Personal narratives of mental illness stigmatization from an insider perspective: A thematic analysis

Lara Wenglorz
s1838784

University of Twente, Faculty of Behavioral, Management and Social Sciences
Department of Psychology

Supervisors
Jacky van de Goor
Anneke Sools

October 19th, 2021

Abstract

This paper investigates real life experiences of mental illness stigmatization and self-stigmatization from the perspective of affected individuals, referred to as the *insider perspective*. Widely spread stigmas from outside are well researched. However, understanding outside stigmas from the insider perspective and how it affects self-stigmatization and feelings of people with a mental illness adds deeper insights into stigmatization research. Ten narratives about personal experiences with mental illness stigmatization from German mental health podcasts were examined. Selection aimed at creating a varied sample, resulting in a balance of gender and wide spectrum of illnesses (e.g., depression, borderline personality disorder, ADHD, anxiety disorder, schizophrenia, substance dependence), however a young age group (18-38 years), with the majority of podcast host having own mental illness experiences. A thematic analysis, based on the distinction between outside stigmas and self-stigmatization (Corrigan & Watson, 2002b) was conducted. Deductively, outside stigmas including need of help, personal responsibility and weakness were identified. Inductively, themes including a generalization of people with a mental illness, treating mental illnesses as a taboo subject, and reducing them on the illness, were added. Participants self-stigmatized as being incompetent, not good enough or refused their diagnosis. Feelings of being alone, wrong, different, or not taken seriously were identified. These were mostly related to being reduced on their illness, the perceived need of help, a lack of understanding and knowledge from outside and issue of taboo. Altogether, people with a mental illness perceived stigmatization as more subtle than expected from research with a great problem lying in self-stigmatization. Limitations include restricted generalizability to other countries and age groups. Future research should dig deeper into identified stigmatization experiences and feelings by conducting narrative interviews.

Keywords: personal narratives, mental illness, stigmatization, mental health, podcast

Contents

Introduction

Mental illness

The number of people suffering from a mental illness is persisting every year (World Health Organization (WHO), 2019a) and still, mental illnesses seem to suffer from a hard status. Most mental illnesses are not visible from the outside, making the subject still very much unenlightened and coming along with stigmatization (Henderson & Thornicroft, 2009). The stigmatization of mental illness follows several negative impacts, ranging from people feeling not taken seriously, hiding their pain (Tucci & Moukaddam, 2017), not seeking treatment, or keeping away from therapy (Tyszkowska & Podgrodzka, 2013). Research on stigmatization mainly covers stigmas held from outside, giving insights into the perspectives of people who are stigmatizing. Less focus is put on the perception of people who are suffering from a mental illness and are being stigmatized. Thus, for understanding stigmatization, it is crucial to investigate how stigmas held within society become visible for people who have a mental illness and how these stigmatization experiences impact them, referred to as the *insider perspective.* The relevance of researching stigmatization of mental illness gets emphasized when looking back to the number of people affected by a mental illness, which did not decline over the past years and so, likely will not be reduced over the upcoming years (WHO, 2019a). In Germany, it is estimated that about 28% of the population suffers from a mental illness (Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e.V. 2020), whereas in the U.S., about 20% of the population is affected, meaning that every fifth person is living with a mental illness (National Institute of Mental Health, 2021).

Stigmatization of mental illness

To date, the stigmatization of mental illness is still a burden for living with a mental illness. The word stigmatization originates from the latin word “stigmat”, which means mark or brand. By holding a stigma, one is presuming a border between a particular group of people and others (Coleman, 1986). The most prominent definition of stigma is derived from Goffman

(1963), who described stigma as "an attribute that is deeply discrediting" (p.3). Thus, mainly negative characteristics are attributed to a stigmatized person (Baumann, 2007). In other words, stigmas are attributes, mostly with a negative connotation, that discriminate one from another, or in a larger context, a group of people from society.

Attempting to understand stigmas of mental illness, Corrigan and Watson (2002b) introduced a model to demonstrate a distinction between public stigma and self-stigma. Public stigma describes the stigmatization from outside, where people show an emotional reaction and behavioral response towards a negative belief they have about a certain group of people. Self-stigma relates to self-stigmatization of people with a mental illness, where people who are affected, show an emotional reaction or behavioral response towards a negative belief, they have about themselves. Even though Corrigan and Watson (2002b) aim at understanding the impact of stigmatization on people with a mental illness, they base their insights on research findings. Furthermore, the relation between stigmatization from outside and self-stigmatization is not addressed within the model. Therefore, adding personal insights from affected individuals can be valuable in deepen stigmatization understanding. Thus, the present study aims to add by learning about the insider perspective on (1) *stigmatization*, (2) *self-stigmatization* and especially, the (3) perceived *relation* between both. First, the current state of outside stigmas is presented, followed by insights about self-stigmatization. Lastly, the present study is set up to explore the insider perspective on both aspects and the perceived relation between stigmatization and self-stigmatization of people with a mental illness.

Stigmatization from outside

Research on stigmatization of mental illness from an outside perspective reveals several, commonly held beliefs, about people with a mental illness. However, qualitative studies on people's stigmas about mental illness consider specific target groups (e.g., police, health professionals) (Hanafiah & Van Bortel, 2015; Van der Sanden et al., 2015; Edwards & Kotera, 2020), pointing to a lack in qualitative studies on mental illness stigmatization from more

diverse samples. Therefore, this paragraph presents quantitative research, relying on surveys and questionnaires, about people's stigmas on mental illness, to summarize a broader picture of mental illness stigmatization.

Baumann (2007) points to a lack of knowledge of outsiders and missing personal contact to affected people, causing stigmatization of mentally ill. Angermeyer and Dietrich (2006) researched stigmas towards people with a mental illness with a literature review including studies from all over Europe over the past 15 years. One stigma they identified is the assumption that people with a mental disorder are perceived as if they are in need of help (Angermeyer et al., 2006). This goes along with the belief that people with a mental illness are incompetent, revealed in a literature review by Parcesepe and Cabassa (2013). There, incompetence was often connected with being lazy, as in the example of people with a diagnosis of ADHD (Parcesepe et al., 2013). Also, incompetence, inability and weakness were highly connected to disorders like depression (Knifton, 2012).

Furthermore, many people perceive mentally ill as dangerous and unpredictable, even disclosing a tendency of distancing themselves towards people with a mental illness (Angermeyer & Dietrich, 2006). This turns out to be one of the most widely spread stigmas, also mentioned in other research on public stigma, described as "the reaction that the general population has to people with mental illness." (Corrigan & Watson, 2002b, p.17; Norman et al., 2008). One striking aspect about the stigma of dangerousness in particular is that it seems to hold especially for people with schizophrenia or a substance or alcohol abuse, compared to people with a mood or anxiety disorder. Connected to that, there is the stigma that people with a mental illness are socially inappropriate or even considered to be insane (Norman et al., 2008). Consequently, this stigma is often accompanied by the attitude that mentally ill should be excluded from society, either by special separation in psychiatric clinics or by enforcing disadvantages on them (Baumann, 2007).

The assumption that mentally ill are responsible for their own illness or have at least contributed to it is another stigma that is discussed in many research papers. This stigma often goes so far to state that people with a mental illness are weak and thus their illness can be contributed to their weakness (Norman et al., 2008). Accordingly, people who are considered strong do not get a mental illness according to this stigma. Mental illness often seems to stand in contrast to physical illness. Therefore, people who live with a physical illness are often pitied by their condition and perceived as strong and admirable, once they learn to live with a serious health condition like cancer (Rüsch et al., 2005). In contrast to that, people with a mental illness are more likely to be held responsible for their own illness (Rüsch et al., 2005). Making people with a mental illness responsible for their condition increases social rejection compared with people who have a physical illness, that is commonly perceived as occurring uncontrollable and without personal responsibility (Feldman & Crandall, 2007). Furthermore, Feldman et al. (2007) found a difference of attitudes between types of mental disorders, which they studied with the help of vignettes, representing each disorder with a "typical" profile according to the DSM-5 criteria, in an undergraduate student sample. Accordingly, stigmas of personal responsibility, as well as dangerousness and rarity of a disorder, were significantly stronger towards people with an antisocial personality disorder, cocaine dependence or paranoid personality compared to social phobia, posttraumatic stress disorder or narcolepsy (Feldman et al., 2007).

The differentiation between different types of disorders, which are also part of the stigmatization, was also addressed in a study by Norman et al. (2008), where stigmas, most importantly concerning the inappropriateness and dangerous of people with a mental illness, were stronger towards people with schizophrenia than people with depression. They discovered the role of perceived social norms within the stigmatization of both aforementioned illnesses and suggested uncertainties about certain illnesses to be a possible contributing factor in stigmatization and related behavior. Thus, a belief in danger, social inappropriateness, personal

responsibility for illness and perceived norm for greater social distance were higher towards people with schizophrenia and thus related to greater social distance (Norman et al., 2008).

Lastly, the only mentioned stigma within research that can be regarded as positively connoted is the belief that people with a mental illness are often associated with a talent for arts or other extraordinary, or being genius (Norman et al., 2008). Overall, just because all these stigmas are known to someone, that does not mean that everyone agrees to them. Corrigan and Watson (2002a) clearly point out that stigmas are still beliefs but that acting according to these beliefs or showing an emotional reaction to them can turn stigmas into prejudice. Consequently, the problem of stigmatization occurs once people treat and degrade others because of their prejudices (Corrigan et al., 2002).

Summarizing the literature on stigmas that people have about people who suffer from a mental illness, eight stigmas are commonly mentioned. These are a presumed (1) *need of help,* (2) *incompetence,* (3) *dangerousness*, (4) *need for separation*, (5) *personal responsibility*, (6) *weakness*, (7) *some mental illnesses are more serious than others* and (8) *talent for arts.*

Stigmatization from inside perspective and self-stigmatization

In contrast to the highly researched outside perspective, including the general population, on the stigmatization of mental illness, insights from people who have a mental illness and suffer from stigmatization are less prevalent. Considering qualitative studies, Dinos et al. (2004) published an interview study in which they investigated the experience with mental illness stigma from the perspective of people with a mental illness. However, they focused on the impact of individuals on experiencing stigmatization in general and did not examine specific stigmas. Beside this, Angermeyer et al. (2004) pointed out missing insights into people's real experiences with stigmatization and started investigating the inside perspective. Most prominent was experienced stigmatization related to interpersonal interactions, where people with a mental illness expected and consequently experienced a rejection of others and avoidance of contact. A review, built on mixed findings from research on inside and outside perspective,

on stigmatization by Baumann (2007) supports the problem of social rejection and exclusion from a social group in multiple life areas (e.g., experiencing discrimination in job application). Adding to the experience of social rejection, a qualitative study on personal experiences of people with a mental illness showed having difficulties when looking for an apartment (Rüsch et al., 2005), or on an interpersonal level, when forming a social network or getting into relationships (Karidi et al., 2010).

In addition to sparse research on how stigmatization from outside is experienced by people with a mental illness, self-stigmatization has been researched. Self-stigma describes beliefs and prejudice about mental illness that people who are affected hold again themselves. As stigmas widely spread in society, people tend to internalize these assumptions and beliefs (Corrigan & Watson, 2002a). Here, one crucial factor lies in the stigmatizion presented in media like movies or news, which in turn reinforces self-stigmatization (Maier et al., 2014). As people experience how they are perceived by others, they start to compare themselves with society and thus perceive themselves as less worthy, appreciated, and respected (Watson et al., 2007), leading to lower self-esteem (Corrigan et al., 2002), a lower sense of self-worth and self-efficacy (Watson et al., 2007). Self-stigmatization can include facing difficulties in social interactions because people often restrain their experiences and emotions from others, as they fear to be judged or feel ashamed about it (Abdullah & Brown, 2011). In the worst case, this can even hinder people from seeking treatment (Mann & Himelein, 2004).

Altogether, research on the inside perspective on stigmatization and self-stigmatization give insights into experiences and consequences of stigmatization. However, qualitative studies, especially on the inside perspective, are sparse and thus, a deeper level of understanding stigmatization and self-stigmatization from the perspective of people who are affected is lacking. Thus, investigating personal experiences of mental illness stigmatization can contribute to a thorough understanding of the problem.

The power of personal narratives

People who are affected by mental illness stigmatization themselves make real life experiences, allowing them to share insights on how they personally perceive and experience long-held beliefs. Getting deeper into personal stories offers the potential of looking behind the facades of people and thus discovering the stigmatization from a closer perspective. The focus on personal stories and narratives is part of the field of narrative psychology. Narrative psychology is concerned with how human beings give meaning to themselves, being in the world and the world around them by sharing, exchanging, and listening to stories (Murray & Sools, 2015). With narratives, meanings and experiences are constructed, they develop over time and in interaction with others. By sharing a story with others, a story gets shaped and thus, contributes to shape the narrator him-/herself in personality (Murray & Sools, 2015). Regarding the purpose of this thesis of understanding stigmatization, exploring personal stories may reveal personal experiences of stigmatization from an insider perspective. Thereby, narratives have the advantage of creating meaning to these experiences to capture a person's attitudes, thoughts, and feelings on this topic. Bailey and Tilley (2002) introduce narratives into research as a way of understanding "meaning rather than truth" (p. 575). Thus, by telling stories about mental illness stigmatization, people can give meaning to their experiences and let others participate in their personal understanding and ideas. Altogether, narratives on mental illness stigmatization can form the overall understanding of it.

Podcasts

A novel way to gain insight into personal narratives is by means of podcasts. Podcasts are audio files that are distributed via online platforms (Jham et al., 2008). Although podcasts gained their high prominence just some years ago, they make up one of the most consumed media in the world of digital media with increasing numbers, by today (Wiethe et al., 2020). In most cases, the owner of the podcast, its so-called host, is talking about a theme, either alone or having a conversation or interview with others (Merhi, 2015). Regarding narratives, studies

show that with increasing flow of media that is reaching people day by day, personal stories get more and more attention (Naslund et al., 2016). According to Waldmann (2020), telling stories from a first-person narrative reduces the distance between people, leading to a closer bond between podcaster and listener. This way, it can be assumed that personal stories may reach the listener and contribute to a raise of awareness. Due to the increasing use of podcasts and the growing interest in personal stories, podcasts are used as a source of personal narratives for this study. As podcast data is already quite rich and available to a great audience, the focus on podcasts was chosen in this study. In this study, German podcasts on mental health and mental illness are investigated. First, because focusing on experiences from people from the same country allows for comparability of findings as people share a similar societal background. Second, research points to a growing interest in mental health topics in Germany (Bramesfeld et al., 2003).

The Present Study

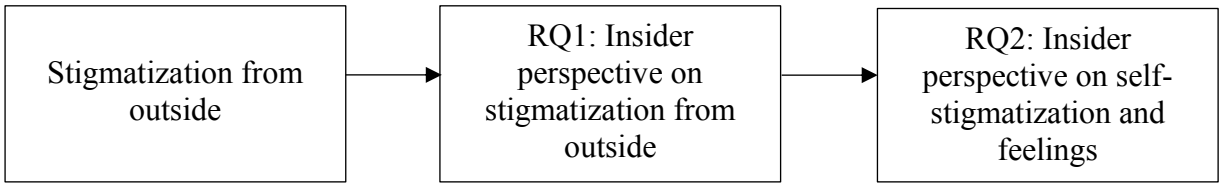
Altogether, stigmatization research shows a gap in knowledge of understanding stigmatization experiences from an insider perspective. Therefore, the present study aims to provide insights on how people with a mental illness perceive stigmatization from outside, their self-stigmatization and the relation between both. Thereby, the study addresses the gap of investigating personal narratives of stigmatization experiences to capture a thorough understanding of the insider perspective and feelings.

The motivation, and objective of the study lies in understanding mental illness stigmatization from personal experiences. Insights and knowledge gained from the study may be used for future research to ultimately contribute to creating awareness for the problem of mental illness stigmatization. One great problem is the perception of people with a mental illness as one uniform group of people. Podcasts invite a listener to closely participate in the insider perspective. Therefore, podcast narratives will be used to learn about the perspective on how people with a mental illness perceive stigmatization from outside, their self-stigmatization

and how they relate both to another. Figure 1 visualizes the conception of the research questions to be answered with the present study.

Figure 1

The relationship between stigmatization from outside, insider perspective on these and its effect on self-stigmatization



The left box represents that there is stigmatization from outside, that is perceived by people who are stigmatized in a certain way (middle box). Finally, this perception affects their self-stigmatization and feelings (right box). To answer the overarching research question on the relation between the middle and right box, two sub-questions were explored:

How does the experience of stigmatization from outside affect self-stigmatization in people with a mental illness?

1. How do people with a mental illness narrate their experience with stigmatization in podcasts about mental illness (i.e., the negative beliefs and behavior of others to their condition)?
2. How do people with a mental illness narrate their experiences of self-stigmatization in podcasts about mental illness (i.e., negative beliefs and behavior about themselves, feelings)?

Methods

Data collection

To explore stigmatization experiences from the insider perspective, mental health podcasts, in which people with a mental illness share their stories about living with a mental illness and being stigmatized, were explored. Podcasts were obtained from the audio streaming platform Spotify. As the study aims to collect personal and individual insights from different people to cover a wide variety of experiences, the main selection requirement was to choose a mixture of people concerning age, gender, and diagnosis, as far as this information were provided. The selection process resulted in a sample with a notable balance in gender, however all from a young age group (18-38). A variation in mental illnesses, including several people with co-morbidity, yet an overrepresentation of people with depression, could be achieved (see Table 1). Other mental illnesses represented in the sample included hypochondria, panic disorder, anxiety disorder, borderline personality disorder, posttraumatic stress disorder, ADHD, schizoaffective disorder, and substance abuse. All podcasts were German and in an interview format with a podcast host talking to a person who has experiences with mental illness. In some cases, the host him-/herself has experiences with a mental illness as well and talks about these from an insider perspective. Based on these criteria, nine podcast episodes from four different podcasts were selected, resulting in a total of 468 minutes of data, which equals about 8 hours.

Table 1

Podcasts, including characteristics like age, gender, diagnosis, and the mental health status of the host

Participant	Podcasts	Characteristics			
		Age	Gender	Diagnosis	Host
1	Der unverhüllt Podcast: Eine Depression wählt	30	Male	Depression, hypochondria	Yes

	nicht nach Geschlecht – Alex über Depression bei Männern				
2	Der unverhüllt Podcast:	18	Male	Depression	Yes
3	„Der Wald, das Feld und der Wind“ – Entstigmatisierung an Schulen, mit Simon und Nina	18	Female	Depression, Eating disorder	
4	Psychonormal – Der Podcast – Alex	-	Male	Depression, panic disorder, anxiety disorder	Yes
5	Psychonormal – Der Podcast – Elsa	-	Female	Borderline personality disorder	
6	Psychonormal – Der Podcast – Kyra	-	Female	Depression, posttraumatic stress disorder, panic disorder	Yes
7	Psychonormal – Der Podcast – Oliver	-	Male	Depression, ADHD	Yes
8	So ist das Leben … mit Depressionen, Borderline und posttraumatischer Belastungsstörung	18	Female	Depression, borderline personality disorder, posttraumatic stress disorder	No
9	So ist das Leben … mit einer schizoaffektiven Störung	27	Female	Schizoaffective disorder	No
10	Sucht und Ordnung – Sonderschüler kriegen keine Schokolade – toxische Kindheit	38	Female	Substance dependence	Yes

Note. Characteristic of the host implies whether the interviewer him-/herself has own experiences with living with a mental illness.

Data analysis

For analyzing the data, a thematic analysis, based on the approach of Braun and Clarke (2012), was used. A thematic analysis allows to identify patterns and concepts to understand meanings and relationships within qualitative data and has the strength of flexibility (Braun & Clarke, 2012). Thus, it was used gain understanding of how people with a mental illness perceive stigmatization from outside, their self-stigmatization, feelings, and its relation. For this purpose, a combination of a deductive and inductive approach was chosen. Deductively, stigmas derived from research were determined in the podcast narratives. Inductively, additional stigmas and experienced effects on the lives of people suffering from mental illness were analyzed.

Regarding a theoretical framework for coding the data, the study was oriented on the model of public stigma and self-stigma by Corrigan and Watson (2002b). Based on the distinction between public stigma and self-stigma, podcast data was coded. Public stigmas were aligned to stigmatization from outside, self-stigma to self-stigmatization beliefs and behavior. Although feelings were not addressed within Corrigan's and Watson's (2002b) model, they were added to the coding scheme. The decision of adding the concept of feelings of people with a mental illness was based on the study purpose of understanding the overall stigmatization experience, for which feelings are considered an essential part (Moen, 2006).

Altogether, the transcripts were analyzed and interpreted from on outside perspective as the researcher itself had never had personal experiences with stigmatization due to mental illness. Thus, a great focus of the analysis lied on empathizing and putting oneself into the inside perspective by carefully listening to the narratives. However, inside, and outside perspective are not clear-cut and may fluctuate along the progress of analysis. Therefore, the researcher engaged in reflexivity, meaning that the influence of own ideas, attitudes, and experiences on the analysis and interpretation of the data was monitored during the process (Finefter-Rosenbluh, 2017).

According to the six steps of a thematic analysis (Braun & Clarke, 2012), analysis started with (1) *familiarization with the data*. All podcast episodes were transcribed with the free-to-use online transcription software happyscribe and checked for correctness by the researcher. For the second step of (2) *generating initial codes*, all transcripts were transferred to Microsoft word with each podcast episode in a separate document. Then, all transcripts were coded on sentence level using color codes by the researcher. Data relevant for the topic of stigmatization of mental illness was coded, initially according to the predefined coding scheme. In the second round, the coding scheme was extended and further specified with the input from the data. About half of the data was not coded as it did not address stigmatization experiences but the overall experience of living with a mental illness, for example: "When I moved to Berlin, being 18 years old and being completely on my own, I noticed it for the first time, because I could not even make some food for myself and my whole flat looked like I never clean it." (Participant 6). Also, data about small talk, that did not convey stigmatization experiences was not coded: "Yes, it's been four years, but it's so cool that we are still in contact and recording this podcast episode today!" (Participant 1). After coding, the third step of (3*) searching for themes* was completed by grouping codes meaningfully into themes, regarding the research questions and adjusted model of public stigma and self-stigma derived from Corrigan and Watson (2002b). For (4) *reviewing potential themes,* codes were reviewed again for each transcript and corresponding quotes were checked for applicability to the themes. For increasing interrater reliability, a randomized mixture of 30 pages of data was given to two fellow students from the master program of psychology of the researcher's network with the purpose of coding. After discussion and agreement on the codes, all codes were printed out and assigned to the corresponded theme by three people. For (5) *defining and naming the themes*, correspondence of the themes and the model by Corrigan and Watson (2002b) was discussed, compared between raters, and the naming was checked for accuracy. Based on that, themes were identified. To answer the research questions, the last step of (6) *producing the report* was

performed within the results section. As all podcasts were recorded in German language, participant quotes were translated into English.

Results

In this paragraph, first, results regarding the first sub-question about the insider perspective on experiences of stigmatization from outside are described. Second, results regarding the second sub-question about the insider perspective on experiences with self-stigmatization are described. Lastly, both experiences are related to each other to explore the main research question and presented in an overview.

How do people with a mental illness narrate their experience with stigmatization in podcasts about mental illness (i.e., the negative beliefs and behavior of others to their condition)?

For investigating the first sub-question about the perception of the insider perspective of stigmatization from outside, stigmatization beliefs and behavior were identified. Deductively, five codes were identified based on coding from prior research. Three stigmas suggested by research (dangerousness, incompetence, talent for arts) could not be identified and coded within the data. Inductively, ten codes were identified within the data. Codes show how people with a mental illness perceive what people who are stigmatizing mental illnesses from outside think or do, referred to as outsiders (see Table 2).

Table 2

Overview of themes and theme descriptions of experience with stigmatization

Themes on stigmatization	Theme descriptions
Need for help	1.1a.) Outsiders believe that I need help
	1.1b.) Outsiders believe that I need medication*
Need for separation	1.2.) I experience exclusion
Personal responsibility	1.3a.) Outsiders believe that I am responsible for my illness

	1.3b.) I experience disregard of mental illnesses in comparison to physical illnesses*
Weakness	1.4.) Outsiders believe that I am weak
Some mental illnesses are more serious than others	1.5.) I experience suggestions about which mental illnesses are serious and which not
Ignorance	1.6a.) I experience misunderstandings about mental illnesses*
	1.6b.) I experience a lack of understanding for my situation*
	1.6c.) I experience treating mental illness as a taboo subject*
Stereotypes	1.7a.) I experience stereotyped thinking*
	1.7b.) I experience gender-related stigmas*
Trend	1.8.) Outsiders believe that I just do it for attention/that it is a trend*
Generalization	1.9.) Outsiders believe that all people with a mental illness are the same*
Reducing on illness	1.10.) I experience being reduced to my illness*

*New codes

1.1a.: Outsiders believe that I need help. The first belief that insiders came across was that they are in constant need of help of others. Here, participants described that other people always assumed that they needed and want help from other people because of their mental illness. This need of help was often projected to their whole person, assuming that people with a mental illness are subordinate and not capable of doing something on their own, as one participant explained: “And people make up indications they see on you that might tell them that you always need help, at least more help than other people.” (Participant 8)

Some participants experienced outsiders offered their help and expected it to be accepted. Insiders reported that they experienced a lack of understanding once they did not accept help from outside. Participants faced situations in which they perceived help as forced and intrusive:

> I think it is about making the other person offer to help but not to stress the other one and overload him/her. And when you make an offer, it can also be that it is not accepted, and you also must be clear about that. Especially as someone who is affected, I see that for people who are not affected themselves it can be totally frustrating, because you think like, 'I make offers and offers and nothing is accepted, nothing works.' (Participant 1)

Other participants emphasized the perceived enforcement of needing help: "You cannot, even with your best will, force someone into therapy. It does not make sense. All people in my surroundings told me to look for help and said that I need help. "(Participant 6). It was perceived that this enforcement of help could result in an "helper's complex, where you force to help … at all costs." (Participant 4). He added how he perceived the problem that results from that: "It will do nothing. Unless the other person is actively approaching you and asking for help." (Participant 4).

1.2b.: Outsiders believe that I just need medication. Related to the stigma of needing help, insiders were confronted with statements that implied that they would only need help in form of medication to clear their situation. Two participants further described that as a stigmatization belief that dismisses their personal situation by advising them to take medication without having any knowledge about them or their circumstances: "And when I say that for me it does not feel the same as for you. And then, for me it is hard when someone says, 'But if you just take your medication then it's alright.' "(Participant 9). Also, it was mentioned that people from outside thus think that medication could cure any illness, in all cases: "… he just said, 'Why couldn't they just simply give her any kind of medication or something?" (Participant 8).

This belief was not only encountered within a personal environment, but also within a professional environment. One participant faced a situation in which her general practitioner wanted to ascribe her medication, against her refusal and personal experiences, to stick to his routine of ascribing medication:

> And within the conversation, because I have an impulse control disorder, the physician told me 'You could just take', I don't even remember the name of it, 'but take medication for it.' And I already took this medication one or two times and it had the same effect as amphetamines and I could not do it, because I never consumed within the weekdays, so I never used drugs throughout the week. And it was too much for me and I just thought 'now he is stigmatizing me because of my drug consumption and illness and in turn he wants to give me drugs in form of medication for my mental illness and I just thought in what kind of world am I living?' (Participant 10)

1.2.: I experience exclusion. Participants talked about experiences where they were excluded from a group of people because of their mental illness. In the context of school, one participant explained that fellow students used to distance themselves from adolescents who harmed themselves as a symptom of a mental illness, followed by a "shitstorm", being "bullied", or seen as "strange", summing it up as a "really terrible handling". She explained:

> There was a lot of gossip and if, at that time there were already people harming themselves, and if it was seen it was commented on, but in a negative way, with the permission to keep oneself away from that person because he/she is scratching him-/herself. (Participant 3)

Another one perceived exclusion by others avoiding her or stop keeping in touch: "From many friends I ended up with barely having no one anymore, because no one wanted to know about it and also not about why I lied to them [to cover up for the diagnosis]." (Participant 9)

Lastly, another participant perceived exclusion in the context of going to a psychiatry. Here, it did not demonstrate the active exclusion done by others, but still gave rise to the stigmatization belief that people with a mental illness are not part of the society: "And they told me in that psychiatry the door is closed, and it was, so I was completely excluded, and I felt like a dangerous criminal." (Participant 8)

1.3a.: Outsiders believe that I am responsible for my illness. Another common stigmatization belief was that insiders are responsible for their illness, implying that it is a personal choice to suffer from a mental illness. In general, participants talked about the experience that they get reactions from outside showing them that many people are looking for a reason or a person that is the crucial reason for having a mental illness: “And then there is the ever-asked question, ‘whom you would give the fault?’” (Participant 1)

Beside looking for crucial events, outsiders believe that people with a mental illness are the reason themselves, where one participant explained: “And I noticed how rooted it is in society that they say that it is kind of your own fault and I had quite some unpleasant encounters with that.” (Participant 8). Contributing to this experience was another participant, stating:

> And at one point I said that I am just ill and that one is not choosing that him-/herself. I mean I was not sitting at home, thinking, ‘let’s be depressive, that is so much fun.’ In the end it is nothing else than, I don’t know, another lifechanging, life-threatening illness, like cancer or something. (Participant 6)

1.3b.: I experience disregard of mental illnesses in comparison to physical illnesses. People with a mental illness shared their observation that others bring up a comparison between mental illnesses and physical illnesses. Thereby, physical illnesses were often taken as more seriously, whereas mental illnesses were rather disregarded as not being serious or even not real, as mentioned: “And the problem I see is that in our society the mental health is not equally important as the physical and therefore it is not taken that seriously.” (Participant 3)

One reason for this behavior from outside seemed to lie in the visibility of illnesses, when considering participant’s narratives, where mental illnesses were described as “something you cannot see, and a broken leg is something that you can see but that does not make a difference” (Interviewer from participant 1). Participants showed frustration about this comparison, saying: “If you are ill, then you are ill, doesn’t matter it if it’s in your head, your heart, your leg or wherever.” (Participant 1)

As mental illnesses are not visible from the outside, people who are affected may not fit the mental representation of someone who seems to be ill, as specifically discussed by one participant:

> They compare it with a broken arm or something like that. But there you can see on the X-ray image 'Okay, this arm is broken, this and that has to be done'. And for mental illnesses there is often the problem, that they are not so tangible for people from outside … I mean not even for the patients themselves. (Participant 5)

From her grandmother she got the reaction that her illness is not visible and due to that not real, as suggested by this quote:

> 'You look good, you can still laugh.' – She had a picture in mind, and her picture also has to be visible on such an X-ray image. Seeing the arm is broken, she believes the arm is broken but I do not fit into her representation, her X-ray image of a mental image and that is where I often seem to offend society at many different places, also family. (Participant 5)

Also, one participant referred to personal responsibility and controllability for having an illness, again. Thus, it uncovers the assumption that, whereas physical illnesses happen to someone, mental illness are often seen as having a personal choice, by prescribing someone's fault: "You cannot ask who is guilty because when you, let's say, have a broken leg ... or let's say you have a brain tumor, you also cannot say that it is someone's fault and you cannot control it." (Participant 8)

1.4.: Outsiders believe that I am weak. Next, a stigmatization belief perceived from the participants was that outsiders think that people who have a mental illness are weak. Thus, it was considered that having an illness is a personal deficiency and negatively attributed to weakness: "… they still talk about people with a depression as if they were sort of weak and about anxious people or people with an anxiety disorder, they still say that these are just coward." (Participant 7). In this context, one participant said that he himself had internalized

this belief before and needed some time to overcome the relation between weakness and illness: "And it would already help if they acknowledged that even brave and strong people can fall into a depression or anxiety disorders. "(Participant 7). He specifically described the discrepancy between what people say and do, from his perspective, as "a lot of people claim, in fact, that they take mental illnesses seriously … but in practice, people with serious mental illnesses are still considered weak." (Participant 7).

1.5.: I experience suggestions about which mental illnesses are serious and which not. Participants identified outsider behavior in which people seemed to assess what type of mental disorders are serious and which of these are less serious. They talked about statements in which others categorize mental illness, although they did not have own experiences with it and thus cannot assess how difficult living with these illnesses is. Based on that, outsiders seemed to show differing reactions regarding their empathy or pity. One participant specifically observed that illnesses that seem to be more common, like depression, are rated as considered less serious: "… start with talking about depression because I think that the other illnesses are more severe for me…" (Interviewer Participant 8), whereas disorders like schizophrenia or personality disorders are rated as more severe: "… then she said that schizophrenia is one of the most serious ones in the world, but she never had it…" (Participant 9)

1.6a.: I experience misunderstandings about mental illnesses. Another stigmatization experience was discussed as the perception of missing knowledge or having incorrect knowledge about mental illnesses. Whether or not they can be made responsible for it, e.g., spreading misinformation or unfortunately not knowing better, it still influences how outsiders deal with people who have a mental illness and how they stigmatize them. Experiences ranged from "wrong information about antidepressants and its intake" to "misconceptions about depressive people always have to feel bad". I think that, at first, many people still have only little knowledge about that [mental illnesses in society]. So, most of the

people hear like, okay he is depressed and have this stereotype in mind, right away", summarized by another one (Participant 4).

One participant saw the main problem in the spread of information via media: "Maybe it's also about the unawareness. But that you have to be careful with the medial consumption in relation to that and that you should take information about mental illnesses only from reliable sources that see only a few." (Participant 4). Related to this unawareness, participants shared the perception, that they get confronted with outsiders who still have misunderstandings, even though they may not always be aware of it: "Nowadays it belongs to good manner to say that you understand mental illnesses and that you take them seriously but what I see is that many still don't understand it and also do not take them seriously." (Participant 7)

1.6b.: I experience a lack of understanding for my situation. In contrast to the abovementioned misunderstandings, a lack of understanding and empathy was another form of stigmatization that people with a mental illness perceived. Here, it implied that outsiders did not show understanding for someone's situation. Thus, contrary to misunderstandings, it was not about wrong information but about reacting without empathic understanding, although one might seem to have information. Outsiders simply "forgot about it right away", "repressed it" or even "did not even it, like 'Yes, aha, okay.'" (Participant 3). In the context of school, it was criticized that "the school itself does nothing about it, like if you miss school because of it … you are considered a school-skipper" (Participant 3).

The miss of understanding for special circumstances or problems that come along when living with a mental illness can be emphasized by the following statement:

> At that time the situation was not perceived as seriously as it was for me, from my whole environment, also family and friends. And there I see part of the problem, that there is a general understanding missing in our society, how to deal with people who start to feel bad in that way. (Participant 1)

Narratives revealed that participants see a crucial factor of stigmatization in this lack of understanding: “What I wish for, in the first place, and that is a big point for me is much more openness towards the topic, much more communication.” (Participant 5)

1.6c.: I experience treating mental illness as a taboo subject. Next, participants recognized stigmatization by treating mental illnesses as a “taboo subject”. This behavior could be perceived in their personal environment, just like in society in general. Two participants, both discussing in one podcast episode, clearly pointed out the problem, that mental illnesses are not talked about and educated at school:

> And I see a lot of people in my surroundings who even have panic attacks during a lesson in school and they skip school a lot because they just cannot stand the pressure, because they cannot keep up, because they have no more energy. And it just isn’t thematized. We learn things about prevention, but we never learn about mental illnesses. We learn about sexually transmitted diseases, but no one know how to deal with a panic attack or how to help people who have a panic attack or even to be aware that they exist. And I perceive that no one even cares. (Participant 3)

Next to their concerns, insiders clearly expressed their desires related to the problem of tabooing, stating “I would have wished for more openness on the topic … I did not experience that I was ever openly talks about it. … We did not learn anything about it.” (Participant 4)

Another participant explicitly called it to be a taboo subject and narrated about how it impacted herself talking about her own situation, mostly in a way that made her not be open about it: “I think there was a turn when I started to overcome my shame and openly talk about it, against the taboo.” (Participant 6).

1.7a.: I experience stereotyped thinking. Another belief from outsiders was that they might have specific “patterns” in mind that they relate to mental illnesses or a particular mental illness. People who suffer from a mental illness noticed that outsiders projected these

stereotypes on them, although they did not know about their personal situation, as indicated by one participant:

> "For many psychiatric diagnoses that I got, I have an atypical kind of illness and there is also this 'thing-thinking' like, an eating disorder has to look like that, a bulimia has to look like that, with bulimia you have to eat and throw up." (Participant 5)

Participants used words like "must" or "has to" to underline that people from outside seemed to put their personal representation of a disorder onto others, as mentioned here: "And that is what is often forgotten, because there is always the opinion that a normal bulimia *has to* look as such." (Participant 5). Another participant added the experience that "depressed people *cannot* smile" (Participant 7).

1.7b.: I experience gender-related stigma. Furthermore, gender-related stigmas were identified, however only experienced by male participants within this study. They described encountering gender-related stigmas by pointing to a "gender difference when it comes to mental illness, not in relation to frequency but men often face more difficulties in talking openly about it." (Participant 1). That seemed to be based on society's gender-roles, were men are perceived as being strong (Murnen & Don, 2012), which then does not fit the impression of a mental illness, as people attributed illness to weakness:

> And I noticed I am not the only man, because there are always these extreme cliches that, so to say, men have to be strong and feed the family, they should not take a time out and are more in a leading position, bla bla bla …(Participant 1)

Interestingly, one participant discussed the differences between depression and burnout, pointing out a situation where a male friend told her that having a burnout seemed to sound more acceptable, and thus, more appropriate for men than for women:

> Just today in a lecture I talked to a fellow student who said that it is hard for men, like that depression are hard for men and talking about it, because it makes them weak. And

> that is why the men rather say burnout, because then it means that they overspend themselves at work and that just sounds better for men. (Participant 7)

1.8.: Outsiders believe that I just do it for attention/ that it is a trend. Another stigmatization belief that was identified within the narratives is that people with a mental illness only simulate or pretend to have a mental illness with the purpose of seeking attention from their surroundings, as mentioned by one participant: "And in school people even ignored me because they thought that I am simulating to get attention." (Participant 8)

Related to that, participants also said that they got told that mental illnesses became a "trend", especially distributed via social media: "I see that for many people a depression is something like a trend and many don't know that it is a real disorder that you can treat or that you have to treat." (Participant 8)

1.9.: Outsiders believe that all people with a mental illness are the same. Insiders talked about a stigmatization belief lying in the generalization of people with a mental illness. Thereby, those people are considered one homogenous group in which one person equals the others, just because of their common attribute of having a mental illness. Insiders perceive that outsider tend to transfer knowledge about one individual onto another:

> Most people hear that someone is depressive and automatically face a stereotype. Or they hear that someone has a borderline personality disorder and drop statements like 'If you know one borderliner, you know them all.' And there is a lot of understanding missing. (Participant 4)

Insider perceived these generalizations also based on particular disorders, describing it as a "challenge" to "tell the person that there is not something like *the* schizophrenia. There are so many forms of this disorder that you cannot just generalize it." (Participant 9).

1.10.: I experience being reduced on my illness. As many experiences suggest, insiders often faced problems in being open about their mental illness. Still, once participants started to share about their mental illness, they realized outsiders who only saw them for their

illness, completely disregarding them as a person, being made up by a more complex and individual personality than just the illness:

> … and I get upset about that because you should first get to know the person and then, if he/she wants to, he/she could talk about the illness, 'this and that is my problem', because looking at people you cannot just see and state what they suffer from. (Participant 1)

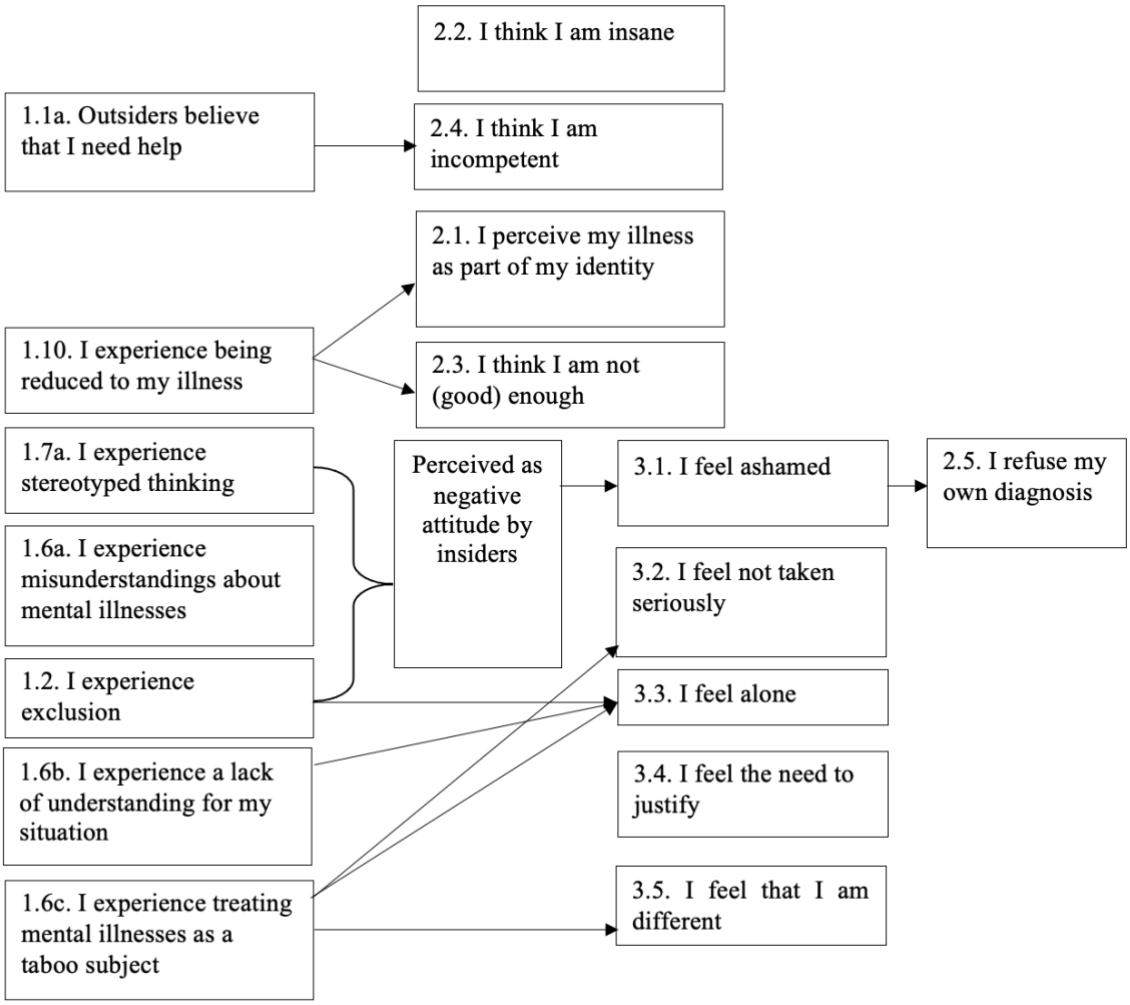
Narratives underline that insider clearly perceive that other people seem to focus on their illness and not themselves as a person, expressing concerns like: "But not everything about a person is only about that. You should not reduce a person on its illness. That is why you do not go to a person and just ask, 'What [illness] do you have?'" (Participant 1).

How do people with a mental illness narrate their experiences of self-stigmatization in podcasts about mental illness (i.e., the negative beliefs about themselves, behavior, and feelings)?

For investigating the second sub-question on the insider perspective of self-stigmatization, beliefs and behavior were identified to describe how individuals with a mental illness think about themselves and what they do in response to their stigmatization experiences. Additionally, feelings that insiders put into relation to stigmatization were identified to capture the impact on people who are affected. Themes on self-stigmatization and feelings are put into relation to outside stigmas, as perceived by people with a mental illness, addressing the overarching research question (see Figure 2).

Figure 2

Relations between outsider beliefs and behavior and insider self-stigmatization beliefs, behavior, and feelings



2.1.: I perceive my illness as part of my identity. One self-stigmatization belief shared by participants was to perceive themselves as if they are completely made up by their illness. For some this led into thinking that their mental illness became part of their own identity. People described that by spending so many thoughts on their mental illness, they started to only see themselves as a representation of someone who is ill. This identification caused one participant to think that she *is* the illness:

> I needed some time to also learn for myself that it is not part of my own identity, that you are not totally … I mean one is not the depression, one is not depressive in that

sense but one is having a depression. It is an illness. – Yes, it is an illness. (Interviewer and participant 3)

Regarding the perceived stigmatization from outside, the self-stigmatization of identifying oneself with a mental illness was related to outsider's behavior of (1.10.) reducing people solely on their illness: "… people only asking about your diagnosis there as if it's the only thing that I can tell them … and I started introducing myself saying that I have a depression." (Participant 1).

Still, narratives give rise to personal improvements, where participants explained that they struggled with the self-stigmatization belief of perceiving their illness as part of their identity, however, manages to distance themselves from this belief with the help of therapy, describing it as:

> "… an important aspect to learn that one is much more than the illness and that this illness is just serving a function and giving you some form of security construct that helps you survive. And as soon as you realize that it is just that and not part of your basis identity and that you just have to strengthen this part then it already gives you a lot of strength. (Participant 3)

2.2.: I think I am insane. Next, stigmatized people expressed their belief that some think or even fear that they are insane. It was explained that they internalized this belief from movies or series, especially older ones: "… you know from these old movies where the crazy ones lived in asylums and stuff…" (Participant 1). Participants said that they have the impression that people in society talk about "mentally ill as insane" (Participant 8). When they realized that they have a mental illness, they feared to become part of this group of insane people.

One participant narrated about his first day at a clinic, where he explained that the stigma of insanity even hindered him from visiting a clinic, at first, until he overcame his belief: "And I saw there are also other people, who are not insane, as I first expected them to be." (Participant

1). Another insider shared this experience: “And that got so far that I felt insane. Like I imagined things that were not real, and I visited physicians and thought that I am insane, because I thought that something must be wrong with me.” (Participant 7). Finally, another narration about the experience of entering a clinic supports the stigmatization belief of insanity. Here, it underlines that people related insanity mostly to psychiatric settings and not to having a mental illness per se:

> And I still remember when I turned around the corner [in the clinic], it was a ward for crisis and emergencies where I got in, and I thought, okay, now I am going to see all these insane. … And then I thought, okay, now you are also in this psychiatry. (Participant 8)

2.3.: I think I am not (good) enough. Participants talked about believing that they are not enough, or as they also described it, not “good enough”. In some cases, this belief was better described with thinking that oneself is wrong: “And I had the situation where I had to say to myself, or where I said to myself, that something is obviously wrong with me.” (Participant 7). The belief of not being enough due to the illness occurred within comparison with other people, as described: “And I was always like the outsider of a group and haunted by the feeling that I do not belong and that I am not enough.” (Participant 7).

From the insider narrations a relation between the self-stigmatization belief of not being enough and the perceived outsider behavior of (1.10.) being reduced on one’s illness became clear. One participant described: “when it gets out to society, as in my case … you are, in the end, only reduced on that [illness], where I had to say that it is not the only thing that is present about me. And how they treated me always gave me the impression that I am not enough as I am.” (Participant 10).

2.4.: I think I am incompetent. Next, many participants said that they encountered situations in which they stigmatized themselves as being incompetent. For the stigma of incompetence, it was not reported that people from outside told insiders to be incompetent but

that they internalized it themselves, stating that they feel to "achieve nothing", are "good-for-nothing" or described as followed: "as I am really not capable of doing anything, nothing worked out and I believed it and was so frustrated" (Participant 8). This belief was strengthened as participants persuaded themselves that the stigma is true:

> Then I sabotage myself kind of, because I always make great plans what I am going to do on one day. That great that even, let's say, the most normal and healthiest person on the world would hardly manage. And then I tear myself down because I think that it is about me, and I think that I cannot manage anything. … Because when I did not do anything that day, and I have a bad day, then I think, 'I accomplished nothing anyway, I did not do something anyway.' (Participant 8)

Another participant described this internalization of being incompetent in a way that he thought that he as a person is not working the way he should and believed that his condition is so bad that nothing would ever have the power to help him, as "… I was sure that I would not return [from the clinic] and that it was my opportunity to prove that I am not able to function in this world and that I am not competent." (Participant 7)

Insiders perceiving themselves as incompetent occurred in relation to the stigma of (1.1a.) needing help, as participants said: "… when they tell you, or more like beg you, to get help its hard, because sometimes I was not ready. But then you think that you are not capable when all your friends want you to accept their offers and then I distanced myself." (Interviewer from participant 1).

2.5.: I refuse my own diagnosis. Self-stigmatization behavior occurred within insiders as a refusal of their own diagnosis or having a mental illness in general. Although refusing had many facets, all were summarized under this one term, as they were all serving the same intention, namely rejecting the mental illness. Especially in the beginning, many participants did not accept that they are ill and thus, tried to find other explanations for the symptoms they were experiencing: "And how did it affect you at that time? So, you already had the disorder,

right? – Yes, but in the beginning I just thought it away, so I did not accept it." (Participant 9), and "But when I started to deal with, especially my borderline personality diagnosis, I noticed that after initial total resistance, how I encounter it totally grateful now." (Participant 5).

Followed by another experience of refusal behavior:

> And I think at that time I first noticed that I am stuck. I could hardly get up. I could not manage to make myself something to eat. My whole flat looked like untidy and that was when I first recognized that something is not right. And I did not ask for help, because I think, I did not admit that for myself. (Participant 6)

Also, it stood out that for a great of participants, refusal behavior related to the step of searching professional treatment, e.g., in a clinic:

> And if someone would have said to me that I have to go to a clinic, at the beginning of my therapy, I would not have accepted that, I would not have gone there. (Participant 1)
>
> And what were you fears in regard to the clinic? – Yes, like I thought it is the last resort, the last opportunity that I have, because there would be no other way to help me. And I did not know such a clinic. I did not know what people are there, what physicians, what psychological team. I thought, I would be, like in an asylum, that one knows, that I will just be locked up. And that's it. Okay, like I had no differential view on that, at all. (Participant 1)

For some, rejecting their mental illness even hindered their treatment: "I just had panic and fear and there was a lot I just denied and dismissed for myself. (…) So, in the clinic, they could not work with me, but more against my symptoms." (Participant 9), and: "And when I had to go to the clinic the first time, I was like a stubborn child, I did not want at all." (Participant 6)

Another one narrated about situations in which she got confronted with having a mental illness from outside, but refused it:

> Yes, I think it was in 2018. It was like, I was not ready for that and to go there [in the clinic]. So, at that time you would have forced me to go there. My mother also always wanted me to go into the clinic, but I said that I did not want to. (Participant 9)

3.1.: I feel ashamed. Due to the stigmatization that people with a mental illness perceived, many found themselves in situations in which they felt "ashamed" for having a mental illness, as the following quote: "No one has to hide a sore throat, but a depression or an eating disorder or something alike, if you even are aware about it, that is not something that you would like to talk about." (Participant 3)

For participants, the feeling of shame stood in relation to perceiving mental illnesses to be a topic that no one should talk about, referring to (1.6c.) outsiders treating it as a taboo: "And at one point I told myself that I had wished that a lot more people would have been so open about it [mental illnesses] so that I did not have these massive fear and shame to talk about it." (Participant 3). In addition to that, people with a mental illness mentioned a (1.6b.) a lack of understanding from their surroundings contributing to a feeling of shame: "they forget that you told them and ask again or are not even interested … it's bad to repeat yourself then, cause it's something you don't want to talk about, of course, cause you're ashamed." (Participant 3).

Being excluded from a group (1.2.) of people enforced the feeling of shame, as it led insiders into thinking that by having a mental illness, they have an attribute that does not fit into other groups of people:" … I kind of lost the friends and people around because I, and I regret it but, then it was all different and I was ashamed, and I did not tell them and then I did not belong anymore I guess." (Participant 9). Whereas another quote adds: "… seeing that you are not part of the society and a long time I did not know or think about it … but it was the shame in the end." (Participant 5).

Another relation between being ashamed and stigmatization was reported to lie in the (1.7a.) patterned and stereotyped thinking insider perceived from outsiders: "… mentally ill cannot be represented cause it's not the norm … meaning that I am not the norm, its bad to

confess that, it was embarrassing …" (Participant 5), also explaining her perception of society that people with a mental illness are the "other ones" that no one wants to see.

Moreover, being ashamed had negative impacts on their behavior, for example, one participant explained that she often lied or behaved differently because of being ashamed: "Most of the times I avoid talking about it or try to gloss over things about my illness, or I try very hard to consciously not do things I would normally do to cover it." (Participant 9). For others, it contributed to the prevention of seeking treatment. Thus, a relation between (2.5.) refusal behavior and shame were evident: "Did you feel ashamed to go into the clinic?" – "Yes, I was feeling terribly ashamed". (Participant 8). This feeling was shared by another participants, who described:

> All people in my surroundings told me to look for help and said that I need help. But, I don't know, maybe I was just ashamed. Yes, I think shame is the right word. And I knew that I am a burden for the others. (Participant 6)

Interestingly, one of the podcast hosts uncovered that her feeling of shame because of being stigmatized by having a mental illness was one contributing factor to her motivation of starting the podcast:

> This was principally also the reason for staring this podcast because we said that we are in a psychiatric clinic and we know, once we get out of here, we again, face the problem, that we cannot be open about it and we don't feel like answering dump questions again or start to tell lies. We just want to be free in saying 'Yes, I was in this psychiatry for three months and yes, I have an eating disorder and I do not have to be ashamed about it. Period.' (Interviewer from participant 3 and 4)

3.2.: I feel not taken seriously. The by far most mentioned feeling because of the stigmatization of mental illnesses was that insiders have the feeling that they are not taken seriously by fellow people in their surroundings, regardless of whether they are strangers, people they have a close connection with, like family or friends, or even general practitioners.

One participant described it as followed: “Very often I have the feeling that people laugh about me because of it. I think that is a bit sad.” (Participant 9). Another one shared an experience with a general practitioner:

> So, my own experience was at the time of my Abitur. There I already had a panic attack. I got up in the middle of the night and thought that I was chocking. Then I went to the general practitioner and described my symptoms and he prescribed globules and today I know that not even the general practitioner took it seriously and recognized it. (Participant 4)

Not being taken seriously also occurred in relation to (1.7a.) stereotyped thinking that outsiders had in mind: “… she said, ‘you look good.’. See, you can even laugh, like you cannot be depressed. See, you are smiling … How can you have depression? That does not make sense, does it? Just eat an apple or something.” (Participant 5). Another relation made by people with a mental illness was to their perception that (1.6c.) mental illnesses are treated as a taboo subject: “… I said that I must go to therapy after the lecture, when he said that it is complete nonsense and that he thinks that it is totally odd to talk about your problems to a random stranger.” (Participant 6)

Another experience shared by some participants was being told that their symptoms only belong to a phase, thereby not taken their mental illnesses seriously:

> So, you felt like you were not taken seriously?” – “Yes, a lot of times in my life, even in my close family environment. Very, very often they said that the illness is probably not real in my case and that it is just a phase and that I am just a little bit depressed. And even if I got them the paper and confronted them with my diagnosis, it was either kept under wraps or laughed about it. (Participant 9)

Another participant narrated about an experience where her symptoms were prescribed to going through a phase of puberty:

> And at the beginning most people really said it is only puberty. And I also heard that from a lot of other patients that even the therapists and psychologist just said that it is a puberty crisis, and they all did not take it seriously. (Participant 8).

3.3.: I feel alone. Next, people with a mental illness experience that they feel alone with their health condition and as if they were the "only person" being in such a situation. Especially mentioned was that insiders miss openness about the topic and thus to meet other people who are in a similar situation and with whom they can "exchange their feelings" and experiences:

> The feeling that I make a fuss, that there is no reason why I am sad. Why am I in a bad mood? Why do I vent it on other people? Because I am so alone with it. Because you do not know anyone, so no role models. Because they aren't any. No examples. You just feel alone with it, and you don't know. (Participant 3)

Also, it was striking, that most people faced the feeling of being alone in the beginning phase of their illness. This phase is considered the time where they may not be even aware of their exact illness, but already felt that something is not the way that it used to be and that they started to feel bad. After accepting their diagnosis and talking about their situation, some participants explained that they came to a point where they realized that they are not alone with their situation anymore. In some cases, this was because of the support and understanding from outside, in other cases because they met other affected people with whom they could share their experiences openly, e.g., also through self-help groups:

> From my perspective, the self-help group is successful in a way that one can see that one is not alone. Especially with depression, the illness talks one into believing that one is the only one who is like that and who is in some way, not normal and just alone. (Participant 7)

3.4: I feel the need to justify. Participants talked about situations in which they felt uncomfortable once the topic of mental illnesses was discussed within a specific group of people or within situations in which they perceived the expectations that they must share about

their personal experiences with living with a mental illness. From the reactions and questions, they received from outside, insiders feel that they are expected to justify oneself for their mental illness and thus suffer from a feeling of need of justification: “And if you are affected then it is very hard that you constantly feel measured by a vignette or a pattern and then you have the feeling that you need to justify yourself, your feelings, and your disorder.” (Participant 5).

3.5: I feel that I am different. Furthermore, it was reported that many people with a mental illness have a feeling of being different than other people. Interestingly, this feeling could often not be specified in terms of *how* they feel different. It was described as a general assumption that from a whole society, insiders have the feeling to deviate from it in some indefinable aspect: “And that kept going, that it was always clear to me that I do not belong, that I do not fit in, that I felt different and that I felt as a stranger and not as part of the group.” (Participant 7) or “When I say that I don’t know and that I have the feeling I am not like normal people, whatever normal means in that context.” (Participant 5)

One person added that she spends a lot of time thinking about what being different, and relating to that, what being normal, means for her. This helps her to understand herself and her thoughts and relation to her own diagnosis and the stigmatization from society, that she perceives: “And that is why I always have this judging feeling in me [about being normal], so what is even normal, good, or bad? And what is being different then?” (Participant 5)

Insiders mentioned the feeling of being different than others in relation to their perception of (1.6c.) the stigma of taboo. Thus, treating mental illnesses as a taboo seemed to have the effect that people with a mental illness feel different: “… when there is no role model because no one talks about it … then, naturally, you think something is wrong and different as with others.” (Participant 7).

Discussion

The aim of the study was to investigate narratives of people living with a mental illness about their perception of *stigmatization from outside* and its impact on their *self-stigmatization*. The primary research question investigated the *relation* between both concepts, addressed in one sub-question, respectively. First, the perception of people who have mental illness of stigmatization from outside was explored. Findings support mental illness stigmas like a need of help, exclusion, personal responsibility, weakness, and the assessment that some mental illnesses are more serious than others, known from prior research. For the latter, depression was perceived as the least severe based on the presumed high prevalence. Stigmatization experiences could be supplemented by the perception of stereotyped thinking, the belief that people are attention-seeking, gender-related stigmas, generalizing people as one group, comparison to physical illnesses, misunderstandings about mental illness, treating mental illnesses as a taboo subject and being reduced on the illness. As a second aspect of understanding the relation between stigmatization and self-stigmatization, the study investigated self-stigmatization experiences. People narrated to perceive their illness as part of their identity, see themselves as insane, not (good) enough, wrong, incompetent, and showed refusal behavior related to their diagnosis and illness. This led to feelings of being ashamed, not taken seriously, alone, a need to justify and different.

Regarding the overarching research question on the relation between stigmatization from outside and self-stigmatization, findings are connected and reflected on. The stigma, known from research, of needing help from outside was complemented by the belief that people with a mental illness are dependent on medication. They encountered frustration or accusations from outside when rejecting help, as they were expected to accept help from every side. They perceived others put more attention to their symptoms and how medication could treat them, and less to their personal story and overall well-being. Participants connected this perceived need of help to the self-stigmatization of seeing themselves as incompetent (i.e., blaming

themselves and their mental illness as making them less capable). Interestingly, this stays in contrast to prior research, which suggests incompetence as an outside stigma (Chung & Wong, 2004). El-Badri & Mellsop (2007), however, stated that more than half of the insiders from their study reported to be treated as less competent by the outside. In this study, however, none of the participants perceived to be treated as incompetent but only as a self-stigmatization belief, as found in another study (Ilic et al., 2013). Thus, findings on the stigma of incompetence are mixed, with support for both, outside and self-stigma, and further investigation is needed for knowing how to deal with the stigma in the future.

The presumed stigma of a need for separation cannot directly be supported by the findings as none of the participants experienced harsh exclusion. Still, some were avoided by other people, especially fellow students, and perceived to not be part of a social group because of their mental illness. Other studies could prove people with a mental illness to be excluded (El-Badri & Mellsop, 2007), not being given a job or being avoided by a group of colleagues (Baldwin & Marcus, 2006; Quinn et al., 2015). Thus, in contrast to literature suggesting harsh exclusion (Baumann, 2007), the present findings only partly support the stigma, however less severe. Findings can possibly be explained when considering people's course of disease. Exclusion was mostly related to a fear from outside (Corrigan et al., 2002). However, none of the participants in the study reported about situations in which they behaved unpredictably or beside themselves.

Participants from this study perceived the stigma of personal responsibility as expected from research (Norman et al., 2008; Feldman & Crandall, 2007). They were blamed for having a choice of becoming mentally ill, or at least, told that they could resist against it, giving them the impression that mental illnesses are self-inflicted. As part of this stigma, people perceived a constant comparison to physical conditions (e.g., cancer, broken leg). Physical illnesses were taken more seriously, shown more empathy, and not ascribed any personal responsibility but that they can happen to anyone. This difference may be explained by the visibility of symptoms.

Research shows that people are more likely to believe in what they can see (Perry, 2011), leading to physical symptoms being taken more seriously than mental ones. Even more this underlines the importance of educating and sharing about mental illness experiences as done within the studied podcasts.

Another interesting finding is that, despite prior literature, suggesting dangerousness and unpredictability as one of the most common stigmas (Corrigan et al., 2002; Angermeyer, et al., 2006; Norman et al., 2008), they were not covered within the podcast narratives of this study. Potentially, this finding can be explained by the characteristics of the sample, representing a younger age group (18-38), grown up in a well-socialized and modern environment. The sample can be explained by recent research on podcast use in Germany, stating that, among 10 million podcast users, about 6.5 million are in the age of 14 to 29 (Lörchner, 2020). Dangerousness and unpredictability were referred to fearing individuals because of threatening or unpredictable behavior (Corrigan et al., 2002), not mentioned in this study. Still, it is not possible to state whether experiences of threatening and unpredictable behavior did not apply to participants in the study or were left out in narrations. Whether the stigma of dangerousness is outdated in a younger generation or dependent on other factors, could be subject to further research.

Apart from the more commonly known stigmas, the study revealed additional stigmatization experiences. Stigmatization experiences were filled with stereotypes, where personal mental representations of people with a mental illness or associated characteristics were projected onto others. Despite widespread stereotypes (e.g., people suffering from depression are lazy) (Parcesepe et al., 2013; Knifton, 2012), participants with a borderline personality disorder especially suffered from the imputation of self-harm, as they encountered avoidance and disgust from others. Along with this, gender-related stigmas were explored, in which men were not expected to suffer from a mental illness, making it harder for them to openly talk about it. Wirth and Bodenhausen (2009) found that the severity of stigmatization

was related to whether the affected person was typical for an illness, as perceived by others. This can be a possible explanation for the findings in this study, as gender-related stigmas were mostly found in the relationship between male and depression, which does not match widespread gender-roles, supporting men to be strong and resistant (Murnen & Don, 2012).

Furthermore, people were accused of only simulating their mental illness, pretending symptoms to create attention from their environment or simply adapting a trend of having a mental illness. Moreover, people with a mental illness perceived behavior in which they were only reduced to their illness. Their behavior or circumstances were automatically attributed to their illness, right away. Research supports this finding, stating that actions and behavior are often attributed to a person's illness and not themselves as a person (Ilic et al., 2013). Regarding the relation to self-stigmatization, people started to perceive their illness as part of their identity in response to being reduced on it (e.g., other people were more interested in their diagnosis than their name). In some cases, this led to internalizing the belief until it became an essential part of their personality. Furthermore, the internalized belief of not being (good) enough was connected to the experience of being reduced on the illness. Some described it as being wrong, however in a sense that was not further described. Still, a categorization of right and wrong got visible, whereas having a mental illness was associated with being wrong. Researching the self-stigmatization of not being good enough due to having a mental illness did not reveal studies supporting this concrete relationship. However, many studies found relations between having a mental illness and a negative self-image (Corrigan & Watson, 2002a). Important to consider is that a feeling of insufficiency could also occur as a symptom of illness, being one of the most common symptoms of depression (WHO, 1993), highly represented in this sample.

Beside a perceived lack of knowledge (e.g., distributing misinformation or misconceptions) about mental illnesses and often related, a lack of understanding (e.g., insensitively treating affected people, no empathy for difficult situations and limitations caused by their illness), findings of the present study add another potential factor in stigmatization,

namely treating it as a taboo subject. Most participants related the stigmatization experience of taboo to the by far most discussed feeling in this study, namely, to feel not taken seriously. Participants reported that it made them think they are not ill enough for deserving treatment which put them under pressure or not respecting their mental health. Apparently, the feeling of being not taken seriously is not substantially covered within prior research. Closer examination if and how this feeling occurs in other samples could help understand its role in stigmatization experiences. Additionally, ignorance and silence had other negative impacts on the affected individuals, giving rise to a relation to feeling ashamed. Participants were ashamed to talk about their illness or went into believing that their situation is not bad enough, putting themselves under pressure and not seeking treatment. Researching this relation points to a vicious cycle in which suppressing symptoms led to a worsening (Stuart & Sartorius, 2005).

Following, the most frequent behavior in response to stigmatization was to refuse one's diagnosis. This includes not accepting their symptoms or at least, not accepting that these are caused by a mental illness. Some could not accept their need of treatment, denied their diagnosis, or lied to others about their mental health. This insight supports findings that many people with a mental illness refuse their diagnosis and do not seek help or treatment (Dinos et al., 2004; Mann et al., 2004). However, Dinos et al. (2004) found a relation to fear of being further stigmatized, which was not thematized within the podcasts. Insights from the present study point to a relation between feeling ashamed and refusal behavior. However, participants did not thoroughly explain their experience and closer examination is needed to understand this relation.

Along the findings, feelings turned out to have a striking impact on people's stigmatization experiences. People narrated about feeling alone, often as if they are not part of a group. Apparently, feeling alone was related to being avoided or excluded by others. However, more people suffering from a mental illness felt alone in response to experience a lack of understanding from their environment. Additionally, many saw the problem and relation

in society's ignorance of still treating mental illnesses as a taboo subject. Since participants missed communication and interaction about other people's experiences, they easily got the impression that they are the only person who is feeling like they do. Following, perceiving mental illnesses as a taboo subject also left affected individuals with the feeling of being different than other people. In a study bs Shrivastava et al. (2012), individuals with a mental illness stated to be ignored by other people from society. Thus, by stigmatizing mental illnesses as a taboo subject that should not be addressed or kept silent about, the feeling of being different is promoted, according to participants. Interesting about the feeling of being different is that none of the participants could further describes this feeling or specific attributes about it but called it a general sense of being different. This indefinability burdened individuals as they reported to ruminate a lot about the feeling of being different. Some participants also pointed to a sense of deviating from a norm. Ilic et al. (2013) found an internalized separation of mentally ill and presumed mentally healthy people in people with a mental illness. Altogether this may point to the problem that mental illnesses are still perceived as a deficiency (Norman et al., 2008).

Strength and Limitations

A strength of the study lies in the variety of perspectives on mental illness. Inclusion of different podcast styles and a wide spectrum of illnesses increased diversity of the sample. Though the study provides deepened insights into the insider perspective, limitations include a rather low external validity with restricted generalizability of findings. Experiences were acquired from young people from Germany due to a higher popularity of podcasts in a younger age group (Lörchner, 2020). Thus, findings are representative only for people coming from similar social and cultural backgrounds and cannot be generalized for other ethnical groups and societies or other age groups. Despite a rich amount of podcast data, the focus did not lie on stigmatization experience but on the overall experience of living with a mental illness.

Therefore, parts of the data did not address the research questions and were screened out, decreasing richness of the data.

Recommendations

As the study could bring insights about new stigmatization experiences and especially, the relation to self-stigmatization and feelings of people with a mental illness, building on these findings is recommended. For making use of the gathered insights but still, respecting the limitation of the missing focus on stigmatization within the podcast, a follow-up study including interviews is recommended. Specifically, feelings related to stigmatization could be explored more thoroughly to understand personal experiences. To deepen the gathered insights, conducting narrative interviews are considered suitable, as they have the potential of creating a comprehensive understanding of personal experiences and meanings (Muylaert et al., 2014).

Conclusion

This thesis investigated experiences of stigmatization and self-stigmatization of people who have a mental illness. Overall, most stigmas from prior research could be supported by the findings, though drastic stigmas like dangerousness, a need for separation and inappropriateness were not narrated by participants. However, stigmatization occurred all over their daily life, leading to the major problem of self-stigmatization and consequential, negative feelings. Internalizing stigmas fostered a negative self-image, characterized by feeling wrong, different, and most frequently mentioned, not taken seriously. To grasp these feelings on a deeper level, further investigation on personal conceptions is recommended. The feeling of being not taken seriously was mostly related to the stigmatizing mental illness as a taboo subject. Another striking relation seems to lie in being reduced on having a mental illness and followingly, perceiving the illness as part of their own identity. Lastly, special attention should be drawn to the stigma of incompetence, often related to a presumed need of help from outside. While the present study supports incompetence as a self-stigma, other studies demonstrate it as an outside stigma, pointing to the need of further investigation. Respecting the limitations that the study

sample was considerable young, and some narrated experiences lack richness, a follow-up study with narrative interviews is recommended, for digging deeper into stigmatization experiences and feelings.

References

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical psychology review*, *31*(6), 934-948.

Angermeyer, M. C., Beck, M., Dietrich, S., & Holzinger, A. (2004). The stigma of mental illness: patients' anticipations and experiences. *International Journal of Social Psychiatry*, *50*(2), 153-162.

Bailey, P. H., & Tilley, S. (2002). Storytelling and the interpretation of meaning in qualitative research. *Journal of advanced nursing*, *38*(6), 574-583.

Baldwin, M. L., & Marcus, S. C. (2006). Perceived and measured stigma among workers with serious mental illness. *Psychiatric Services*, *57*(3), 388-392.

Baumann, A. E. (2007). Stigmatization, social distance, and exclusion because of mental illness: the individual with mental illness as a 'stranger'. *International review of psychiatry*, *19*(2), 131-135.

Bramesfeld, A., Wismar, M., & Albrecht, D. (2003). Förderung der psychischen Gesundheit und Prävention psychischer Störungen: Gibt es bevölkerungsbezogene Konzepte? Ein Blick ins Ausland. *Das Gesundheitswesen*, *65*(04), 226-235.

Braun, V., & Clarke, V. (2012). Thematic analysis.

Chung, K. F., & Wong, M. C. (2004). Experience of stigma among Chinese mental health patients in Hong Kong. *Psychiatric Bulletin*, *28*(12), 451-454.

Coleman, L. M. (1986). Stigma. In *The dilemma of difference* (pp. 211-232). Springer, Boston, MA.

Corrigan, P. W., Rowan, D., Green, A., Lundin, R., River, P., Uphoff-Wasowski, K., White & Kubiak, M. A. (2002). Challenging two mental illness stigmas: Personal responsibility and dangerousness. *Schizophrenia bulletin*, *28*(2), 293-309.

Corrigan, P. W., & Watson, A. C. (2002a). The paradox of self-stigma and mental illness. *Clinical psychology: Science and practice*, *9*(1), 35.

Corrigan, P. W., & Watson, A. C. (2002b). Understanding the impact of stigma on people with mental illness. *World psychiatry*, *1*(1), 16.

Corrigan, P. W., & Watson, A. C. (2007). How children stigmatize people with mental illness. *International Journal of Social Psychiatry*, *53*(6), 526-546.

Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e.V. (2020). *Basisdaten Psychische Erkrankungen.* Retrieved from https://www.dgppn.de/_Resources/Persistent/a2e357dac62be19b5050a1d89ffd8603cfdb8ef9/20201008_Factsheet.pdf

Dinos, S., Stevens, S., Serfaty, M., Weich, S., & King, M. (2004). Stigma: the feelings and experiences of 46 people with mental illness: qualitative study. *The British Journal of Psychiatry*, *184*(2), 176-181.

Edwards, A. M., & Kotera, Y. (2020). Mental health in the UK police force: A qualitative investigation into the stigma with mental illness. *International Journal of Mental Health and Addiction*, 1-19.

El-Badri, S., & Mellsop, G. (2007). Stigma and quality of life as experienced by people with mental illness. *Australasian Psychiatry*, *15*(3), 195-200.

Feldman, D. B., & Crandall, C. S. (2007). Dimensions of mental illness stigma: What about mental illness causes social rejection?. *Journal of social and clinical psychology*, *26*(2), 137-154.

Finefter-Rosenbluh, I. (2017). Incorporating perspective taking in reflexivity: A method to enhance insider qualitative research processes. *International Journal of Qualitative Methods*, *16*(1), 1609406917703539.

Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity.* New York: Simon & Schuster.

Hanafiah, A. N., & Van Bortel, T. (2015). A qualitative exploration of the perspectives of mental health professionals on stigma and discrimination of mental illness in Malaysia. *International journal of mental health systems*, *9*(1), 1-12.

Henderson, C., & Thornicroft, G. (2009). Stigma and discrimination in mental illness: Time to Change. *The Lancet*, *373*(9679), 1928-1930.

Ilic, M., Reinecke, J., Bohner, G., Röttgers, H. O., Beblo, T., Driessen, M., ... & Corrigan, P. W. (2013). Belittled, avoided, ignored, denied: Assessing forms and consequences of stigma experiences of people with mental illness. *Basic and Applied Social Psychology*, *35*(1), 31-40.

Jham, B. C., Duraes, G. V., Strassler, H. E., & Sensi, L. G. (2008). Joining the podcast revolution. *Journal of Dental Education*, *72*(3), 278-281.

Karidi, M. V., Stefanis, C. N., Theleritis, C., Tzedaki, M., Rabavilas, A. D., & Stefanis, N. C. (2010). Perceived social stigma, self-concept, and self-stigmatization of patient with schizophrenia. *Comprehensive psychiatry*, *51*(1), 19-30.

Knifton, L. (2012). Understanding and addressing the stigma of mental illness with ethnic minority communities. *Health Sociology Review*, *21*(3), 287-298.

Lörchner, J. (2020, September 18). Neue Studie: Mehr als 10 Millionen Deutsche hören Podcasts! *Podigee. https://www.podigee.com/de/blog/neue-studie-mehr-als-10-millionen-deutsche-hören-podcasts*

Maier, J. A., Gentile, D. A., Vogel, D. L., & Kaplan, S. A. (2014). Media influences on self-stigma of seeking psychological services: The importance of media portrayals and person perception. *Psychology of Popular Media Culture*, *3*(4), 239.

Mann, C. E., & Himelein, M. J. (2004). Factors associated with stigmatization of persons with mental illness. *Psychiatric Services*, *55*(2), 185-187.

Merhi, M. I. (2015). Factors influencing higher education students to adopt podcast: An empirical study. *Computers & Education*, *83*, 32-43.

Moen, T. (2006). Reflections on the narrative research approach. *International Journal of Qualitative Methods*, *5*(4), 56-69.

Murnen, S. K., & Don, B. P. (2012). Body image and gender roles. *Encyclopedia of body image and human appearance*, *1*, 128-134.

Murray, M., & Sools, A. (2015). Narrative research in clinical and health psychology, pp 133-145. In: Rohleder, P. & Lyons, A. (Eds.), *Qualitative research in clinical and health psychology.* Palgrave Macmillan

Muylaert, C. J., Sarubbi, V., Gallo, P. R., Neto, M. L. R., & Reis, A. O. A. (2014). Narrative interviews: an important resource in qualitative research. *Revista da Escola de Enfermagem da USP*, *48*, 184-189.

Naslund, J. A., Aschbrenner, K. A., Marsch, L. A., & Bartels, S. J. (2016). The future of mental health care: peer-to-peer support and social media. *Epidemiology and psychiatric sciences*, *25*(2), 113-122.

National Institute of Mental Health (2021). *Mental Illness.* Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness

Norman, R. M., Sorrentino, R. M., Windell, D., & Manchanda, R. (2008). The role of perceived norms in the stigmatization of mental illness. *Social psychiatry and psychiatric epidemiology*, *43*(11), 851.

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.

Perry, B. L. (2011). The labeling paradox: Stigma, the sick role, and social networks in mental illness. *Journal of health and social behavior*, *52*(4), 460-477.

Quinn, D. M., Williams, M. K., & Weisz, B. M. (2015). From discrimination to internalized mental illness stigma: The mediating roles of anticipated discrimination and anticipated stigma. *Psychiatric Rehabilitation Journal*, *38*(2), 103.

Rüsch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European psychiatry*, *20*(8), 529-539.

Shrivastava, A., Johnston, M., & Bureau, Y. (2012). Stigma of mental illness-1: Clinical reflections. *Mens sana monographs*, *10*(1), 70.

Stuart, H., & Sartorius, N. (2005). Fighting stigma and discrimination because of mental disorders. *Advances in psychiatry*, *2*, 79-86.

Tucci, V., & Moukaddam, N. (2017). We are the hollow men: The worldwide epidemic of mental illness, psychiatric and behavioral emergencies, and its impact on patients and providers. *Journal of emergencies, trauma, and shock*, *10*(1), 4.

Tyszkowska, M., & Podogrodzka, M. (2013). Stigmatization on the way to recovery in mental illness– the factors directly linked to psychiatric therapy. *Psychiatr. Pol*, *47*(6), 1011-1022.

Van Der Sanden, R. L., Bos, A. E., Stutterheim, S. E., Pryor, J. B., & Kok, G. (2015). Stigma by association among family members of people with a mental illness: A qualitative analysis. *Journal of Community & Applied Social Psychology*, *25*(5), 400-417.

Waldmann, E. (2020). From Storytelling to Storylistening: How the Hit Podcast S-Town Reconfigured the Production and Reception of Narrative Nonfiction. *Ex-centric Narratives: Journal of Anglophone Literature, Culture and Media*, (4), 28-42.

Watson, A. C., Corrigan, P., Larson, J. E., & Sells, M. (2007). Self-stigma in people with mental illness. *Schizophrenia bulletin*, *33*(6), 1312-1318.

Wiethe, L., Rudeloff, C., & Tellkampf, U. (2020). Zwischen Unterhaltung und Interaktion: Über das Warum der Podcast-Nutzung. *kommunikation@ gesellschaft*, *21*(2).

Wirth, J. H., & Bodenhausen, G. V. (2009). The role of gender in mental-illness stigma: A national experiment. *Psychological Science*, *20*(2), 169-173.

World Health Organization (WHO). (1993). *The ICD-10 classification of mental and behavioural disorders*. World Health Organization.

World Health Organization. (2019a). *Mental health: Fact sheet.* Retrieved from https://www.euro.who.int/__data/assets/pdf_file/0004/404851/MNH_FactSheet_ENG.Pdf

World Health Organization. (2019b). *Mental disorders.* Retrieved from https://www.who.int/en/news-room/fact-sheets/detail/mental-disorders