

Based on these objectives, the following pages begin with a discussion about the types of microaggressions, the existing evidence regarding the nature of ableist

microaggressions, and the potential impact of microaggressions on PWD. Next, I provide a more detailed explanation of Glick and Fiske's (1996) theory and its potential applicability when conceptualizing ableist microaggressions. A statement on the purpose of the current study and the guiding research questions is then discussed.

Microaggressions

Types of Microaggressions

To reiterate, microaggressions have been characterized as the “slights, snubs, or insults” that occur in daily interactions and that intentionally or unintentionally harm the targeted person (Sue, 2010). Three forms of microaggressions exist: microassaults, microinsults, and microinvalidations (Sue, 2010).

Of the three forms, microassaults are the most overtly negative form of microaggression characterized by conscious, blatantly harmful beliefs or actions toward a marginalized person or group (Sue, 2010). Examples of microassaults experienced by PWD may include bullying, exploitation, and discrimination. Because of the overtly negative nature of microassaults, these microaggressive experiences resemble the hostility aspect of ambivalent ableism.

Microinsults and microinvalidations, in contrast, occur more subtly and thereby resemble the benevolent aspect of ambivalent ableism. Specifically, microinsults are the well-intentioned comments about or actions toward a marginalized person or group that carry demeaning unconscious messages (Sue, 2010). Examples of microinsults toward PWD may include comments such as “You get around great for being in a wheelchair” or “You’re so inspirational.” Such comments could imply surprise that the disabled person

is able to be independent or that he or she has surpassed the expectations for being someone with a disability.

Similarly, microinvalidations are comments that unintentionally deny the marginalized identity of the individual and fail to acknowledge differences in power and privilege between the marginalized and dominant group (Sue, 2010). Examples of microinvalidations directed at PWD may include statements such as “We all have a disability of some sort” or “I don’t think of you as disabled.” Not only do such comments minimize and deny disability as being part of the person’s identity, they also ignore the inequities that exist for PWD and thereby provide the perpetrator with an escape from needing to advocate for change (Sue, 2010).

Ableist Microaggressions

To date, researchers have explored the microaggressions as experienced by individuals with physical disabilities (Bell, 2015; Keller & Galgay), sensory disabilities (Chapple, 2013; Keller & Galgay, 2010), psychiatric disabilities (Gonzales, Davidoff, Nadal, & Yanos, 2014), and unspecified disabilities (Davila, 2012; Davila, 2015). Most relevant to the current study were the findings reported by Keller and Galgay (2010) and Bell (2015) regarding microaggressions experienced by individuals with physical impairments.

First, Keller and Galgay (2010) explored the topic of microaggressions by conducting focus groups of participants who self-identified as having physical, sensory, and/or cognitive impairments. Upon analysis of participant narratives, Keller and Galgay (2010) concluded that the microaggressions described by participants appeared through 10 main themes: denial of personal identity, denial of disability experience, denial of

privacy, helplessness, secondary gain, spread effect, infantilization, patronization, second-class citizenship, and desexualization. Although the themes were not further categorized by type of microaggression, evidence of all three forms of (microassaults, microinsults, and microinvalidations) was present. For example, the themes of second-class citizenship and desexualization represented microassaults because the individuals were overtly denied equal opportunity to benefit from services or to enter into a relationship. Microinsults, on the other hand, were exemplified by themes such as infantilization, patronization, secondary gain, and helplessness because the individuals were perceived as inspirational and were the targets of well-intentioned efforts to help. Finally, microinvalidations were represented by themes such as denial of personal identity and denial of disability experience because part of the individuals' realities was being minimized.

Influenced by the work of Keller and Galgay (2010), Bell (2015) also explored the microaggressions reported by individuals with physical disabilities. Overlapping with the themes described by Keller and Galgay (2010), Bell (2015) reported that participants frequently felt excluded due to inaccessibility (second-class citizenship), treated as children (infantilization), assumed to have cognitive disabilities (spread effect), overlooked as potential significant others (desexualization), and perceived as needing assistance (helplessness). Additional themes described by Bell (2015) included participants feeling pitied and overlooked, perceived as abnormal, seen as having magical powers, and that others desired for them to hide their impairments. As with Keller and Galgay (2010), although Bell (2015) did not categorize the identified microaggressions

according to microassaults, microinsults, and microinvalidations, all three forms were exemplified within the narratives.

In addition to identifying ableist microaggressions, Bell (2015) also explored how the microaggressions personally impacted targeted individuals. One impact participants described was feeling as though they were caught in a double-bind wherein they sometimes needed to ask for assistance but did not want to be pitied or perceived as needy for having done so. The impact of microaggressions also appeared in participants' attempts to pass or cover their disability through the use of humor or by hiding the impairment. Further, participants described pretending to not be bothered by the misguided kindness from others in order to avoid conflict.

Potential Impact on Disabled Target

As indicated by the findings from Bell (2015), ableist microaggressions can have a variety of consequences for PWD. In addition to the consequences described by Bell (2015), perceived and internalized stigma can also have detrimental effects on PWD. According to Brohan, Slade, Clement, and Thornicroft (2010), perceived stigma has been defined as a person's perception of the public attitudes that exist toward him or herself as a member of a marginalized group and the fear that he or she will experience discrimination due to this marginalized identity. In comparison, internalized stigma occurs when a marginalized person is not only aware of the public attitudes toward his or her group, but agrees with these attitudes and internalizes them as being personally true about him or herself (Corrigan & Kosyluk, 2014). Perceived and internalized stigma have been shown to cause declines in mental health (Norman, Windell, Lynch, & Manchanda,

2011), poor self-esteem and self-efficacy (Corrigan, Watson, & Barr, 2006), and to lower quality of life (Tang & Wu, 2012).

People with disabilities may also respond to being the targets of ableism by engaging in impression management strategies as an attempt to minimize the negativity and discomfort surrounding disability (Smart, 2001). Two common forms of impression management among PWD have been those of passing and covering, both of which have been characterized by attempts to hide and/or compensate for a disability (Goffman, 1963). Attempts to pass/cover provide support for Johnson's (2006) argument that "individuals receive privilege because they are *perceived* by others as belonging to privileged groups and social categories" (p. 34). Therefore, in an attempt to benefit from the privileges of being a nondisabled person, PWD may choose not to disclose their diagnoses and/or may emphasize other personal characteristics in order to draw attention away from the impairment. Additionally, efforts to pass/cover may appear through the person's selection of clothes (Kaiser, Freeman, & Wingate, 1985; Kaiser et al., 1987), use of humor (Berger, 2013; Goffman, 1963), and attempts to minimize the appearance or impact of impairments (e.g., attending speech therapy to speak more "normally;" Smart, 2001). By engaging in these behaviors, PWD attempt to bridge the societal gap between themselves and PWOD.

Ambivalent Ableism

Glick and Fiske (1996)

Based on the emerging findings of ableist microaggressions, evidence exists that PWD have been the targets of both overt (e.g., bullying) and covert (e.g., patronization) forms of ableism. For the purpose of the current study, we have termed these

dichotomous experiences as examples of “ambivalent ableism,” a concept which was derived from Glick and Fiske’s (1996) theory of ambivalent sexism. Namely, Glick and Fiske (1996) proposed that women have been the targets of both hostile and benevolent forms of sexism. As detailed in their theory, hostile sexism has been described as the overtly negative beliefs and behaviors toward women. Examples of such hostility may include sexual assault, sexual harassment, discrimination, and perceptions of and incompetence (Glick & Fiske, 1996). Benevolent sexism, on the other hand, has been described as attitudes and behaviors toward women that are subjectively positive on the surface but that hold negative underlying messages (Glick & Fiske, 1996; Glick & Fiske, 2012). An example of a benevolent sexist attitude may be the belief that women should be protected, wherein the underlying message is that women are considered weak and unable to defend themselves (Glick & Fiske, 2012).

Applicability to Ableism

Influenced by Glick and Fiske (1996), for the purpose of the current study, hostile ableism has been defined as the conscious, overtly negative attitudes, comments, and behaviors toward PWD. Benevolent ableism, on the other hand, has been defined as the well-intentioned but unconsciously negative attitudes, comments, and behaviors toward PWD. Although the theory of ambivalent sexism has yet to be studied in the context of disability, previous research findings on ableist attitudes and microaggressions have exemplified hostile and benevolent forms of ableism. For instance, similar to the perceived inferiority of women, PWD have been perceived as inferior to people without disabilities (PWOD) as evidenced through implicit biases against PWD (e.g., Wilson & Scior, 2014), desires to date PWOD (e.g., Hergenrather & Rhodes, 2007), and efforts to

cure or treat impairments (e.g., Berger, 2013). Additionally, PWD have been viewed as incompetent (e.g., Louvet, Rohmer, & Dubois, 2009), and have been the targets of bullying (e.g., Blake et al., 2012), discrimination (e.g., U.S. Equal Employment Opportunity Commission, 2014), and exploitation (e.g., Rosen, 2006). On the other hand, PWD have also been treated as children (e.g., Liesner & Mills, 1999) and labeled as sources of inspiration (e.g., Young, 2014). Because many of these proposed examples of hostile and benevolent forms of ableism overlap with examples of ableist microaggressions, it seems reasonable to predict that ambivalent ableism can be used as a lens to conceptualize and categorize ableist microaggressions.

Purpose of the Study

Given the limited research on ableist microaggressions and ambivalent ableism, the primary objectives of the current study were two-fold: 1) To validate previous findings about the nature of microaggressions experienced by PWD; and 2) To explore the basic applicability of Glick and Fiske's (1996) theory in conceptualizing and categorizing the perceptions of PWD regarding encountered microaggressions. In addition, because being the target of negative attitudes and treatment can have detrimental effects, a subsequent objective of the current study was to investigate the personal impact of ableist microaggressions and ambivalent ableism on participants.

A qualitative methodology was employed to explore the perceptions of people with physical disabilities as they pertained to these objectives. Further, three research questions were used to guide this exploration: 1) How do people with physical disabilities narrate their experiences with microaggressions and ambivalent ableism?; 2) How, if at all, do the microaggressions reported by people with physical disabilities resemble the

categories of hostile ableism and benevolent ableism?; and 3) How do people with physical disabilities believe that microaggressions and ambivalent ableism have impacted their lives?

Method

Participants

To participate in the study, individuals had to meet the following eligibility criteria: (a) be at least 18 years old; (b) have a permanent physical disability that was visible to others; (c) not have a dual diagnosis of a severe mental illness and/or an intellectual disability; (d) be willing and able to participate in a one-hour interview; and (e) be willing and able to share their experiences of having a disability. Participants were recruited through the disability center at a university in the United States, a local independent living center (ILC), and community partners of the selected ILC. These recruitment sites were selected not only because they were located locally but also because of their notoriety in serving disabled students and individuals in the community. With the exception of gender, age, and nature of the impairment, participant demographic information was not collected as an additional level of anonymity. A summary of participant pseudonyms and collected demographics has been provided in Table 4.1.

Table 4.1

Summary of Participant Demographics for Study Three

Name	Gender	Age	Congenital/Acquired	Diagnosis
Aaron	Male	33	Congenital	Cerebral Palsy
Robert	Male	49	Acquired	Paralysis
Brent	Male	25	Acquired	Traumatic Brain Injury
Diane	Female	34	Congenital	Spina Bifida
Sophia	Female	49	Congenital	Osteogenesis Imperfecta
James	Male	58	Congenital	Cerebral Palsy
Bruce	Male	56	Congenital	Missing one arm Vision impairment
Madison	Female	21	Congenital	Missing one arm
Lara	Female	18	Acquired	Paralysis
Amber	Female	21	Acquired	Nerve damage in leg
Brittney	Female	23	Congenital	Multiple Sclerosis
Daniel	Male	60	Congenital	Muscular Dystrophy

Thirty-two individuals responded to the recruitment ad. However, 18 respondents did not follow through with the interview and/or did not meet the eligibility criteria and two respondents were turned away because saturation for the study had already been reached. Therefore, the final participant sample consisted of 12 individuals. Of these 12 individuals, six (50%) were male and eight (75%) reported that their disability was congenital. Participants ranged in age from 18 to 60 years old with a mean age of 37.25 years old. Reported diagnoses included cerebral palsy (n=2; 17%), paralysis (n=2; 17%),

missing limbs (n=2; 17%), nerve damage (n=1; 8%), multiple dystrophy (n=1; 8%), multiple sclerosis (n=1; 8%), osteogenesis imperfecta (n=1; 8%), spina bifida (n=1; 8%), traumatic brain injury (n=1, 8%), and vision impairment (n=1; 8%). Six participants (50%) used wheelchairs, four (33%) participants were ambulatory with assistive devices (i.e., cane, crutches, walker, scooter), and two participants (17%) reported occasionally wearing prosthetic arms. Two participants (17%) shared that, when they did not use their assistive devices, they were able to pass as nondisabled.

Researcher Positionality

The principal researcher for this study was a Caucasian female in her late-twenties with a physical disability. She has devoted her undergraduate and graduate studies to exploring the attitudinal barriers encountered by PWD. Her disability status positioned her as an in-group member of the physically disabled culture when interviewing participants and, therefore, aided in establishing rapport and interpreting responses. To protect against researcher bias, she was self-reflexive and used multiple methods to assess for validity.

Data Sources

Data was collected through informal conversational interviews with participants. The interviews followed an informal conversational approach whereby predetermined questions were asked as they naturally arose in the interview and were supported by follow-up questions as needed. Examples of interview questions included “What does ‘disability’ mean to you?,” “Please describe a time when you were treated negatively because of your disability;” “Tell me about a time when you felt that others treated you

positively because you have a disability;” and “How have the attitudes from others impacted how you perceive yourself as a disabled person?.”

Procedure

To recruit participants for this study, an ad was distributed via email to students registered for disability services at a university in the United States. The ad was also posted and distributed via email to individuals receiving services at a local independent living center (ILC) as well as to individuals associated with partner agencies of the ILC. Included on the ad was a brief statement about the purpose and goals of the study, a list of participant eligibility criteria, and instructions to contact the principal investigator if interested in participating. In response to each email message received from potential participants, the principal investigator replied with a welcome note and an attachment of the informed consent form. Participants were asked to review the consent form before proceeding to schedule the interview. Interviews were then arranged for participants who found the information in the consent form to be acceptable. With the exception of one interview that occurred via phone, all interviews were conducted individually in private study rooms at a local university. Interview took approximately 30 to 60 minutes to complete.

At the start of each interview, the investigator provided a brief overview of the purpose of the study and ensured participants that their answers would be kept confidential unless disclosure was deemed necessary to protect them or another person from harm. The investigator further explained to participants that their interviews would be audio recorded and that the audio file would be deleted once transcription was complete. Participants were also reminded that their participation in the study was strictly

voluntary, that they did not need to disclose any information that they did not wish to share, and that they would be given a pseudonym to protect their identity. Finally, participants were asked to sign the informed consent form if they had not done so already. The signed consent forms and coding sheet of the participant pseudonyms were then placed in a locked cabinet approved by the institutional review board. Finally, the interviews were transcribed verbatim and any identifiable information was omitted or falsified. The transcribed interview files were then secured with a password known only to the principal investigator and the audio files were deleted.

Data Analysis

Lieblich et al.'s (1998) holistic content analysis methodology was adapted to analyze the transcribed interviews of narratives shared by participants. Holistic content analysis was designed for the purpose of analyzing the life stories of participants. In this regard, the purpose of the current study differs from the intent of Lieblich et al.'s (1998) methodology in that stories were gathered related to the topic of ableism rather than to entire life stories.

The initial step of analysis was to transcribe the interviews and to read them several times to form overall impressions of each interview. These overall impressions were noted on the final page of each transcript and were compared with the notes for the other interviews. Second, the interviews were coded by labeling common themes such as bullying, othering, helping, infantilizing, dating, overprotecting, internalizing, passing/covering, distancing, educating, and more.

Once the 12 interviews had been analyzed, a list of all potential themes, along with their corresponding quotes, were compiled and examined for consistency and potential

overlap between themes. Themes indicative of ableist microaggressions were then categorized as examples of either hostile ableism or benevolent ableism. Specifically, themes were categorized as exemplifying hostile ableism if the participant expressed being the target of overtly negative attitudes or behaviors because of his or her impairment. In contrast, themes were categorized as exemplifying benevolent ableism if the participant expressed being the target of attitudes or behaviors that were likely well-intentioned on the surface but that carried underlying, offensive messages. Finally, themes were categorized as exemplifying impact when the participants spoke about their reactions to the hostile and benevolent forms of microaggressions.

Following an initial categorization of the themes, the investigator met with another professional in the field to seek additional insight about the correctness of the themes and their assigned categories. Further, the professional assisted with identifying additional areas of overlap between the themes and determining appropriate names for the themes.

Validity

As recommended by Maxwell (2013), multiple strategies were employed to ensure strong validity of the data and the investigator's interpretation of the data. First, because participants were recruited from multiple sites, this helped to increase generalizability of the data. Further, by interviewing each participant individually and then transcribing the interviews verbatim, rich data was collected that contained multiple examples of the each theme. Second, member checks were used wherein participants were provided with a draft of the article and were invited to review it for accuracy. Member checks not only provided participants with an opportunity to determine if their statements were quoted and interpreted correctly but also to confirm that their anonymity

was being protected in the article. Finally, participants were continually added to the sample until saturation of the data was achieved.

Results

The microaggressions described by participants offered support for the themes identified by Keller and Galgay (2010) and Bell (2015). Particular overlap with results detailed in previous studies included themes related perceived abnormality of disability, desexualization, helplessness, infantilization, and impression management. New themes that emerged in participant narratives included overall perceived otherness of disability, experiences with victimization, and internalized stigma. Participant narratives also provided emergent evidence that ableist microaggressions resemble ambivalent ableism. Namely, the microaggressions described by participants exemplified hostile and benevolent forms of ableism in that some attitudes and behaviors of perpetrators were overtly negative (e.g., bullying) while others were likely well-intentioned (e.g., helping).

Hostile Ableism

Hostile ableism, defined as the conscious, overtly negative attitudes, comments, and behaviors toward PWD, was exemplified by the themes of othering, victimizing, and desexualizing. Briefly, the theme of othering was characterized by participants' descriptions of feeling perceived as abnormal and feeling as though their impairments caused them to be hypervisible to others. The theme of victimizing was characterized by participants' experiences with teasing/bullying, discrimination, exploitation, and abuse because of their impairments. Finally, the theme of desexualizing was characterized by participants' experiences of being rejected as desirable sexual partners and as not representing the stereotypical images of masculinity and femininity. All three themes

were indicative of microassaults because the perpetrators were described as exhibiting conscious and overtly negative beliefs and behaviors toward the participants.

Othering. The first major theme for hostile ableism was that of othering, which included the two subthemes of categorization and hypervisibility. Within the narratives, all participants described a sense of otherness surrounding disability. In many cases, this “otherness” was related to disability being perceived as “different” or not “normal.” Participants also expressed that PWD tend to be categorized or labeled based solely on their disability identity. For example, Brent shared that he felt PWD get “stamped with a disability identity,” suggesting that disability consumes the person and that other aspects of the person’s identity are less significant. Lara shared similar sentiments in her description of receiving special education services after acquiring a disability:

[Special education] is so separated from everything else and people think that it’s such a bad thing, which it is a bad thing because people aren’t exposed to it... All the labels of being like ‘We’re people but *they’re* special ed,’ you know. And like when people talk about the whole ‘short bus’ thing... basically the short bus would be the special ed bus where they would have only seven kids on it and I just remember kids saying, ‘Oh, you’re so stupid, do you ride the short bus on the way home?’ sort of thing. When I got in high school, I opted to be on that bus... I guess people would look at me and be like ‘Oh, yeah, she’s on the short bus. Special ed – there she is.’

As suggested by the examples from Brent and Lara, an “us” versus “them” mentality appears to exist around disability. This was also evidenced by other participant accounts of being perceived as “inhuman,” “broken,” and as “nothing.” Again, these perceptions

imply a sense of otherness in that the disabled person is seen as being different from and lesser than his or her nondisabled peers.

Another form of otherness that appeared in the narratives was the experience of hypervisibility. Namely, four participants explained that their impairments caused them to stand out in a crowd and to be easily remembered when in other contexts. Amber shared her experience of hypervisibility:

I like the anonymity of a big school but the scooter kind of erased that and now I'm not anonymous anymore; I'm the kid on the scooter. Like every class remembers me. I'll be in a 600 person class and I'll leave and then see someone at the cafeteria and they'll be like 'Hey, I know you, you're in my class.' And I'm like, 'Yeah, the only reason you know me is because I'm on a scooter. That was a 600 person class and you were nowhere near seated next to me.' So, yeah, I feel like I'm the firefly next to all the flies, like the person who has to stand out whether they want to or not.

The presence of hypervisibility was also evidenced by the accounts of people staring. Brittney, who has multiple sclerosis and does not use her walker every day, described her experience of people staring:

I can tell the difference when I have my walker and when I don't have my walker. Total difference. I know when I have my walker, I'm stared at, just glared. I can hear the little talking. I'm not stupid, I may walk around with headphones just to drown out the noise but I've heard groups of people make comments about the fact that I'm a young person with a walker.

Because the nature of Brittney's condition allows her to pass as nondisabled on occasion, her experience provides valuable evidence regarding the sense of otherness attached to disability. When she does not use the walker, she does not experience others staring or talking about her – in that moment, she is perceived as able-bodied and is, therefore, able to blend in with the crowd. However, this changes when she uses the walker. The stares and comments from others suggest that the walker causes her to suddenly be viewed as different.

Victimizing. Eight participants shared that they had been treated poorly in their interactions with peers, strangers, and relationships. Hence, the second major theme derived from the narratives was that of victimizing, which appeared in four forms: teasing/bullying, discrimination, exploitation, and abuse.

The most common form of victimization that appeared in the narratives was that of teasing/bullying, as reported by seven participants. Aaron provided one example of when he was bullied by childhood peers because of his disability:

I'd be pushed over or I'd be called names... I remember this one time, I was in grade school and I had surgery on both legs and I was in this wheelchair and both legs were sprawled out and stuff and... even though I had a buddy of mine pushing me in my wheelchair, some kid tipped me over into the irrigation. Both of my casts got soaked and I had to be re-casted for another six weeks.

Similarly, other participants shared that having a disability caused them to be easy targets to be laughed at, called names, made fun of, and singled out. Although several participants discussed these experiences as happening during their childhood years,

others described them as also occurring into adulthood. All participants shared that the teasing/bullying negatively impacted their self-esteem and self-image.

Experiences indicative of discrimination, exploitation, and abuse also appeared as examples of victimization but were represented sparingly by only one or two participants each. Specifically, discrimination was exemplified when Daniel was denied employment due to the perception that he would not be able to perform the functions of the job and would be considered a liability. Brittney shared another example of discrimination stating that, because her disability is sometimes hidden, people assume that she is parking in handicap spots illegally and have required her to move her car even though she has a disability placard.

Two participants also shared examples of exploitation. For instance, James stated that he had been conned by personal assistants in the past. Robert, on the other hand, explained that he felt that having a disability causes others to “zoom in on you as if you are the bull's-eye. You know, they know they can get some money off of you.” In both cases, the disabled person was seen as vulnerable and an easy target to take advantage. Finally, one participant shared that she had been abused in the past.

Desexualizing. Five participants described incidences wherein they felt desexualized because of their disability and reported that others overtly rejected them as potential sexual partners due to the presence of their physical impairments. For example, Aaron explained how disclosing his disability once led to the woman ending the relationship:

I joined eHarmony once and I did a lot of research on my own about whether or not I should disclose my disability or just not say anything. So I tried it and I said,

‘Okay, I’m not going to disclose my disability.’ I felt really bad about not doing it, but I wanted to try it this way to see what would happen, so I did. I got a couple of replies... I had been talking to this woman for about a month or two, we had really gotten to know each other and it got to the point where I was like, ‘I have to tell you something.’ And I just knew by saying that it was like, ‘Okay, are you an ax murderer or what?’ So um I said, ‘I have a disability. It doesn’t affect who I am and how I am as a person but it’s a part of my life.’ I never heard from that person again.

Daniel also expressed that he was popular in high school because he drove a car and yet was not viewed as potential dating material:

There were girls who thought I was great. I’d take them to lunch, take them home, ask them out on a date and, I actually heard this from one of my friends who I drove all over – I asked her out on a date and [she said], ‘Well, I’d like to but that’s the day I’m going to be washing my hair.’ I am serious. I said, ‘Okay, great, how about the day before?’ [She said], ‘Well, that’s when I’m making cookies.’ I mean, they would tell me these things face to face like I’m too stupid to really understand they don’t want to be seen with somebody that limps.

These two narratives support previous research findings that PWD have been viewed as asexual and have not been perceived as desirable sexual partners by the general public (Berger, 2013). Further, the experiences shared by Aaron and Bruce could also be indicative of the underlying belief that PWD should only be in sexual relationships with other PWD.

A second form of desexualization that emerged in the narratives was the perception that participants did not represent the stereotypical image of masculinity or femininity. For example, Bruce shared, “I was like everybody's friend but I was never really viewed as potential relationship material. I think a large part of it was the whole disability thing and you know having the one arm verses being a football player or whatever.” Robert also explained that, when he became paralyzed, “all of [his] sexuality was taken away from [him] or at least had to be re-defined.” The accounts from both Bruce and Robert reflect the belief that men with disabilities are perceived as less masculine than those without disabilities. Indeed, Gerschick and Miller (1995) argued that, because impairments may cause some men with disabilities to need additional assistance, disabled men are less likely to be perceived as “real men.”

In addition, because disability has frequently been perceived as a deficit, physical impairments challenge stereotypical beliefs about what is considered beautiful. This, again, can cause PWD to become desexualized and to encounter attitudinal barriers when dating. Amber shared one such example:

I had a guy flirting with me, well we were flirting, and then he goes, 'You know, you'd be really hot if you weren't a cripple.' That was actually one of the first times that I realized that people didn't see me, they saw the bike. Like they didn't see me as a person, they saw a person on a bike. Like, I can't be attractive unless I'm not on it. That's really painful because it's college. I want to have a relationship, like a normal relationship with somebody.

Here again, Amber's example points to the desexualization of PWD with the underlying belief that disability is an unwanted characteristic and, therefore, is not considered "beautiful."

Benevolent Ableism

Benevolent ableism was exemplified by the themes of helping and infantilizing. Namely, the theme of helping was characterized by participants being provided with unwanted and unsolicited assistance. The theme of infantilizing, on the other hand, was characterized by participants being overprotected, spoken to as if children, and perceived as having cognitive disabilities. Infantilization was also exemplified by invasions to privacy with participants being asked to disclose information about their impairments to others. These themes were indicative of microinsults because the perpetrators were believed to be well-intentioned in their interactions with participants but participants interpreted the interactions to be demeaning.

Helping. The most widely supported theme for benevolent ableism was that of helping. In particular, with the exception of one participant, all participants shared that they felt perceived as being helpless and that they were the frequent recipients of unsolicited assistance. As Madison explained:

Sometimes people want to compensate for me or like try to accommodate me without me asking for help. It's like, if I need help, I'll ask you for help. I don't know, sometimes I feel insulted, like they think I absolutely need the help because I'm without that second arm to like carry something... sometimes it makes me seem lesser.

Diane also provided several examples of how she considers unsolicited offers to help to be condescending:

I'm extremely independent and I wouldn't go somewhere if I didn't know that I could get home, or open the door or get back in my car, right? All of these are things that people do, right?... I mean, I could be getting my chair out of the car, which I do however many times a day? Getting the door – which, again how many times a day do you go through doors? I mean, in stores, at restaurants... [people say], 'Can I carry that for you?' or people just take things out of my hands, right, to be helpful... I would assume that when people ask me if I need help, it's because they're making an assumption that it's hard for me or that I'm struggling and sometimes I'll say, 'Do I look like I need help?' and they're like, 'No,' and I'm like 'Right... what do you think you could even do?'

In some cases, the unsolicited “help” caused the person with a disability to experience unnecessary barriers to living independently. James provided an example of such an experience:

I leave [the bag on my wheelchair] open and people want to shut it. I tell them that I cannot open it. They say, 'When you get home, you ask somebody to open it.' I tell them, 'I live by myself!' They say, 'What? You can't live by yourself!' And I say, 'Yeah, I can!' It happens all the time.

As these participants' narratives illustrated, although well-intentioned, unsolicited attempts to help can be problematic and unwelcome. According to Keller and Galgay (2010), unsolicited helping implies the belief that “the presence of disability is equal to a state of helplessness in a wide range of settings and tasks.” Implicit within this belief is

also the assumption that the approach used by PWOD is superior to that used by PWD when completing a given task.

In contrast to the other participants, Brittney did not experience unsolicited assistance as offensive but rather welcomed the help:

I truthfully think it's nice if someone tries to help me. I think it's a blessing. I'm hoping they're doing it for good reasons and not just because it's funny, but I think it's good, personally. It's better than them being mean about it or not helping. I'd rather someone help me out of nowhere, I know I've done it for people who are more disabled than me and I would hope that they would do the same for me.

A potential explanation for this exception to the theme of helping could be related to the nature of Brittney's impairment. Namely, because Brittney is able to pass and is thereby not consistently perceived as disabled by outsiders, she may receive fewer offers to help. As a result, Brittney may be more accepting of unsolicited assistance than someone who is being offered help excessively.

Infantilizing. Nine participants shared that they had been viewed or treated in an infantilizing manner, that is, as children (Smart, 2001). In the current study, participant experiences of infantilization appeared through four main avenues: overprotection, motherese speech, invasions of privacy, and perceptions of spread.

Five participants stated that they felt that they had been overprotected as children because of their disability. In many cases, this overprotection was practiced by concerned, well-meaning family members. Diane, however, shared that growing up she

also felt overprotected by school staff and that decisions were frequently made about her without her input:

I think a lot of teachers growing up when I was younger were protective or would just kind of say like “Oh, you don’t need to participate in this.” Or, you know, just wanting to make things easier for me and making a lot of decisions about how I would participate in class.

For Sophia, the experience of being overprotected has continued even into adulthood:

I have an older brother and an older sister. One treats me like I was a grown up and one treats me like I was a kid. And I try to tell my sister that I’m not a kid, you know, I’m an adult. I know what’s good and what’s bad for me... my sister thinks I can’t do stuff on my own. She treats me like I was her daughter.

Three participants provided examples of when others have spoken to them using motherese speech, which is characterized by using simple sentences, speaking slower or in a higher pitch, and using pauses after each sentence (Newport, 1975). As Lara explained:

People sometimes get this weird tone of voice like I’m a child and I’m like, I’m 18. If you want me to start swearing when I talk to you so that you realize I’m not a child, I can... Like especially friends of relatives, whenever I talk to them, they’re always like ‘Oh, hi, how are you doing?’ in a high pitch. I’m like, why are you talking like that? Stop, it’s weird. I just want to be talked to like a normal person.

Daniel provided a similar example of being spoken to as if a child:

People will get in my face and talk as if I'm a child or that my brain is completely mush so that I can't understand anything. [They'll say], 'Is there something I can help you with?' And they'll look into me and they'll kind of cock their head like they're talking to a little child... it's very demeaning.

As Daniel alluded to in his comment, perceptions of spread served as another form of infantilization reported by participants. Spread occurs when outsiders assume that impairment in one area suggests impairment in another area (Wright, 1964). The most frequent example of spread, occurring in six participant narratives, was the belief that participants had not only physical impairments but had cognitive impairments as well.

Finally, three participants shared that they sometimes felt that their privacy was being invaded when others questioned them about the nature of their disability. Lara explained that, by having a disability, she thinks that "people feel like they have this magical golden ticket to just ask away about your life." Amber shared a similar experience with regard to her roommate:

[The roommate approached Amber and said,] "Why don't you tell me things? Like when you have a bad day, why don't you just come and tell me this stuff?" And I was like "Because first of all you are not privileged to my personal information. I don't have to tell you anything."... She felt she deserved to know everything about my disability when I don't have to tell her anything.

As these examples imply, due to the presence of disability, people tended to lower boundaries to a level that may be expected when interacting with a child. Such interactions were considered benevolent ableism because the questioning from

perpetrators was likely rooted in curiosity and a desire to better understand the person's impairment. However, in doing so, the targets privacy was violated.

Impact on Disabled Target

The personal impact of being a target of ambivalent ableism varied greatly across participants. However, despite the diversity in answers, two major themes were observed in how ambivalent ableism influenced participants' response to being disabled. These themes included passing/covering and internalizing. The theme of passing/covering was characterized by participants describing efforts to appear nondisabled and to direct attention away from their impairments. The theme of internalizing was characterized by participants' expressing that they felt a responsibility to educate others about disability and to be a positive representative of PWD. Further, internalization was also characterized by participants' perceiving disability as something unwanted and desiring to no longer be disabled.

Passing/Covering. Seven participants described examples of when they intentionally or unintentionally used a form of passing or covering during their interactions with others. Because a person's motive is similar whether he or she attempts to "pass" as someone who is not disabled or attempts to direct attention away from the disability through "covering," examples of both concepts are discussed together. The most obvious examples of attempts to pass/cover were provided by the participants whose physical impairments were not always visible. For example, Amber and Brittany reported having conditions that cause pain when walking and other unpredictable symptoms. Even though both participants shared that it was in their best interest to use their assistive devices for mobility (e.g., walker, cane, scooter), they sometimes chose not

to use the devices in order to pass as nondisabled. However, both participants explained that choosing to pass and not use the devices has consequences. Brittany shared her experience:

I'm stubborn enough to hide [my disability], hide through the pain, because I don't want people to see. I have such difficulty with letting people see me at my worst, so I have no issues fighting through the pain just to get through the day, to go home, and crash and just scream because I'm hurting so bad. But it's better than having to deal with people looking at me.

As evidenced in Brittany's quote, the decision to pass as nondisabled was tied to the earlier theme of otherness, specifically the subtheme of hypervisibility. Both Amber and Brittany expressed that using their assistive devices caused others to stare at them. This hypervisibility was so uncomfortable for them that they elected to hide their disabilities and to suffer the consequences for having done so.

In contrast, two additional participants explained that they have sometimes used assistive devices in order to pass/cover their impairment. Namely, Bruce and Samantha, who were each born with one arm, explained that they have sometimes worn prosthetic arms to make their impairment less apparent. Bruce shared that he has sometimes felt that others view him as more credible when he wears the prosthesis:

I could tell when I walked into the room in business meetings [wearing the prosthetic arm] that people looked at me differently... They saw me as more physically normal. They thought I had a second arm and so, when they saw I had the second arm, they thought, 'Ok, maybe it's a little dinged up or maybe a stroke or just kind of bruised or something.' My impression was that they didn't think I

had a cognitive disability, just an arm that was a little dinged up and that I was more acceptable as a qualified professional.

Further, three participants stated that they sometimes overcompensated for their impairments or felt as though they had to “prove [their] worth” (Madison). For example, Aaron and Diane shared that they sometimes overcompensate for their impairments in order to be perceived as being on the same level as PWOD. Aaron described his attempts to overcompensate when he first became employed:

I feel like I had to really step up my game I guess and I had to really prove myself, which I don't believe a person should have to do in a job, especially if you have a disability, but it was what I had to do. I feel like I had to go above and beyond what I should in order to prove that I could do... in order to prove a point, I guess.

In other words, because of his disability, Aaron felt that the employers already held doubts about his capabilities and that any mistake would be attributed to his disability rather than to the process of learning a new job.

Other forms of passing/covering that appeared in the narratives included the use of humor, avoidance of disability-related accommodations, and selection of cosmetics and clothing.

Internalizing. With the exception of two participants, all participants expressed a form of internalized stigma; that is, they accepted or took responsibility for the societal beliefs about disability. The most frequently observed form of internalization appeared in participant beliefs was that they were responsible for educating others about disability and that they needed to be positive representatives of PWD. However, none of the

participants considered their role as an educator or representative to be a bad thing. For example, Robert explained that he feels like an ambassador for PWD when traveling abroad. He shared that, even though hotel personnel frequently speak to the nondisabled accompanying party rather than to him, he does not confront the person – “I don’t want to come off as the angry guy in a wheelchair” or to leave them with a bad memory of PWD because “the next [disabled] person is going to be the one suffering the consequence.”

Further, Brent and Aaron also explained that nondisabled individuals cannot be expected to know how to interact with PWD if those with disabilities are not willing to educate. According to Brent, “if you’re in a society that doesn’t know you, you know the things you need to say. Otherwise, there are going to be mistakes and you’re going to feel [helped] too little or too much.” In other words, if the disabled person is in the company of people who are unfamiliar with his or her abilities, the person needs to self-advocate and tell the people how to best assist him or her.

Internalization also appeared through participants’ perceptions of disability as being something unwanted. Desires to no longer be disabled were primarily expressed by participants who had acquired their impairments in recent years or who had a condition that was progressive. Therefore, participants’ desire to change their ability status was also likely a reflection of their current stage of adjustment to having a disability.

Discussion

To reiterate, the purpose of the current study was to validate previous findings described by Keller and Galgay (2010) and Bell (2015) about the nature of microaggressions experienced by individuals with physical disabilities. Further, the study was conducted to explore the potential of Glick and Fiske’s (1996) theory in

conceptualizing ableist microaggressions and to investigate the personal impact of these microaggressions on participants. In line with these objectives, three research questions were proposed: 1) How do people with physical disabilities narrate their experiences with microaggressions?; 2) How, if at all, do the microaggressions reported by people with physical disabilities resemble the categories of hostile ableism and benevolent ableism?; and 3) How do people with physical disabilities believe that microaggressions and ambivalent ableism have impacted their lives?

Overall, participants' descriptions of ableist microaggressions aligned with the microaggressions reported in other studies by people with physical disabilities (Bell, 2015; Keller & Galgay, 2010). Specifically, participants expressed being the targets of five major forms of microaggressions: othering, victimizing, desexualizing, helping, and infantilizing. These findings overlapped with those described by Keller and Galgay (2010) and Bell (2015) in that encounters with desexualization, perceived helplessness, infantilization, and spread were reported by all three participant samples. Surprisingly, the experience of being victimized through teasing/bullying, exploitation, discrimination, and abuse showed the least amount of overlap with minimal examples appearing in only Bell (2015). A potential explanation for this lack of overlap could be due to the fact that Keller and Galgay (2010) and Bell (2015) primarily investigated subtle forms of ableism (i.e., microinsults and microinvalidations). Because victimization is an overt form of ableism (i.e., microassault), examples of such may have been less likely to appear in their studies.

Apart from seeking to validate the nature of microaggressions toward people with physical disabilities, the current study was also conducted to investigate the basic

applicability of Glick and Fiske's (1996) theory of ambivalent sexism in understanding the experiences of people with disabilities. In particular, the current study served as an initial exploration into how ableist microaggressions could be categorized into hostile and benevolent forms of ableism. To reiterate, we defined hostile ableism as the conscious, overtly negative attitudes, comments, and behaviors toward PWD, while benevolent ableism was defined as the well-intentioned but unconsciously negative attitudes, comments, and behaviors toward PWD.

The narratives gathered from participants provided evidence that ableist microaggressions appear in both hostile and benevolent forms. Specifically, hostile ableism was represented by the microaggressions of othering, victimizing, and desexualizing. Examples of these microaggressions included participants being viewed as abnormal, being bullied, and being rejected as a potential sexual partner. These microaggressions were categorized as hostile ableism because, in most cases, the perpetrator's perceptions of or actions toward the disabled target were intentionally negative. In contrast, benevolent ableism was represented by the microaggressions of helping and infantilizing. These microaggressions were exemplified by targets being the recipients of unsolicited attempts to help, being treated and spoken to as if children, and being perceived as having a cognitive impairment.

Finally, the narratives shared by participants were able to shed light on how the microaggressions they have encountered have influenced their self-perception and role as PWD. Attempts to pass/cover were one reaction to having impairments and living in a society that values able-bodiedness. Two participants explained that they have overcompensated for having a disability, particularly in the area of being successful at

school or work. Here, the compensatory model (Kaiser et al., 1987) was exemplified in that, though these individuals could not control their disability (something that is perceived as undesirable by society), they could control their performance at school and work.

Along similar lines, participants also shared that they believed part of their responsibility as disabled individuals was to be positive representatives of the disability community and to educate others about disability. This position of being a disability representative aligns with Smart's (2001) argument that disabled individuals are assigned a "solo status" and are expected to be spokesmen for the disability community. Even though none of the participants reported this role as being something negative, Smart (2001) explained that danger exists in holding a representative role because the person becomes seen as a category and anything he or she does or says becomes generalized as being true for other disabled individuals.

Conclusion

Findings from the current study validate the existence and nature of microaggressions experienced by people with physical disabilities. Specifically, the themes of othering, desexualizing, helping, infantilizing, and passing/covering overlapped with the themes identified by Keller and Galgay (2010) and Bell (2015). New themes of victimizing and internalizing also emerged in the participant narratives, thus highlighting the needed for researchers to continue in their efforts to uncover additional microaggressions experienced by PWD.

In an attempt to contribute new insight for conceptualizing ableist microaggression, the current study also served as an initial exploration into the

applicability of Glick and Fiske's (1996) theory for conceptualizing ableist microaggressions as examples of hostile and benevolent ableism. Evidence from the current study indicates that this dichotomous framework of ambivalent ableism could be appropriate for understanding the experiences of PWD. However, future research is needed to further refine the concept of ambivalent ableism and to adapt Glick and Fiske's (1996) theory to be applicable to PWD.

The current study was not without limitations. Although member checks and input of an outside professional aided to ensure accuracy of the coding and interpretation of narratives, analysis was largely conducted by the primary investigator. Therefore, one limitation reflects the possibility that other researchers would have coded the narratives differently. A second limitation of the study was that only individuals with visible physical disabilities were eligible to participate. Although the intention of this eligibility criterion was to hone in on microaggressions encountered by people with physical disabilities, it also limited the ability to examine the complexity of microaggressions cross-disability. Finally, a third limitation of the study was that the participant sample was one of convenience, thereby limiting the generalizability of the results.

Nevertheless, the findings of this study can aid researchers, educators, and counselors in better understanding the overt and covert attitudinal barriers encountered by PWD. This awareness, in turn, can assist researchers to better develop strategies that more directly target ableist attitudes. An increased awareness of microaggressions and ambivalent ableism would also be beneficial to professionals who work with disabled consumers. Namely, being knowledgeable about the forms of ableism consumers

encounter in their daily interactions would enhance counselors' effectiveness in aiding consumers to navigate these experiences.

CHAPTER V

CONCLUSIONS

The three studies presented within this dissertation generated insight into the nature of attitudinal ableism as a significant barrier for individuals with psychiatric disabilities, substance use disorders, and physical disabilities. Each study had a slightly different emphasis and, therefore, the sequential presentation of all three provided a unique opportunity to examine attitudinal ableism multidimensionally. In this concluding chapter, I begin by briefly summarizing the purpose, methods, and results of each study. I then discuss potential implications and future directions of the three studies in the areas of practice, education, and research.

Study One

Summary. The purpose of the first study (see Chapter II), “Implicit Bias toward People with Mental Illness: A Systematic Literature Review,” was to synthesize the implicit (unconscious) biases toward individuals with mental illness. An examination of the implicit biases toward these individuals was significant given that unconscious beliefs can influence behavior (Perugini, Richetin, & Zogmaister, 2010) and may, therefore, contribute to discrimination. In order to form a comprehensive understanding of available evidence regarding implicit bias toward people with mental illness, an extensive search of peer-reviewed articles was conducted and 19 articles were selected. Analysis of these articles was then guided by three research questions: (1) How was implicit bias toward people with mental illness represented in the articles?; (2) What factors influenced the valence of implicit associations toward people with mental illness?; and (3) How did implicit biases compare to explicit attitudes toward people with mental illness?

Analysis of the articles led to a variety of findings regarding the nature of implicit biases toward people with mental illness. Most noteworthy among these results was the finding that participants in 63% of the studies showed negative implicit biases against people with mental illness. These negative biases appeared in many forms such as in participants associating mental illness with *'bad'* and *'dangerous.'* Additionally, participants in 89% of the studies completed instruments designed to measure their explicit biases toward mental illness. Participants' explicit biases were then compared to their implicit biases in 65% of the studies. Most interesting among these comparisons was the relationship between participants' implicit biases and their explicit desires for social distance from people with mental illness. Of the four research teams who explored this relationship, half concluded that participants who showed negative implicit associations against people with mental illness also consciously desired to remain distant from such individuals. This finding was significant because it provides evidence that the attitudinal barriers encountered by people with mental illness reside at both implicit and explicit levels.

Also noteworthy were the efforts from the researchers to identify factors that could improve implicit biases. Specifically, 42% of the researchers investigated the influence of potential moderators such as attitude-change interventions and prior contact with such individuals. As Lincoln et al. (2008), Zvonkovic and Lucas-Thompson (2015), and Saporito et al. (2011) reported, participants who took part in interventions showed improvement in their explicit but not implicit biases toward people with mental illness. Further, only Peris et al. (2008) and Stull et al. (2013) stated that participants with prior contact showed positive implicit associations regarding people with mental illness. These

findings highlight the difficulty in changing implicit biases as well as the continued need for researchers to explore strategies to address implicit biases.

Research. While researchers have done a nice job of investigating the presence of implicit bias toward people with mental illnesses, several opportunities exist for researchers to further examine and attempt to change these biases. Namely, additional research would be beneficial in three areas: (1) an investigation into the implicit biases held by children; (2) the development and implementation of attitude change strategies; and (3) an understanding of the consequences of holding implicit biases against oneself.

First, additional research is needed regarding the implicit biases of children and adolescents toward people with mental illness. To date, only O'Driscoll et al. (2012) and Saporito et al. (2011) have explored such biases among youth. Contributing additional research to this area of study would be particularly important considering that the implicit biases held by children appear to remain stable throughout adulthood (Baron & Banaji, 2006; Dunham, Baron, & Banaji, 2008). Although only O'Driscoll et al. (2012) and Saporito et al. (2011) explored the implicit biases of youth toward people with mental illness, a larger number of researchers have investigated the implicit biases of youth toward racial minorities (e.g., Baron & Banaji, 2006; Castelli, Zogmaister, & Tomelleri, 2009; Sinclair, Dunnm & Lowery, 2005). For example, Castelli et al. (2009) concluded that children as young as three years old have shown in-group preferences. Additionally, children's implicit racial beliefs have positively correlated with those of their parents' (Castelli et al., 2009; Sinclair et al., 2005). By reviewing the existing evidence on implicit racial biases among youth, researchers can reach informed decisions about how to examine the implicit biases of youth toward people with mental illness.

Second, researchers should continue efforts to develop and implement effective interventions for changing implicit attitudes toward people with mental illness. As Rydell and McConnell (2006) explained, changes to implicit biases occur slowly. Therefore, longitudinal studies would be beneficial to determine if participant implicit biases change when participants are engaged in interventions over a period of time. Indeed, the findings from Vezzali, Capozza, Giovannini, and Stathi (2011) demonstrated the potential positive influence of extended interventions on implicit racial biases. In their study, Vezzali et al. (2011) instructed 5th grade students to imagine having positive interactions with immigrants and then to write about and discuss the imagined interactions. These imagined interactions occurred once a week for three consecutive weeks. On week four, students completed an instrument measuring their implicit biases toward immigrants. Vezzali et al. (2011) concluded that students who had participated in the interventions showed less implicit racial biases than students who were in the control condition.

In applying Vezzali et al.'s (2011) methodology to mental illness, participants could be instructed to imagine having positive interactions with people who have varying psychiatric diagnoses. Additionally, participants could be asked to adopt the perspective of someone with a mental illness in order to increase empathy for such individuals (Amodio & Mendoza, 2010; Galinsky & Moskowitz, 2000). If interventions such as these began in early childhood, it is possible that they would help to weaken the implicit biases about mental illnesses later in life.

Finally, researchers should continue to investigate the presence and potential consequences of internalized stigma held implicitly by people with mental illness. As noted at the conclusion of chapter IV, researchers have recently begun to explore implicit

associations about mental illness held by people with psychiatric diagnoses. Emergent data has indicated that people with mental illness implicitly associate mental illness with being bad (Rüsch, Corrigan, Todd, & Bodenhausen, 2010a), guilty (Rüsch, Todd, Bodenhausen, & Corrigan, 2010b; Rüsch, Todd, Bodenhausen, & Corrigan, 2010c), and shameful (Rüsch, Todd, Bodenhausen, Olschewski, & Corrigan, 2010d). Further, researchers have noted correlations between implicit associations and explicitly reported quality of life (Rüsch et al., 2010a), perceived legitimacy of discrimination (Rüsch et al., 2010b), perceived responsibility (Rüsch et al., 2010d), and just world beliefs (Rüsch et al., 2010c). To extend these findings, researchers could investigate other implicit associations held by people with mental illness such as associations between mental illness and danger, incompetence, and blameworthiness. Researchers could then examine the correlation between these implicit associations and participants' explicitly reported responses on measures testing internalized stigma, willingness to seek treatment, treatment adherence, and coping behaviors.

Education. As concluded in study one, efforts to change implicit attitudes through the use of educational strategies have not been effective. Nevertheless, education remains a meaningful tool for removing the barriers caused by implicit and explicit biases against people with mental illness. Three implications for education include: (1) the need for teachers to expose grade school students to positive content related to mental illness; (2) the need for professors to understand the potential influence of implicit biases in their students' interactions with consumers who have mental illnesses; and (3) the need to educate employees in social media of their role in combating implicit biases against people with mental illness.

First, efforts to educate and change implicit associations related to mental illness should begin in grade school. Because implicit attitudes require more time to change than explicit attitudes (Rydell & McConnell, 2006), teachers should seek opportunities to casually incorporate references to mental illness into their lessons and class activities. Pulling from the research on implicit racial biases, Žeželj, Jakšić, and Jošić (2015) concluded that everyday exposure to racial minorities positively correlated with implicit preferences. As such, it is possible that casual but frequent experiences of associating mental illness with something that is nonthreatening could aid children in developing positive implicit representations of mental illness. In turn, children may be less likely to hold implicit biases against mental illness and may be more open to seeking mental health treatment later in life.

Second, educators who teach in behavioral health related fields should be informed about the implicit attitudes their students may hold regarding mental illness and the influence these attitudes could have on their work with consumers. The implicit association of mental illness with danger was one pattern that emerged in study one. This stereotype that people with mental illness are dangerous can be particularly harmful because it resides on both conscious (e.g., Corrigan et al., 2002) and unconscious (e.g., Omori et al., 2012) levels among perpetrators. Furthermore, perceptions of danger can result in the avoidance of people with mental illness (Brener et al., 2013; Vertilo & Gibson, 2014). In teaching aspiring behavioral health professionals, educators should therefore acknowledge that students may hold biases against people with mental illness and should facilitate opportunities that contradict these biases.

Conversely, because implicit biases can be resistant to change (e.g., Lincoln et al., 2008; Saporito et al., 2011; Zvonkovic & Lucas-Thompson, 2015), educators should also teach students to control their biases. According to Fazio, Jackson, Dunton, and Williams (1995), individuals who are highly motivated to avoid acting on their implicit biases may be successful in controlling automatic responses. As such, educators should attempt to motivate students by informing them of the potential influence of implicit biases on behavior.

Finally, employees in social media need to be educated about how they could help eradicate the attitudinal barriers encountered by people with mental illness. The involvement of such employees would be particularly beneficial as the attitudes toward people with mental illness can be influenced by the media (Hoffner, Fujioka, Cohen, & Seate, 2015). As McGinty, Webster, Jarlenski, & Barry, (2014) explained, the topic of mental illness has most frequently been event-focused wherein the culprit is someone with a psychiatric diagnosis. This causes people to associate mental illness with danger and thus contributes to the stigmatization of people with mental illness. To change this, employees in the media need to be taught about the importance of discussing mental illness outside the context of crime.

Practice. Implicit attitudes toward people with mental illness can also influence multiple aspects of the counseling experience for both the counselor and the consumer. Two primary implications of research on implicit attitudes for practice include: (1) the need for counselors to be self-reflective about the implicit biases they may hold toward their consumers and the potential consequences of these biases on the therapeutic

relationship; and (2) the need for counselors to be aware of how the implicit biases of others could impact the consumer's interactions.

First, counselors need to be self-reflective and should seek to identify any potential implicit biases that may be impacting their work with consumers. The need for such efforts was evidenced by the findings from Omori et al. (2012) who concluded that clinical students implicitly associated schizophrenia with criminal stimuli. The existence of such associations could be potentially problematic given that implicit attitudes can influence behavior (Perugini et al., 2010). It is possible that rehabilitation counselors who implicitly associate consumers with being criminals may be less likely to recommend a consumer for a job. Therefore, counselors need to remain motivated to control their implicit biases and to practice frequent self-reflection in an effort to prevent underlying beliefs from interfering with the counseling relationship.

Second, counselors should educate themselves about the potential implicit biases consumers encounter from others. Implicitly associating mental illness with danger, incompetence, and blameworthiness could influence how others respond to someone with a mental illness. Indeed, Brener et al. (2013) and Vertilo and Gibson (2014) concluded that participants who implicitly associated mental illness with danger were more likely to explicitly express a desire for distance from such individuals. By being aware that implicit biases exist and that they can influence stigmatizing behaviors, counselors gain a clearer understanding of the reality experienced by their consumers. In turn, rapport and effectiveness of the counseling relationship is likely to improve.

Study Two

Summary. The purpose of the second study (see Chapter III), “Stigma and Substance Use: An Investigation into the Mediating Effects of Personality, Social Support, and Coping in the Pathway between Perceived and Internalized Stigma,” was to explore potential mediators along the pathway between perceived and internalized stigma among people with substance use. To reiterate, perceived stigma refers to the negative public attitudes an individual believes to exist toward his or her stigmatized group while internalized stigma occurs when an individual accepts the negative public attitudes as being true about him or herself (Luoma et al., 2007). Although both forms of stigma can have damaging effects on stigmatized targets (Corrigan et al., 2012; Glass, Kristhansson, & Bucholz, 2013; Kleim et al., 2008; Schomerus et al., 2011), researchers have reported that the consequences of internalized stigma have been more severe (Corrigan, Watson, & Barr, 2006; Norman, Windell, Lynch, & Manchanda, 2011). Therefore, research is needed to identify factors that can help prevent perceived stigma from becoming internalized. Study two thus served as an initial investigation into identifying potential mediators along the pathway. In particular, the potential mediating effects of participant personality characteristics, social support, and coping behaviors were investigated. As such, study two was guided by the following research question: How, if at all, do personality characteristics, social support, and coping behaviors mediate the pathway between perceived and internalized stigma among people with substance use concerns?

In answering this question, 125 participants who self-identified as having substance use concerns completed a questionnaire. Included in this questionnaire were five Likert-scale instruments designed to explore participants’ perceived stigma, internalized stigma,

personality, social support, and coping behaviors. Participant answers were then compiled into SPSS and analysis was performed using Preacher and Hayes' (2008) methodology. Results indicated that maladaptive coping behaviors and high levels of positive social support (particularly affectionate social support) were significant mediators in the pathway between perceived and internalized stigma. Namely, participants who experienced high levels of perceived stigma were more likely to use maladaptive coping and to develop internalized stigma. In contrast, participants who experienced perceived stigma but who received positive social support (especially in the form of affectionate support) were significantly less likely to develop internalized stigma. Participants' personality characteristics and adaptive coping behaviors, however, were not significant mediators in the pathway.

The findings from study two were noteworthy because they emphasized the presence of perceived and internalized stigma among people with substance use disorders. This emphasis was particularly valuable as researchers have primarily studied perceived and internalized stigma in relation to people with mental illness (e.g., Cerit, Filizer, Tural, & Tufan, 2012; Corrigan et al., 2012; Drapalski et al., 2013). Although the attitudes toward the individuals with mental illness and substance use disorders have frequently overlapped (e.g., Corrigan et al., 2002; Corrigan et al., 2005; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Peluso & Blay, 2008; Schomerus, Matschinger, & Angermeyer, 2006), past research suggests that individuals with substance use disorders have been more stigmatized than those with mental illness (Corrigan et al., 2005; Pescosolido et al., 2010). Therefore, honing in on stigma specific to substance use was significant.

The findings from study two were also noteworthy because potential mediators were identified in regards to the pathway between perceived and internalized stigma. Namely, the maladaptive coping behaviors and social support of people with substance use concerns were identified as significant mediators between the two stigmas. Identification of these mediators was particularly important as knowledge of their mediating effects will help inform the work of counselors in their efforts to support consumers in recovering from substance use disorders.

Research. Given that study two was an initial attempt to identify mediating factors along the pathway between perceived and internalized stigma, multiple possibilities exist for future research on the topic. Two areas where additional research would be beneficial include: (1) further investigation into the specific aspects of social support that are most beneficial in preventing perceived stigma from becoming internalized; and (2) exploration into the mediating effects of other variables in the pathway between perceived and internalized stigma.

First, additional research is needed to further understand the mediating role of social support in the pathway between perceived and internalized stigma. In our study, we identified affectionate forms of social support as most significantly mediating this pathway. What is not yet understood, however, are the specific aspects of affectionate social support that were most beneficial. Pin pointing these aspects would aid counselors in not only encouraging their consumers to seek such forms of support but also in educating the consumer's family and friends about the most beneficial forms of support. Although tangible and emotional/informational forms of support were not significant mediators of the pathway in study two, their potential benefits to consumers should not

be dismissed. Rather, future research is needed to should further explore the benefits of all types of support in the lives of people with substance use disorders and to determine how specific forms of support mediate the impact of stigma.

In examining the effects of social support, researchers should also aim to have participant samples wherein males and females are represented fairly equally. Near equal representation across gender would be important as researchers have concluded that the preferred type of social support differs between men and women (Ashton & Fuehrer, 1993). To this end, separate analyses for male and female participants regarding the mediating effects of affectionate support, tangible support, and emotional/informational support could offer valuable insight.

Second, additional research is needed to explore the mediating effects of other variables in the pathway between perceived and internalized stigma among people with substance use disorders. In line with the mediating effects of social support, participation in family-based interventions may be one such mediator in the pathway. Investigating the mediating effects of family-based interventions would be particularly important as counselors have been encouraged to involve the family when treating someone with a substance use disorder (Meyers, Apodaca, Flicker, & Slesnick, 2002). Participation in community reinforcement and family training (CRAFT) and behavioral couples and family therapy (BCT/BFT) in particular have been shown to positively impact recovery from substance use disorders (Copello, Templeton, & Velleman, 2006; Meis et al., 2013; Meyers et al., 2002). Specifically, participation in CRAFT, BCT, and BFT has led to increases in consumers' willingness to enter treatment, longer periods of sobriety, and

improved family relationships (Copello et al., 2006; Meis et al., 2013; Meyers et al., 2002).

Considering the already documented benefits of family-based interventions, it seems likely that participation in these interventions would also help prevent perceived stigma from becoming internalized. To test these potential mediating effects, researchers could use a true experimental design involving random assignment of consumers and their families. For example, consumers and their families could be randomly assigned to either a control condition (individual counseling) or to treatment condition (CRAFT, BCT, or BFT). Prior to and following participation in the assigned conditions, consumers could complete instruments measuring perceived stigma, social support, and internalized stigma. Analyses would then be performed to determine if participation in the treatment conditions strengthened consumers' perceptions of social support significantly more than participation in the control condition. Finally, path analysis could be used to determine if the perceived social support served as a mediator between perceived and internalized stigma.

Another variable that may mediate the pathway between perceived and internalized stigma is a person's stage of change. As detailed in Prochaska and DiClemente's (1984) Transtheoretical Model, individuals cycle through a number of stages in their efforts to change a desired behavior. Specifically, the stages of change include pre-contemplation (person does not believe a problem exists), contemplation (person has considered making a change), preparation (person has decided to make a change and is developing a plan of action), action (person is engaged in the steps to make the change), and maintenance (person strives to maintain the changes that he or she has made).

Similar to individuals in the pre-contemplation and contemplation stages of change, individuals experiencing high levels of perceived and internalized stigma have been less willing to seek treatment (Bathje & Pryor, 2011; Keyes et al., 2010). Therefore, individuals who are in the early stages of change may also experience higher levels of perceived and internalized stigma. As the person progresses through the stages, he or she develops more skills to manage his or her substance use disorder. The acquisition of such skills could, in turn, help reduce internalized stigma by creating distance between the person and those who are in the throes of a substance use disorder. As such, the later stages of change (i.e., preparation, action, and maintenance) could serve as increasingly significant mediators between perceived and internalized stigma.

Education. Rehabilitation counselors, health care professionals, individuals with substance use disorders, and their family and friends need to be educated about the nature and damaging effects of stigma surrounding substance use. Specifically, educational efforts are needed in three areas: (1) campaign facilitators need to be taught to integrate information about the stigma that can impede on recovery; (2) members of a consumer's support network need to be taught about the benefits of positive social support in preventing perceived stigma from becoming internalized; and (3) members of a consumer's support network need to be taught about the influence of maladaptive coping behaviors in the pathway between perceived and internalized stigma.

First, as Schomerus (2014) discussed, many campaigns aimed at educating others about recovering from substance use disorders focus primarily on prevention and treatment of such disorders. Although information on these topics is certainly important, campaign facilitators also need to educate others about the stigma of having a substance

use disorder. Understanding such attitudinal barriers is vital because perceived and internalized stigma can interfere with an individual's willingness to seek treatment (Bathje & Pryor, 2011; Chandra & Minkovitz, 2006; Cunningham et al., 1993; Komiya, Good, & Shred, 2000). By being taught about the common stereotypes encountered by people with substance use disorders, members of the person's support network can offer words of encouragement and support that counter the stereotypical beliefs.

Second, family members, friends, rehabilitation counselors, and other professionals need to be educated about role of positive social support in preventing perceived stigma from becoming internalized. In study two of this dissertation, we concluded that affectionate forms of support were the most beneficial for mediating the effects of stigma. Therefore, family members and friends should be encouraged to show the person love and affection by hugging and spending time together to relax or to do something fun. Individuals recovering from substance use disorders should also be encouraged to evaluate the relationships in their lives and to seek out healthy forms of social support.

Third, individuals with substance use disorders and members in their social network need to be educated about the maladaptive coping behaviors that hasten the pathway between perceived and internalized stigma. Joking about the addiction, denying that a problem exists, giving up on making positive changes, and being self-critical are examples of maladaptive coping behaviors that need to be remedied. Educating family members, friends, and counselors about the unhealthy coping behaviors that influence internalized stigma would assist in the identification of these behaviors. In turn, treatment and support could be used to address and replace the unhealthy coping behaviors.

Practice. The results from study two offer valuable insight that can be used to enhance counselors' ability to facilitate an effective therapy experience for consumers. Three main implications for counseling consumers during their recovery from a substance use disorder include: (1) counselors should explore consumer's level of perceived and internalized stigma; (2) counselors should emphasize the role of social support; and (3) counselors should work with consumers to identify and eliminate maladaptive coping behaviors.

First, counselors should explore and challenge consumers' faulty beliefs that stem from perceived and internalized stigma. In particular, counselors should consider using cognitive behavioral therapy (CBT) in their efforts to reduce the internalized stigma experienced by consumers (Okkakhume, 2012). The benefits of CBT for this purpose were documented by Okkakhume (2012) who reported that consumers with mental illness showed a significant reduction in internalized stigma after receiving the treatment. Similar results were also noted by Morrison et al. (2013) who concluded that participants with signs of mental illness continued to show reduced levels of internalized stigma 12 months after receiving CBT. Although Okkakhume (2012) and Morrison et al. (2013) only explored the effects of CBT in reducing internalized stigma among people with mental illness, dual-diagnosis of mental illness and substance use disorders is fairly common (SAMHSA, 2013). Therefore, the benefits of CBT in reducing internalized stigma likely extend to people with substance use disorders.

Second, counselors should encourage consumers to seek positive forms of support in an effort to prevent perceived stigma from becoming internalized. An important first step in achieving this objective would be for counselors to facilitate conversations with

consumers about the characteristics of healthy versus unhealthy relationships. Interactions with friends who drink or use substances can cause someone in recovery to relapse (Mohr, Averna, Kenny, & Del Boca, 2001). In place of such relationships, counselors should encourage consumers to surround themselves with people who are encouraging and who help maintain a drug and alcohol-free environment (Mohr et al., 2001). Participation in self-help groups such as alcoholics anonymous in particular has been beneficial for people recovering substance use disorders (Humphreys, Mankowski, Moos, & Finney, 1999).

Finally, counselors should work with consumers to identify and eliminate unhealthy coping behaviors, such as using drugs and alcohol. Although important, this step may be challenging when the consumer is in denial or is not ready to change his or her behaviors. Motivational interviewing may thus be a necessary preliminary step in order to get the consumer to a place where he or she is open to change (Pilkey, Steinberg, & Martino, 2015). The active involvement of family members is also critical in this process as they can provide insight into the consumer's coping behaviors and can encourage the consumer to engage in adaptive types of coping. Even though the results from study two indicated that only maladaptive coping behaviors mediated the pathway between perceived and internalized stigma, the development of healthy coping behaviors should still be emphasized in counseling. Eliminating unhealthy coping behaviors would be counterproductive if consumers were not equipped with the tools or insight to replace those behaviors with healthier coping strategies.

Study Three

Summary. The purpose of the third study (see Chapter IV), “A Narrative Inquiry of Ambivalent Ableism: Understanding how Physically Disabled Adults Perceive Microaggressions,” was to expand on existing research regarding ableist microaggressions perceived by people with physical disabilities and to suggest a new framework for conceptualizing these microaggressions. Subsequently, the study was conducted with the intent of understanding the personal impact of being the target of ableist microaggressions.

The development of study three was largely influenced by the research of Keller and Galgay (2010), Bell (2015), and Glick and Fiske (1996). First, the study was influenced by the work of Keller and Galgay (2010) and Bell (2015) who reported findings about the nature of microaggressions experienced by people with physical disabilities. Examples of microaggressions identified in their studies included desexualization, perceived helplessness, and infantilization. Study three was conducted in an effort to validate these findings, to identify additional microaggressions, and to investigate the personal impact of these microaggressions.

Second, the study was influenced by Glick and Fiske’s (1996) theory of ambivalent sexism. As detailed in their theory, Glick and Fiske (1996) argued that women encounter both hostile and benevolent forms of sexism exemplified by blatant sexist attitudes or behaviors on the one hand (hostile sexism) and well-intentioned but demeaning attitudes or behaviors on the other hand (benevolent sexism). Because PWD have also encountered both overt and covert types of prejudice, study three served as an initial exploration into the applicability of Glick and Fiske’s (1996) theory for understanding encounters with

ableism. More specifically, we sought to determine if the ableist microaggressions described by participants could be conceptualized as exemplifying hostile and benevolent forms of ableism.

Three questions guided the research: (1) How do people with physical disabilities narrate their experiences with microaggressions and ambivalent ableism?; (2) How, if at all, do the microaggressions reported by people with physical disabilities resemble the categories of hostile ableism and benevolent ableism?; and (3) How do people with physical disabilities believe that microaggressions and ambivalent ableism have impacted their lives?

In answering these questions, twelve participants with visible, physical disabilities were interviewed for the study. Each interview was transcribed and analyzed for major themes of microaggressive experiences. These themes were then categorized as representing either hostile ableism, benevolent ableism, or impact on the target. Namely, microaggressions categorized as hostile ableism included othering, victimizing, and desexualizing; microaggressions categorized as benevolent ableism included helping and infantilizing; and impacts of the microaggressions resulted in participants passing/covering and internalizing.

The findings from study three were noteworthy because they not only offered validation of previously identified ableist microaggressions (i.e., othering, desexualizing, helping, infantilizing), but they also provided evidence of additional microaggressions (i.e., victimizing). Further, the responses from participants in study three offered new insight into potential consequences that stem from being the target of microaggressive comments and behaviors. The substantial overlap of these findings with previous research

is significant because it speaks to the prevalence and damaging effects of ableist microaggressions. Finally, the findings from study three were noteworthy in that they offered initial evidence that Glick and Fiske's (1996) theory could be used to conceptualize ableist microaggressions.

Research. Only in recent years have researchers begun to investigate the microaggressions experienced by people with disabilities. As such, many possibilities exist for future study. Three areas for future research on ableist microaggressions include: (1) additional exploration into the conceptualization of ableist microaggressive experiences as examples of ambivalent ableism; (2) further investigation into the nature of ableist microaggressions across disability; and (3) development of a quantitative instrument to measure the nature and prevalence of ableist microaggressions.

First, additional research is needed to explore the applicability of Glick and Fiske's (1996) theory for conceptualizing ableist microaggressions. Specifically, researchers should seek to further identify if and how ableist microaggressive experiences can be categorized as examples of hostility and benevolence. Given that Glick and Fiske's (1996) theory was developed based on sexism, future research on ambivalent ableism may indicate a need to revise the definitions of hostile ableism and benevolent ableism in order to best represent the attitudes toward PWD. As Tringo (1970) concluded, a hierarchy of disability exists based on the type of impairment (e.g., people with physical disabilities are perceived more positively than people with psychiatric disabilities). Therefore, the type of impairment may also influence variability in the definitions of hostile and benevolent ableism. This potential variability, in turn, emphasizes the need

for researchers to explore how experiences with ambivalent ableism change or remain the same across disability.

Second, regardless of the framework used to conceptualize ableist microaggressions, research on microaggressive experiences of PWD is still in the beginning stages. As such, researchers need to continue to validate the nature and coding of ableist microaggressions. To date, researchers have explored microaggressions experienced by participants with physical disabilities (Bell, 2015; Keller & Galgay, 2010), psychiatric disabilities (Gonzales, Davidoff, Nadal, & Yanos, 2014), hearing impairments (Chapple, 2012), and miscellaneous mild disabilities (Dávila, 2015). Missing from this research is information about the microaggressions experienced by people with vision impairments, developmental disabilities, and episodic conditions (e.g., autoimmune diseases). By investigating ableist microaggressions from the perspectives of people with varying types of impairments, researchers would gain a more comprehensive understanding of the nature of such microaggressions. Subsequently, researchers could more readily identify the types of ableist microaggressions that occur most frequently and that are most in need of ameliorative efforts.

Finally, researchers should develop a quantitative instrument to measure the nature and prevalence of ableist microaggressions. Although the data generated from a quantitative instrument would not be as rich as data collected from participant interviews, researchers would be able to investigate the problem of microaggressions on a larger scale. In so doing, this would increase the generalizability of research on ableist microaggressions and would aid researchers in designing the most effective interventions for addressing the microaggression.

The format of an ableist microaggression instrument could be modeled off of Nadal's (2011) Racial and Ethnic Microaggressions Scale (REMS)–Checklist. Specifically, Nadal's (2011) REMS checklist contained six subscales for a total of 45 items. Examples of the items included statements such as “I was told that people of color do not experience racism anymore” and “Someone assumed that I spoke a language other than English.” Participants were then instructed to mark each microaggression they had encountered in the last six months. To apply Nada's (2011) instrument design to ableist microaggressions, participants may be asked to respond to statements such as “I was told that I was inspirational” and “Someone spoke to me as if I was a child.” Again, participants would be asked to mark each microaggression that they had encountered in the last six months.

Education. Education is another important tool for raising awareness of ableist microaggressions and for addressing these barriers. Changes to course curriculum in particular could be beneficial in these efforts. Specifically, two implications for improving course curriculum include: (1) the need for the topic of disability to be more interwoven across fields of study, and (2) the need for future professionals in disability-related fields to be taught about ableist microaggressions.

First, in an effort to increase the acceptance of disability and prevent microaggressions from occurring in the first place, the topic of disability should be interwoven throughout course curriculum. As multiple participants suggested in study three, PWD are frequently perceived as “the other.” Divisions in curriculum likely contribute to this sense of otherness given that the topic of disability is frequently only discussed in disability-related classes or is reserved for isolated class discussions.

According to Linton (1998), a more inclusive approach would be to integrate the topic of disability throughout the curriculum and to discuss the experiences of PWD alongside the experiences of people without disabilities (PWOD). This would provide students with an opportunity to learn about disability in a way that is not othering and to perceive PWD on more equal terms as those without disabilities.

Second, adding the topics of ambivalent ableism and microaggressions to graduate level curriculum would be important. Regardless of whether the consumer is seeking counseling services or medical treatment, rapport plays a significant role in the consumer-professional relationship (Campbell, 2009; Van Staden et al., 2006; Young, 2013). Therefore, in order for consumers to obtain the greatest benefit from services, aspiring professionals need to be educated about the microaggressions that their disabled consumers may experience as offensive. One example of a microaggression that could arise in the consumer-professional relationship is the assumption that the consumer desires to be “normal” (French, 2004). By being aware of ableist microaggressions, aspiring professionals would improve their interactions with disabled consumers and would be better equipped to advocate for their consumers.

Practice. An awareness of ableist microaggressions is also vital for facilitating an effective therapeutic experience. Implications from study three with regards to counseling include: (1) counselors need to be knowledgeable about the hostile and benevolent forms of microaggressions that impact their consumers; and (2) counselors need to support consumers in processing their microaggressive experiences and in developing strategies for responding to such experiences.

First, counselors need to be informed about the microaggressions encountered by their consumers with disabilities. While most counselors would likely acknowledge that having a disability causes their consumers to be at increased risk for discrimination and bullying, counselors may be less aware of the more subtle forms of ableism. As such, counselors may unintentionally engage in microaggressions when working with disabled consumers (Palombi, 2012). Examples of microaggressions by counselors may appear in statements such as “I am sure that none of these events is related to your disability” and “perhaps you should have had a more positive attitude when interacting with your peers” (Esten & Willmott, 1994; Palombi, 2012). Counselors who engage in microaggressions such as these are likely to damage the therapeutic alliance (Owen, Tao, Imel, Wampold, & Rodolfa, 2014) and to leave their consumers feeling misunderstood and invalidated. Therefore, in order for the counseling relationship to be most effective, counselors should be self-reflective about their attitudes toward PWD and to educate themselves about the common microaggressions experienced by PWD (Owen et al., 2014). Further still, counselors should be open to feedback from their consumers and should not be defensive or dismissive when consumers describe behaviors and comments that they experience as offensive.

Second, counselors should support consumers in processing their microaggressive experiences and in developing strategies for responding to such behaviors and comments. As recommended by Nadal, Griffin, Wong, Hamit, and Rasmus (2014), validating the microaggressive experiences described by consumers is an important first step. Not only does this validation help the consumer to feel understood but it can also aid in establishing rapport. Nadal et al. (2014) further encouraged counselors to guide

consumers in thoroughly processing their microaggressive experiences in order to prevent the experiences from becoming internalized. Finally, incorporating role playing exercises into the therapy may be beneficial. In so doing, consumers would have an opportunity to “try on” different responses in a safe environment.

Final Thoughts

The studies presented within this dissertation have provided new insight regarding the multidimensionality of attitudinal ableism and the potential impacts of ableist attitudes on PWD. As indicated by the findings from these studies, the attitudinal barriers encountered by PWD reside on both conscious and unconscious levels, are both blatant and subtle in nature, and can have a variety of damaging effects on disabled targets. Therefore, given the complexity of attitudinal ableism, the combined efforts of researchers, educators, and counselors are needed to eradicate the attitudinal barriers encountered by PWD. The concluding chapter of this dissertation has included multiple ideas for achieving this goal.

REFERENCES

- Allport, G. W. (1954). *The nature of prejudice*. Cambridge MA: Addison Wesley.
- Amodio, D. M., & Mendoza, S. A. (2010). Implicit intergroup bias: Cognitive, affective, and motivational underpinnings. In B. Gawronski, B. K. Payne, B. Gawronski, B. K. Payne (Eds.), *Handbook of implicit social cognition: Measurement, theory, and applications* (pp. 353-374). New York, NY, US: Guilford Press.
- Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: A review of population studies. *Acta Psychiatrica Scandinavica*, *113*(3), 163-179. doi:10.1111/j.1600-0447.2005.00699.x
- Angermeyer, M. C., & Matschinger, H. (1996). The effect of violent attacks by schizophrenic persons on the attitude of the public towards the mentally ill. *Social Science & Medicine*, *43*(12), 1721-1728. doi:10.1016/S0277-9536(96)00065-2
- Annual Disability Statistics Compendium. (2014). 2014 Annual disability statistics compendium - Tables by topic overview. Retrieved from <http://disabilitycompendium.org/compendium-statistics>
- Appel, P. W., Ellison, A. A., Jansky, H. K., & Oldak, R. (2004). Barriers to enrollment in drug abuse treatment and suggestions for reducing them: Opinions of drug injecting street outreach clients and other system stakeholders. *The American Journal of Drug and Alcohol Abuse*, *30*(1), 129-153. doi:10.1081/ADA-120029870
- Ashton, W. A., & Fuehrer, A. (1993). Effects of gender and gender role identification of participant and type of social support resource on support seeking. *Sex Roles*, *28*(7-8), 461-476. doi:10.1007/BF00289608

- Baron, A. S., & Banaji, M. R. (2006). The development of implicit attitudes: Evidence of race evaluations from ages 6 and 10 and adulthood. *Psychological Science, 17*(1), 53-58. doi:10.1111/j.1467-9280.2005.01664.x
- Badoux, A. (2000). Social support in healthy and psychologically distressed French populations. *Psychology, Health & Medicine, 5*(2), 143-154.
doi:10.1080/713690180
- Bathje, G. J., & Pryor, J. B. (2011). The relationships of public and self-stigma to seeking mental health services. *Journal of Mental Health Counseling, 33*(2), 161-177.
Retrieved from <http://essential.metapress.com/content/u5rx1h34687w/>
- Bell, A. K. (2015). Nothing about us without us: A qualitative investigation of the experiences of being a target of ableist microaggressions. *Dissertation Abstracts International, 75*.
- Berger, K.S. (2008). *The developing person: Through the life span* (7th ed.). New York, NY: Worth Publishers.
- Berger, R. J. (2013). *Introducing disability studies*. Boulder: Lynne Rienner Publishers.
- Blake, J. J., Lund, E. M., Zhou, Q., Kwok, O., & Benz, M. R. (2012). National prevalence rates of bully victimization among students with disabilities in the United States. *School Psychology Quarterly, 27*(4), 210-222.
doi:10.1037/spq0000008
- Brault, M.W. (2012). Americans with Disabilities: 2010. *Current population reports*, P70-131, U.S. Census Bureau, Washington, DC. Retrieved from <https://www.census.gov/prod/2012pubs/p70-131.pdf>

- Brener, L., Rose, G., von Hippel, C., & Wilson, H. (2013). Implicit attitudes, emotions, and helping intentions of mental health workers toward their clients. *Journal of Nervous and Mental Disease*, 201(6), 460-463.
doi:10.1097/NMD.0b013e318294744a
- Brohan, E., Slade, M., Clement, S., & Thornicroft, G. (2010). Experiences of mental illness stigma, prejudice and discrimination: a review of measures. *BMC Health Services Research*, 1080-90. doi:10.1186/1472-6963-10-80
- Bureau of Labor Force Statistics, U.S. Department of Labor. (2015). *Persons with a disability: Labor force characteristics – 2014*. Retrieved from <http://www.bls.gov/news.release/pdf/disabl.pdf>
- Bureau of Labor Statistics, U.S. Department of Labor. (2014). Almost 60% of people with a disability age 25 and older had a high school education or less in 2013. *The Economics Daily*. Retrieved from http://www.bls.gov/opub/ted/2014/ted_20141010.htm
- Campbell, K. S. (2009). Physicians and patients: How professionals build relationships through rapport management. In G. F. Hayhoe, H. M. Grady, G. F. Hayhoe, H. M. Grady (Eds.) , *Connecting people with technology: Issues in professional communication* (pp. 145-154). Amityville, NY, US: Baywood Publishing Co.
- Carver, C. S. (1997). You want to measure coping but your protocol's too long: Consider the Brief COPE. *International Journal of Behavioral Medicine*, 4(1), 92-100.
doi:10.1207/s15327558ijbm0401_6

- Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, *56*(2), 267-283. doi:10.1037/0022-3514.56.2.267
- Castelli, L., Zogmaister, C., & Tomelleri, S. (2009). The transmission of racial attitudes within the family. *Developmental Psychology*, *45*(2), 586-591.
doi:10.1037/a0014619
- Centers for Medicare & Medicaid Services. (2015). *NHE fact sheet*. Retrieved from <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>
- Cerit, C., Filizer, A., Tural, Ü., & Tufan, A. (2012). Stigma: A core factor on predicting functionality in bipolar disorder. *Comprehensive Psychiatry*, *53*(5), 484-489.
doi:10.1016/j.comppsy.2011.08.010
- Chandra, A., & Minkovitz, C. S. (2006). Stigma starts early: Gender differences in teen willingness to use mental health services. *Journal of Adolescent Health*, *38*(6), 754.e1-754.e8. doi:10.1016/j.jadohealth.2005.08.011
- Chappel, J. N. (1973). Attitudinal barriers to physician involvement with drug abusers. *Jama: The Journal of the American Medical Association*, *224*, 7, 1011-3. Retrieved from <http://jama.jamanetwork.com/article.aspx?articleid=348187>
- Chapple, R. (2013). Being a deaf woman in college is hard. Being Black just adds: Understanding the complexities of intersecting the margins. *Dissertation Abstracts International Section A*, *73*.

- Cheon, B. K., & Chiao, J. Y. (2012). Cultural variation in implicit mental illness stigma. *Journal of Cross-Cultural Psychology, 43*(7), 1058-1062.
doi:10.1177/0022022112455457
- Chronister, J., Chou, C., & Liao, H. (2013). The role of stigma coping and social support in mediating the effect of societal stigma on internalized stigma, mental health recovery, and quality of life among people with serious mental illness. *Journal of Community Psychology, 41*(5), 582-600.
doi:10.1002/jcop.21558
- Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin, 98*(2), 310-357. doi:10.1037/0033-2909.98.2.310
- Commission on Rehabilitation Counselor Certification. (2015). Rehabilitation counseling scope of practice. Retrieved from <https://www.crc certification.com/scope-of-practice>
- Copello, A. G., Templeton, L., & Velleman, R. (2006). Family interventions for drug and alcohol misuse: Is there a best practice?. *Current Opinion in Psychiatry, 19*(3), 271-276. doi:10.1097/01.yco.0000218597.31184.41
- Corrigan, P. W., & Kosyluk, K. A. (2014). Mental illness stigma: Types, constructs, and vehicles for change. In P. W. Corrigan (Ed.), *The stigma of disease and disability: Understanding causes and overcoming injustices* (pp. 35-56). Washington, DC, US: American Psychological Association. doi:10.1037/14297-003
- Corrigan, P. W., Larson, J., Sells, M., Niessen, N., & Watson, A. C. (2007). Will filmed presentations of education and contact diminish mental illness stigma?.

Community Mental Health Journal, 43(2), 171-181. doi:10.1007/s10597-006-9061-8

Corrigan, P. W., Lurie, B. D., Goldman, H. H., Slopen, N., Medasani, K., & Phelan, S. (2005). How adolescents perceive the stigma of mental illness and alcohol abuse. *Psychiatric Services (Washington, D.C.)*, 56, 5, 544-50.

doi:10.1176/appi.ps.56.5.544

Corrigan, P., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behavior*, 44(2), 162-179. doi:10.2307/1519806

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsçh, N. (2012).

Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services*, 63(10), 963-973. doi:10.1176/appi.ps.201100529

Corrigan, P. W., & O'Shaughnessy, J. R. (2007). Changing mental illness stigma as it exists in the real world. *Australian Psychologist*, 42(2), 90-97.

doi:10.1080/00050060701280573

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, 54(9), 765-776. doi:10.1037/0003-066X.54.9.765

Corrigan, P. W., & Penn, D. L. (2015). Lessons from social psychology on discrediting psychiatric stigma. *Stigma and Health*, 1(S), 2-17. doi:10.1037/2376-6972.1.S.2

Corrigan, P. W., Powell, K. J., & Rüsçh, N. (2012). How does stigma affect work in people with serious mental illnesses?. *Psychiatric Rehabilitation Journal*, 35(5), 381-384. doi:10.1037/h0094497

- Corrigan, P. W., River, L., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., & ... Kubiak, M. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin*, 27(2), 187-195. Retrieved from <http://schizophreniabulletin.oxfordjournals.org/>
- Corrigan, P. W., Rowan, D., Green, A., Lundin, R., River, P., Uphoff-Wasowski, K., & ... Kubiak, M. (2002). Challenging two mental illness stigmas: Personal responsibility and dangerousness. *Schizophrenia Bulletin*, 28(2), 293-309. Retrieved from <http://schizophreniabulletin.oxfordjournals.org/>
- Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology*, 25, 8, 875-884. doi:10.1521/jscp.2006.25.8.875
- Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *The British Journal of Psychiatry: The Journal of Mental Science*, 177, 4-7. doi:10.1192/bjp.177.1.4
- Crocker, J., & Major, B. (1989). Social stigma and self-esteem: The self-protective properties of stigma. *Psychological Review*, 96(4), 608-630. doi:10.1037/0033-295X.96.4.608
- Cunningham, J. A., Sobell, L. C., Sobell, M. B., Agrawal, S., & Toneatto, T. (1993). Barriers to treatment: Why alcohol and drug abusers delay or never seek treatment. *Addictive Behaviors*, 18, 3, 347-353. doi:10.1016/0306-4603(93)90036-9

- Dávila, B. (2015). Critical race theory, disability microaggressions and Latina/o student experiences in special education. *Race, Ethnicity & Education, 18*(4), 443-468.
doi:10.1080/13613324.2014.885422
- Dávila, B. A. (2012). Negotiating 'special' identities: Latina/o student experiences in special education. *Dissertation Abstracts International Section A, 73*, 2302.
- Dobkin, P. L., De Civita, M., Paraherakis, A., & Gill, K. (2002). The role of functional social support in treatment retention and outcomes among outpatient adult substance abusers. *Addiction, 97*(3), 347-356.
doi:10.1046/j.1360-0443.2002.00083.x
- Dovidio, J., Hewstone, M., Glick, P., & Esses, V. (2010). Prejudice, stereotyping and discrimination: Theoretical and empirical overview. In J. Dovidio, M. Hewstone, P. Glick, & V. Esses (Eds.), *The SAGE handbook of prejudice, stereotyping and discrimination*. (pp. 3-29). London: SAGE Publications Ltd. doi:
<http://dx.doi.org.ezproxy1.library.arizona.edu/10.4135/9781446200919.n1>
- Drapalski, A. L., Lucksted, A., Perrin, P. B., Aakre, J. M., Brown, C. H., DeForge, B. R., & Boyd, J. E. (2013). A model of internalized stigma and its effects on people with mental illness. *Psychiatric Services, 64*(3), 264-269.
doi:10.1176/appi.ps.001322012
- Dunham, Y., & Banaji, M.R. (2009). The invariance of intergroup bias across the lifespan. Manuscript submitted for publication.
- Dunham, Y., Baron, A. S., & Banaji, M. R. (2008). The development of implicit intergroup cognition. *Trends in Cognitive Sciences, 12*(7), 248-253.
doi:10.1016/j.tics.2008.04.006

- Dunton, B. C., & Fazio, R. H. (1997). An individual difference measure of motivation to control prejudiced reactions. *Personality and Social Psychology Bulletin*, 23(3), 316-326. doi:10.1177/0146167297233009
- Eagly, A. H., & Chaiken, S. (1993). *The psychology of attitudes*. Orlando, FL, US: Harcourt Brace Jovanovich College Publishers.
- Ebneter, D. S., & Latner, J. D. (2013). Stigmatizing attitudes differ across mental health disorders: A comparison of stigma across eating disorders, obesity, and major depressive disorder. *Journal of Nervous and Mental Disease*, 201(4), 281-285.
- Economou, M., Louki, E., Peppou, L. E., Gramandani, C., Yotis, L., & Stefanis, C. N. (2012). Fighting psychiatric stigma in the classroom: The impact of an educational intervention on secondary school students' attitudes to schizophrenia. *International Journal of Social Psychiatry*, 58(5), 544-551. doi:10.1177/0020764011413678
- Economou, M., Peppou, L.E., & Stefanis, C.N. (2012). Medical students' beliefs and attitudes toward schizophrenia before and after undergraduate psychiatric training in Greece. *Psychiatry and Clinical Neurosciences*, 66(1), 17-25. doi:10.1111/j.1440-1819.2011.02282.x
- Ehrlich-Ben Or, S., Hasson-Ohayon, I., Feingold, D., Vahab, K., Amiaz, R., Weiser, M., & Lysaker, P. H. (2012). Meaning in life, insight and self-stigma among people with severe mental illness. *Comprehensive Psychiatry*, doi:10.1016/j.comppsy.2012.07.011

- Esten, G., & Willmott, L. (1993). Double bind messages: The effects of attitude towards disability on therapy. *Women & Therapy, 14*(3-4), 29-41.
doi:10.1300/J015v14n03_05
- Fazio, R. H. (2007). Attitudes as object-evaluation associations of varying strength. *Social Cognition, 25*(5), 603-637. doi:10.1521/soco.2007.25.5.603
- Fazio, R. H., Jackson, J. R., Dunton, B. C., & Williams, C. J. (1995). Variability in automatic activation as an unobtrusive measure of racial attitudes: A bona fide pipeline?. *Journal of Personality and Social Psychology, 69*(6), 1013-1027.
doi:10.1037/0022-3514.69.6.1013
- Fazio, R. H., & Towles-Schwen, T. (1999). The MODE model of attitude-behavior processes. In S. Chaiken, Y. Trope (Eds.), *Dual-process theories in social psychology* (pp. 97-116). New York, NY, US: Guilford Press.
- Franz, L., Carter, T., Leiner, A., Bergner, E., Thompson, N., & Compton, M. (2010). Stigma and treatment delay in first-episode psychosis: A grounded theory study. *Early Intervention in Psychiatry, 4*(1), 47-56. doi:10.1111/j.1751-7893.2009.00155.x
- French, S. (2004). Enabling relationships in therapy practice. In Swain, J., Clark, J., French, S., Reynolds, F., & Parry, K. *Enabling Relationships in Health and Social Care*. Oxford: Butterworth-Heinemann.
- Galinsky, A. D., & Moskowitz, G. B. (2000). Perspective-taking: Decreasing stereotype expression, stereotype accessibility, and in-group favoritism. *Journal of Personality and Social Psychology, 78*(4), 708-724. doi:10.1037/0022-3514.78.4.708

- Gerschick, T. J., & Miller, A. S. (1995). Coming to terms: Masculinity and physical disability. In D. F. Sabo, D. F. Gordon, D. F. Sabo, D. F. Gordon (Eds.), *Men's health and illness: Gender, power, and the body* (pp. 183-204). Thousand Oaks, CA, US: Sage Publications, Inc.
- Glass, J. E., Kristjansson, S. D., & Bucholz, K. K. (2013). Perceived alcohol stigma: Factor structure and construct validation. *Alcoholism, Clinical and Experimental Research*, *37*, 237-46. doi:10.1111/j.1530-0277.2012.01887.x
- Glick, P., & Fiske, S. T. (2012). An ambivalent alliance: Hostile and benevolent sexism as complementary justifications for gender inequality. In J. Dixon, M. Levine, J. Dixon, M. Levine (Eds.), *Beyond prejudice: Extending the social psychology of conflict, inequality and social change* (pp. 70-88). New York, NY, US: Cambridge University Press.
- Glick, P., & Fiske, S. T. (1996). The ambivalent sexism inventory: Differentiating hostile and benevolent sexism. *Journal of Personality and Social Psychology*, *70*(3), 491-512. doi:10.1037/0022-3514.70.3.491
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, N.J: Prentice-Hall.
- Gonzales, L., Davidoff, K. C., Nadal, K. L., & Yanos, P. T. (2015). Microaggressions experienced by persons with mental illnesses: An exploratory study. *Psychiatric Rehabilitation Journal*, *38*(3), 234-241. doi:10.1037/prj0000096
- Greenwald, A. G., McGhee, D. E., & Schwartz, J. L. (1998). Measuring individual differences in implicit cognition: The implicit association test. *Journal of Personality and Social Psychology*, *74*, 6, 1464-80.

- Hengartner, M. P., Loch, A. A., Lawson, F. L., Guarniero, F. B., Wang, Y., Rössler, W., & Gattaz, W. F. (2013). Public stigmatization of different mental disorders: A comprehensive attitude survey. *Epidemiology and Psychiatric Sciences*, 22(3), 269-274. doi:10.1017/S2045796012000376
- Hergenrather, K., & Rhodes, S. (2007). Exploring undergraduate student attitudes toward persons with disabilities: Application of the disability social relationship scale. *Rehabilitation Counseling Bulletin*, 50(2), 66-75. doi:10.1177/00343552070500020501.
- Hoffner, C. A., Fujioka, Y., Cohen, E. L., & Atwell Seate, A. (2015). Perceived media influence, mental illness, and responses to news coverage of a mass shooting. *Psychology of Popular Media Culture*, doi:10.1037/ppm0000093
- Humphreys, K., Mankowski, E. S., Moos, R. H., & Finney, J. W. (1999). Do enhanced friendship networks and active coping mediate the effect of self-help groups on substance abuse?. *Annals of Behavioral Medicine*, 21(1), 54-60. doi:10.1007/BF02895034
- Ienciu, M., Romoșan, F., Bredicean, C., & Romoșan, R. (2010). First episode psychosis and treatment delay — Causes and consequences. *Psychiatria Danubina*, 22(4), 540-543. Retrieved from http://www.hdbp.org/psychiatria_danubina/2010_Vol_22_No_4.html
- Jennings, K.S., Cheung, J.H., Britt, T.W., Goguen, K.N., Jeffirs, S.M., Peasley, A.L., & Lee, A.C. (2015). How are perceived stigma, self-stigma, and self-reliance related to treatment seeking? A three-path model. *Psychiatric Rehabilitation Journal*, 38(2), 109-116. doi:10.1037/prj0000138

- Johnson, A.G. (2006). *Privilege, power, and difference*. (2nd ed.). New York, NY: McGraw Hill
- Jones, N., & Corrigan, P. W. (2014). Understanding stigma. In P. W. Corrigan (Ed.), *The stigma of disease and disability: Understanding causes and overcoming injustices* (pp. 9-34). Washington, DC, US: American Psychological Association.
doi:10.1037/14297-002
- Kaiser, S. B., Freeman, C. M., & Wingate, S. B. (1985). Stigmata and negotiated outcomes: Management of appearance by persons with physical disabilities. *Deviant Behavior*, 6(2), 205-224. doi:10.1080/01639625.1985.9967670
- Kaiser, S. B., Wingate, S. B., Freeman, C. M., & Chandler, J. L. (1987). Acceptance of physical disability and attitudes toward personal appearance. *Rehabilitation Psychology*, 32(1), 51-58. doi:10.1037/h0091558
- Karpinski, A., & Steinman, R. B. (2006). The Single Category Implicit Association Test as a measure of implicit social cognition. *Journal of Personality and Social Psychology*, 91(1), 16-32. doi:10.1037/0022-3514.91.1.16
- Keller, R.M. & Galgay, C.E. (2010). Microaggressive experiences of people with disabilities. In Sue, D. W. (Ed.). *Microaggressions and marginality: Manifestation, dynamics, and impact*. Hoboken, N.J: Wiley.
- Kelly, J. F., & Westerhoff, C. M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *The International Journal on Drug Policy*, 21, 3, 202-7.
doi:10.1016/j.drugpo.2009.10.010

- Keyes, K. M., Hatzenbuehler, M. L., McLaughlin, K. A., Link, B., Olfson, M., Grant, B. F., & Hasin, D. (2010). Stigma and treatment of alcohol disorders in the United States. *Comprehensive Psychiatry*, *51*, 6. Retrieved from <http://www.comppsyjournal.com/issues>
- Kleim, B., Vauth, R., Adam, G., Stieglitz, R. D., Hayward, P., & Corrigan, P. (2008). Perceived stigma predicts low self-efficacy and poor coping in schizophrenia. *Journal of Mental Health Abingdon*, *17*, 5, 482-491. doi:10.1080/09638230701506283
- Knox, W. J. (1971). Attitudes of psychiatrists and psychologists toward alcoholism. *The American Journal of Psychiatry*, *127*, 12, 1675-9. Retrieved from <http://ajp.psychiatryonline.org/article.aspx?articleid=152352>
- Komiya, N., Good, G. E., & Sherrod, N. B. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of Counseling Psychology*, *47*(1), 138-143. doi:10.1037/0022-0167.47.1.138
- Kopera, M., Suszek, H., Bonar, E., Myszka, M., Gmaj, B., Ilgen, M., & Wojnar, M. (2014). Evaluating explicit and implicit stigma of mental illness in mental health professionals and medical students. *Community Mental Health Journal*, doi:10.1007/s10597-014-9796-6
- Laudet, A. B., Morgen, K., & White, W. L. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and

drug problems. *Alcoholism Treatment Quarterly*, 24(1-2), 33-73.

doi:10.1300/J020v24n01_04

Lee, T., Yang, Y., Chen, P., Hung, N., Lin, S., Chang, F., & Cheng, S. (2006).

Different dimensions of social support for the caregivers of patients with schizophrenia: Main effect and stress-buffering models. *Psychiatry and*

Clinical Neurosciences, 60(5), 546-550. doi:10.1111/j.1440-

1819.2006.01556.x

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis, and interpretation*. London: Sage.

Liesener, J. J., & Mills, J. (1999). An experimental study of disability spread: Talking to

an adult in a wheelchair like a child. *Journal of Applied Social Psychology*, 29(10),

2083-2092. doi:10.1111/j.1559-1816.1999.tb02296.x

Lincoln, T. M., Arens, E., Berger, C., & Rief, W. (2008). Can antistigma campaigns be

improved? A test of the impact of biogenetic vs psychosocial causal explanations

on implicit and explicit attitudes to schizophrenia. *Schizophrenia Bulletin*, 34(5),

984-994. doi:10.1093/schbul/sbm131

Link, B. G. (1987). Understanding labeling effects in the area of mental disorders:

An assessment of the effects of expectations of rejection. *American*

Sociological Review, 52(1), 96-112.

Link, B. G., & Phelan, J. C. (2001). CONCEPTUALIZING STIGMA. *Annual Review of*

Sociology, 27363.

Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999).

Public conceptions of mental illness: Labels, causes, dangerousness, and

social distance. *American Journal of Public Health*, 89(9), 1328-1333.

doi:10.2105/AJPH.89.9.1328

Linton, S. (1998). *Claiming disability: Knowledge and identity*. New York and London:

New York University Press.

Loch, A. A., Wang, Y., Guarniero, F. B., Lawson, F. L., Hengartner, M. P., Rössler, W.,

& Gattaz, W. F. (2014). Patterns of stigma toward schizophrenia among the
general population: A latent profile analysis. *International Journal of Social*

Psychiatry, 60(6), 595-605. doi:10.1177/0020764013507248

Louvet, E., Rohmer, O., & Dubois, N. (2009). Social judgment of people with a disability

in the workplace. *Swiss Journal of Psychology*, 68, 3, 153-159.

Lund, E. M., & Boggero, I. A. (2014). Sick in the head? Pathogen concerns bias implicit

perceptions of mental illness. *Evolutionary Psychology*, 12(1), 706-718.

Luoma, J. B., O'Hair, A. K., Kohlenberg, B. S., Hayes, S. C., & Fletcher, L. (2010).

The development and psychometric properties of a new measure of perceived
stigma toward substance users. *Substance Use & Misuse*, 45, 1-2.

doi:10.3109/10826080902864712

Luoma, J. B., Twohig, M. P., Waltz, T., Hayes, S. C., Roget, N., Padilla, M., &

Fisher, G. (2007). An investigation of stigma in individuals receiving
treatment for substance abuse. *Addictive Behaviors*, 32, 7, 1331-1346.

doi:10.1016/j.addbeh.2006.09.008

Lysaker, P. H., Roe, D., & Yanos, P. T. (2007). Toward understanding the insight

paradox: Internalized stigma moderates the association between insight and
social functioning, hope, and self-esteem among people with schizophrenia

spectrum disorders. *Schizophrenia Bulletin*, 33(1), 192-199.

doi:10.1093/schbul/sbl016

Mannarini, S., & Boffo, M. (2014). An implicit measure of associations with mental illness versus physical illness: Response latency decomposition and stimuli differential functioning in relation to IAT order of associative conditions and accuracy. *Plos ONE*, 9(7).

Margetić, B., Jakovljević, M., Ivanec, D., Margetić, B., & Tošić, G. (2010).

Relations of internalized stigma with temperament and character in patients with schizophrenia. *Comprehensive Psychiatry*, 51(6), 603-606.

doi:10.1016/j.comppsy.2010.02.010

Marie, D., & Miles, B. (2008). Social distance and perceived dangerousness across four diagnostic categories of mental disorder. *Australian and New Zealand Journal of Psychiatry*, 42(2), 126-133.

Maxwell, J. (2013). *Qualitative research design: An interactive approach*. Thousand Oaks, CA: SAGE.

McGinty, E. E., Webster, D. W., Jarlenski, M., & Barry, C. L. (2014). News media framing of serious mental illness and gun violence in the United States, 1997-2012.

American Journal of Public Health, 104(3), 406-413.

doi:10.2105/AJPH.2013.301557

McLaughlin, D. D., McKenna, H. H., Leslie, J. J., Moore, K. K., & Robinson, J. J.

(2006). Illicit drug users in Northern Ireland: Perceptions and experiences of health and social care professionals. *Journal of Psychiatric and Mental Health Nursing*, 13(6), 682-686. doi:10.1111/j.1365-2850.2006.01015.x

- Meis, L. A., Griffin, J. M., Greer, N., Jensen, A. C., MacDonald, R., Carlyle, M., & ... Wilt, T. J. (2013). Couple and family involvement in adult mental health treatment: A systematic review. *Clinical Psychology Review, 33*(2), 275-286.
doi:10.1016/j.cpr.2012.12.003
- Meyers, R. J., Apodaca, T. R., Flicker, S. M., & Slesnick, N. (2002). Evidence-based approaches for the treatment of substance abusers by involving family members. *The Family Journal, 10*(3), 281-288. doi:10.1177/10680702010003004
- Mittal, D., Corrigan, P., Sherman, M. D., Chekuri, L., Han, X., Reaves, C., & ... Sullivan, G. (2014). Healthcare providers' attitudes toward persons with schizophrenia. *Psychiatric Rehabilitation Journal, 37*(4), 297-303. doi:10.1037/prj0000095
- Mohr, C. D., Averna, S., Kenny, D. A., & Del Boca, F. K. (2001). 'Getting by (or getting high) with a little help from my friends': An examination of adult alcoholics' friendships. *Journal of Studies on Alcohol, 62*(5), 637-645.
- Monteith, L. L., & Pettit, J. W. (2011). Implicit and explicit stigmatizing attitudes and stereotypes about depression. *Journal of Social and Clinical Psychology, 30*(5), 484-505. doi:10.1521/jscp.2011.30.5.484
- Morrison, A. P., Birchwood, M., Pyle, M., Flach, C., Stewart, S. K., Byrne, R., & ... French, P. (2013). Impact of cognitive therapy on internalised stigma in people with at-risk mental states. *The British Journal of Psychiatry, 203*(2), 140-145.
doi:10.1192/bjp.bp.112.123703
- Mueller, B., Nordt, C., Lauber, C., Rueesch, P., Meyer, P. C., & Roessler, W. (2006). Social support modifies perceived stigmatization in the first years of

mental illness: A longitudinal approach. *Social Science & Medicine*, 62, 1, 39-49. doi:10.1016/j.socscimed.2005.05.014

National Institute of Mental Health. (2012). *Any mental illness (AMI) among adults*.

Retrieved from <http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml>

Nadal, K. L. (2011). The Racial and Ethnic Microaggressions Scale (REMS):

Construction, reliability, and validity. *Journal of Counseling Psychology*, 58(4), 470-480. doi:10.1037/a0025193

Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014). The impact of racial microaggressions on mental health: Counseling implications for clients of color. *Journal of Counseling & Development*, 92(1), 57-66. doi:10.1002/j.1556-6676.2014.00130.x

Newport, E. L. (1975). Motherese: The speech of mothers to young children. *Dissertation Abstracts International*, 36, 2503.

Norman, R. G., Gawronski, B., Hampson, E., Sorrentino, R. M., Szeto, A., & Ye, Y.

(2010). Physical proximity in anticipation of meeting someone with schizophrenia: The role of explicit evaluations, implicit evaluations and cortisol levels. *Schizophrenia Research*, 124(1-3), 74-80.

doi:10.1016/j.schres.2010.07.021

Norman, R. M. G., Windell, D., Lynch, J., & Manchanda, R. (2011). Parsing the relationship of stigma and insight to psychological well-being in psychotic disorders. *Schizophrenia Research*, 133, 3-7.

doi:10.1016/j.schres.2011.09.002

- O'Driscoll, C., Heary, C., Hennessy, E., & Mckeague, L. (2012). Explicit and implicit stigma towards peers with mental health problems in childhood and adolescence. *Journal of Child Psychology & Psychiatry*, *53*(10), 1054-1062.
doi:10.1111/j.1469-7610.2012.02580.x
- Okhakhume, A. (2012). Influence of psychological factors on self and perceived stigma and the efficacy of cognitive behaviour therapy in symptoms reduction among mentally ill patients. *IFE Psychologia: An International Journal*, *20*(2), 54-71.
- Omori, A., Tateno, A., Ideno, T., Takahashi, H., Kawashima, Y., Takemura, K., & Okubo, Y. (2012). Influence of contact with schizophrenia on implicit attitudes towards schizophrenia patients held by clinical residents. *BMC Psychiatry*, *12*
- Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice*, *45*(4), 283-290. doi:10.1037/a0037420
- Palamar, J. J. (2012). A pilot study examining perceived rejection and secrecy in relation to illicit drug use and associated stigma. *Drug and Alcohol Review*, *31*, 4, 573-9. doi:10.1111/j.1465-3362.2011.00406.x
- Palombi, B. J. (2013). Women with disabilities: The cultural context of disability, feminism, able-bodied privilege, and microaggressions. In C. Z. Enns, E. N. Williams, C. Z. Enns, E. N. Williams (Eds.) , *The Oxford handbook of feminist multicultural counseling psychology* (pp. 199-220). New York, NY, US: Oxford University Press.

- Parcesepe, A. M., & Cabassa, L. J. (2013). Public stigma of mental illness in the United States: A systematic literature review. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(5), 384-399.
doi:10.1007/s10488-012-0430-z
- Park, S. G., Bennett, M. E., Couture, S. M., & Blanchard, J. J. (2012). Internalized stigma in schizophrenia: Relations with dysfunctional attitudes, symptoms, and quality of life. *Psychiatry Research*, doi:10.1016/j.psychres.2012.08.040
- Park, N., Peterson, C., & Seligman, M. P. (2004). Strengths of character and well-being. *Journal of Social and Clinical Psychology, 23*(5), 603-619.
doi:10.1521/jscp.23.5.603.50748
- Payne, B. K., & Gawronski, B. (2010). A history of implicit social cognition: Where is it coming from? Where is it now? Where is it going?. In B. Gawronski, B. K. Payne (Eds.), *Handbook of implicit social cognition: Measurement, theory, and applications* (pp. 1-15). New York, NY, US: Guilford Press.
- Peluso, É., & Blay, S. (2008). Public perception of alcohol dependence. *Revista Brasileira De Psiquiatria, 30*(1), 19-24. doi:10.1590/S1516-44462008000100004
- Peris, T. S., Teachman, B. A., & Nosek, B. A. (2008). Implicit and explicit stigma of mental illness: Links to clinical care. *Journal of Nervous and Mental Disease, 196*(10), 752-760. doi:10.1097/NMD.0b013e3181879dfd
- Perugini, M., Richetin, J., & Zogmaister, C. (2010). Prediction of behavior. In B. Gawronski, B. K. Payne (Eds.), *Handbook of implicit social cognition:*

Measurement, theory, and applications (pp. 255-277). New York, NY, US: Guilford Press.

- Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., & Link, B. G. (2010). 'A disease like any other'? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *The American Journal of Psychiatry*, *167*(11), 1321-1330. doi:10.1176/appi.ajp.2010.09121743
- Petty, R. E., & Briñol, P. (2010). Attitude structure and change: Implications for implicit measures. In B. Gawronski, B. K. Payne, B. Gawronski, B. K. Payne (Eds.) , *Handbook of implicit social cognition: Measurement, theory, and applications* (pp. 335-352). New York, NY, US: Guilford Press.
- Pilkey, D., Steinberg, H., & Martino, S. (2015). Evidence-based treatments for substance use disorders. In A. D. Kaye, N. Vadivelu, R. D. Urman, A. D. Kaye, N. Vadivelu, R. D. Urman (Eds.) , *Substance abuse: Inpatient and outpatient management for every clinician* (pp. 209-227). New York, NY, US: Springer Science + Business Media. doi:10.1007/978-1-4939-1951-2_17
- Preacher, K. J., & Hayes, A. F. (2008). Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models. *Behavior Research Methods*, *40*(3), 879-891. doi:10.3758/BRM.40.3.879
- Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing the traditional boundaries of therapy*. Homewood, IL: Dow-Jones/Irwin.
- Raguram, R., & Weiss, M. G. (1997). EMIC interview for outpatient psychiatry and stigma. Instrument for collaborative research, National Institute of Mental

Health and Neuro Sciences, Bangalore, and Swiss Tropical Institute, Basel.
Revised December 1997.

- Renty, J., & Roeyers, H. (2006). Quality of life in high-functioning adults with autism spectrum disorder: The predictive value of disability and support characteristics. *Autism, 10*(5), 511-524. doi:10.1177/13623613060666604
- Ritsher, J., & Phelan, J. C. (2004). Internalized stigma predicts erosion of morale among psychiatric outpatients. *Psychiatry Research, 129*(3), 257-265. doi:10.1016/j.psychres.2004.08.003
- Rosen, D. B. (2006). Violence and exploitation against women and girls with disability. *Annals of The New York Academy of Sciences, 1087*(1), 170-177. doi:10.1196/annals.1385.002
- Rosen, D. D., Greenberg, D., Schmeidler, J., & Shefler, G. (2008). Stigma of mental illness, religious change, and explanatory models of mental illness among Jewish patients at a mental-health clinic in North Jerusalem. *Mental Health, Religion & Culture, 11*(2), 193-209. doi:10.1080/13674670701202945
- Rubin, S. E., & Roessler, R. T. (2008). *Foundations of the vocational rehabilitation process (6th ed.)*. Austin, TX, US: PRO-ED.
- Ruch, W., Proyer, R. T., Harzer, C., Park, N., Peterson, C., & Seligman, M. P. (2010). Values in Action Inventory of Strengths (VIA-IS): Adaptation and validation of the German version and the development of a peer-rating form. *Journal of Individual Differences, 31*(3), 138-149. doi:10.1027/1614-0001/a000022

- Rüsch, N., Corrigan, P. W., Todd, A. R., & Bodenhausen, G. V. (2010a). Implicit self-stigma in people with mental illness. *Journal of Nervous and Mental Disease, 198*(2), 150-153. doi:10.1097/NMD.0b013e3181cc43b5
- Rüsch, N., Todd, A. R., Bodenhausen, G. V., & Corrigan, P. W. (2010b). Biogenetic models of psychopathology, implicit guilt, and mental illness stigma. *Psychiatry Research, 179*(3), 328-332. doi:10.1016/j.psychres.2009.09.010
- Rüsch, N., Todd, A. R., Bodenhausen, G. V., & Corrigan, P. W. (2010c). Do people with mental illness deserve what they get? Links between meritocratic worldviews and implicit versus explicit stigma. *European Archives of Psychiatry and Clinical Neuroscience, 260*(8), 617-625. doi:10.1007/s00406-010-0111-4
- Rüsch, N., Todd, A. R., Bodenhausen, G. V., Olschewski, M., & Corrigan, P. W. (2010d). Automatically activated shame reactions and perceived legitimacy of discrimination: A longitudinal study among people with mental illness. *Journal of Behavior Therapy and Experimental Psychiatry, 41*(1), 60-63. doi:10.1016/j.jbtep.2009.10.002
- Rydell, R. J., & McConnell, A. R. (2006). Understanding implicit and explicit attitude change: A systems of reasoning analysis. *Journal of Personality and Social Psychology, 91*(6), 995-1008. doi:10.1037/0022-3514.91.6.995
- Sadler, M. S., Meagor, E. L., & Kaye, K. E. (2012). Stereotypes of mental disorders differ in competence and warmth. *Social Science & Medicine, 74*(6), 915-922. doi:10.1016/j.socscimed.2011.12.019

- Saporito, J.M., Ryan, C., & Teachman, B.A. (2011). Reducing stigma toward seeking mental health treatment among adolescents. *Stigma Research and Action, 1*(2), 9-21.
- Satoshi, S., Otake, K., Park, N., Peterson, C., & Seligman, M. P. (2006). Convergence of character strengths in American and Japanese young adults. *Journal of Happiness Studies, 7*(3), 311-322. doi:10.1007/s10902-005-3647-7
- Schomerus, G. (2014). The stigma of alcohol and other substance abuse. In P. W. Corrigan, P. W. Corrigan (Eds.), *The stigma of disease and disability: Understanding causes and overcoming injustices* (pp. 57-72). Washington, DC, US: American Psychological Association. doi:10.1037/14297-004
- Schomerus, G., Corrigan, P. W., Klauer, T., Kuwert, P., Freyberger, H. J., & Lucht, M. (2011). Self-stigma in alcohol dependence: Consequences for drinking-refusal self-efficacy. *Drug and Alcohol Dependence, 114*(1), 12-17. doi:10.1016/j.drugalcdep.2010.08.013
- Schomerus, G. G., Matschinger, H. H., & Angermeyer, M. C. (2006). Alcoholism: Illness beliefs and resource allocation preferences of the public. *Drug and Alcohol Dependence, 82*(3), 204-210. doi:10.1016/j.drugalcdep.2005.09.008
- Sharaf, A. Y., Ossman, L. H., & Lachine, O. A. (2012). A cross-sectional study of the relationships between illness insight, internalized stigma, and suicide risk in individuals with schizophrenia. *International Journal of Nursing Studies, 49*(12), 1512-1520. doi:10.1016/j.ijnurstu.2012.08.006
- Sherbourne, C. D., & Stewart, A. L. (1991). The MOS social support survey. *Social Science & Medicine, 32*(6), 705-714. doi:10.1016/0277-9536(91)90150-B

- Shook, N. J., & Fazio, R. H. (2008). Interracial roommate relationships: An experimental field test of the contact hypothesis. *Psychological Science, 19*(7), 717-723. doi:10.1111/j.1467-9280.2008.02147.x
- Sinclair, S., Dunn, E., & Lowery, B. S. (2005). The relationship between parental racial attitudes and children's implicit prejudice. *Journal of Experimental Social Psychology, 41*(3), 283-289. doi:10.1016/j.jesp.2004.06.003
- Skok, A., Harvey, D., & Reddihough, D. (2006). Perceived stress, perceived social support, and wellbeing among mothers of school-aged children with cerebral palsy. *Journal of Intellectual and Developmental Disability, 31*(1), 53-57. doi:10.1080/13668250600561929
- Smart, J. (2001). *Disability, society, and the individual*. Gaithersburg, MD: Aspen
- Smith, S. M., Dawson, D. A., Goldstein, R. B., & Grant, B. F. (2010). Examining perceived alcoholism stigma effect on racial-ethnic disparities in treatment and quality of life among alcoholics. *Journal of Studies on Alcohol and Drugs, 71*, 2, 231-6. Retrieved from http://www.jsad.com/jsad/article/Examining_Perceived_Alcoholism_Stigma_Effect_on_RacialEthnic_Disparities_i/4434.html
- Social Security Administration. (2014). Table 7.A1—Number of recipients of federally administered payments, total payments, and average monthly payment, by source of payment, eligibility category, and age, December 2013. Retrieved from <https://www.ssa.gov/policy/docs/statcomps/supplement/2014/7a.pdf>

- Sriram, N., & Greenwald, A.G. (2009). The Brief Implicit Association Test. *Experimental Psychology*, 56, 283-294.
- Stier, A., & Hinshaw, S. P. (2007). Explicit and implicit stigma against individuals with mental illness. *Australian Psychologist*, 42(2), 106-117.
doi:10.1080/00050060701280599
- Stull, L. G., McGrew, J. H., Salyers, M. P., & Ashburn-Nardo, L. (2013). Implicit and explicit stigma of mental illness: Attitudes in an evidence-based practice. *Journal of Nervous and Mental Disease*, 201(12), 1072-1079.
doi:10.1097/NMD.0000000000000056
- Substance Abuse and Mental Health Services Administration. (2007). *Results from the 2006 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-32, DHHS Publication No. SMA 07-4293). Rockville, MD. Retrieved from <http://www.oas.samhsa.gov/nsduh/2k6nsduh/2k6results.pdf>
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm#ch5
- Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2014). *The NSDUH Report: Substance Use and*

Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings. Rockville, MD. Retrieved from <http://www.samhsa.gov/data/sites/default/files/NSDUH-SR200-RecoveryMonth-2014/NSDUH-SR200-RecoveryMonth-2014.pdf>

Sue, D.W. (2010). Microaggressions, marginality, and oppression: An introduction. In

Sue, D. W. (Ed.). *Microaggressions and marginality: Manifestation, dynamics, and impact*. Hoboken, N.J: Wiley.

Takahashi, H., Ideno, T., Okubo, S., Matsui, H., Takemura, K., Matsuura, M., & ...

Okubo, Y. (2009). Impact of changing the Japanese term for “schizophrenia” for reasons of stereotypical beliefs of schizophrenia in Japanese youth. *Schizophrenia Research, 112*(1-3), 149-152. doi:10.1016/j.schres.2009.03.037

Takizawa, T., Kondo, T., Sakihara, S., Ariizumi, M., Watanabe, N., & Oyama, H.

(2006). Stress buffering effects of social support on depressive symptoms in middle age: Reciprocity and community mental health. *Psychiatry and Clinical Neurosciences, 60*(6), 652-661. doi:10.1111/j.1440-1819.2006.01579.x

Tang, I., & Wu, H. (2012). Quality of life and self-stigma in individuals with

schizophrenia. *Psychiatric Quarterly, 83*(4), 497-507. doi:10.1007/s11126-012-9218-2

Teachman, B. A., Wilson, J. G., & Komarovskaya, I. (2006). Implicit and explicit stigma

of mental illness in diagnosed and healthy samples. *Journal of Social and Clinical Psychology, 25*(1), 75-95. doi:10.1521/jscp.2006.25.1.75

- Teige-Mocigemba, S., Klauer, K. C., & Sherman, J. W. (2010). A practical guide to implicit association tests and related tasks. In B. Gawronski, B. K. Payne (Eds.), *Handbook of implicit social cognition: Measurement, theory, and applications* (pp. 117-139). New York, NY, US: Guilford Press.
- Thomas, A., Doyle, A., & Vaughn, D. (2007). Implementation of a computer based Implicit Association Test as a measure of attitudes toward individuals with disabilities. *Journal of Rehabilitation, 73*(2), 3-14.
- Tringo, J. L. (1970). The hierarchy of preference toward disability groups. *The Journal of Special Education, 4*(3), 295-306. doi:10.1177/002246697000400306
- Uhlmann, C., Kaehler, J., Harris, M. H., Unser, J., Arolt, V., & Lencer, R. (2014). Negative impact of self-stigmatization on attitude toward medication adherence in patients with psychosis. *Journal of Psychiatric Practice, 20*(5), 405-410. doi:10.1097/01.pra.0000454787.75106.ae
- U.S. Equal Employment Opportunity Commission. (2014). *Americans with Disabilities Act of 1990 (ADA) Charges (includes concurrent charges with Title VII, ADEA, and EPA) FY 1997- FY 2014*. Retrieved from <http://www.eeoc.gov/eeoc/statistics/enforcement/ada-charges.cfm>
- Van Staden, C. W., Joubert, P. M., Pickworth, G. E., Roos, J. L., Bergh, A. -, Krüger, C., & ... Lindeque, B. G. (2006). The conceptualisation of 'soft skills' among medical students before and after curriculum reform. *South African Psychiatry Review, 9*(1), 33-37.

- Vertilo, V., & Gibson, J. M. (2014). Influence of character strengths on mental health stigma. *The Journal of Positive Psychology, 9*(3), 266-275.
doi:10.1080/17439760.2014.891245
- Vezzali, L., Capozza, D., Giovannini, D., & Stathi, S. (2012). Improving implicit and explicit intergroup attitudes using imagined contact: An experimental intervention with elementary school children. *Group Processes & Intergroup Relations, 15*(2), 203-212. doi:10.1177/1368430211424920
- Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 6, 603-13. doi:10.1001/archpsyc.62.6.603
- Wang, X., Huang, X., Jackson, T., & Chen, R. (2012). Components of implicit stigma against mental illness among Chinese students. *Plos ONE, 7*(9).
- Wigboldus, D. H. J., Holland, R. W., & van Knippenberg, A. (2005). *Single target implicit associations*. Unpublished manuscript.
- Williams, K. L., & Galliher, R. V. (2006). Predicting depression and self-esteem from social connectedness, support, and competence. *Journal of Social and Clinical Psychology, 25*(8), 855-874. doi:10.1521/jscp.2006.25.8.855
- Wilson, M. C., & Scior, K. (2014). Attitudes towards individuals with disabilities as measured by the Implicit Association Test: A literature review. *Research in Developmental Disabilities, 35*(2), 294-321. doi:10.1016/j.ridd.2013.11.003
- Wilson, T. D., Lindsey, S., & Schooler, T. Y. (2000). A model of dual attitudes. *Psychological Review, 107*(1), 101-126. doi:10.1037/0033-295X.107.1.101

- Wright, B. A. (1964). Spread in adjustment to disability. *Bulletin of The Menninger Clinic*, 28(4), 198-208.
- Yazicioğlu, K., Duyan, V., Karataş, K., Özgül, A., Yılmaz, B., Duyan, G., & Aksu, S. (2006). Effects of sociodemographic characteristics, illness process, and social support on the levels of perceived quality of life in veterans. *Military Medicine*, 171(11), 1083-1088.
- Young, M. (2013). The therapeutic relationship. In *Learning the art of helping: Building blocks and techniques* (pp. 51-78). Upper Saddle River, New Jersey: Pearson Education, Inc.
- Young, S. (2014). *I'm not your inspiration, thank you very much*. Retrieved from https://www.ted.com/talks/stella_young_i_m_not_your_inspiration_thank_you_very_much/transcript?language=en
- Yow, T. S., & Mehta, K. (2010). Perceived stigma and coping strategies among Asians with schizophrenia: The Singapore case. *International Social Work*, 53(3), 379-392. doi:10.1177/0020872809359866
- Žeželj, I., Jakšić, I., & Jošić, S. (2015). How contact shapes implicit and explicit preferences: Attitudes toward Roma children in inclusive and non-inclusive environment. *Journal of Applied Social Psychology*, 45(5), 263-273. doi:10.1111/jasp.12293
- Zvonkovic, A., & Lucas-Thompson, R. G. (2015). Refuting the myth of the 'violent schizophrenic': Assessing an educational intervention to reduce schizophrenia stigmatization using self-report and an Implicit Association Test. *Social Work in Mental Health*, 13(3), 201-215. doi:10.1080/15332985.2014.924463