

# Mental Illness Stigma and Microaggressions: An Experimental Study of Familiarity and Relationship Quality

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Familiarity (i.e., relationship closeness) and relationship quality (i.e., the degree of negativity/positivity) have been suggested as critical components, affecting stigmatizing attitudes toward those with mental illnesses. The present study experimentally tested components of, and expanded upon, a recent theoretical framework by P. W. Corrigan and Nieweglowski (2019), which proposes a convex (u-shaped) curvilinear relationship between familiarity and stigma (i.e., people hold the most stigma toward others at the lowest and highest levels of familiarity) rather than a linear one (i.e., stigma simply decreases as familiarity increases). By examining how both familiarity and relationship quality affect public stigma broadly, as well as microaggressions specifically, this research adds to the growing body of literature on mental illness stigma. Undergraduate students ( $N = 242$ ) were randomly assigned to read one of six vignettes via a 2 (quality: positive vs. negative)  $\times$  3 (familiarity: coworker, cousin, romantic partner) between-subjects factorial design. Following, participants completed measures assessing stigmatizing attitudes and microaggression endorsement toward the vignette character. There was a significant main effect of relationship quality on stigmatizing attitudes only; on average, those in the three negative conditions had significantly higher stigmatizing attitudes than those in the positive conditions. Conversely, familiarity only had a significant main effect on microaggressions, wherein higher familiarity groups demonstrated higher microaggression endorsement. No significant interactions were found for either variable. These results suggest that stigmatizing attitudes and microaggressions may be functionally different, and further research is required to clarify current theoretical frameworks in understanding how relational contexts impact these negative attitudes.

## Clinical Impact Statement

This study suggests that mental illness microaggressions and stigmatizing attitudes are conceptually different constructs based on the impact that familiarity and relationship quality have on their endorsement. These findings highlight the necessity of further studies in mental illness microaggressions and provide clinical utility in identifying likely scenarios where clients may be experiencing increased stigma based on relationship factors.

**Keywords:** mental illness, public stigma, microaggressions, familiarity, contact/relationship quality

**Supplemental materials:** <https://doi.org/10.1037/sah0000471.supp>

The observed lifetime prevalence of mental illnesses (MIs) in Western nations hovers around 45%, with first onset typically occurring in childhood and adolescence (Jacobi et al., 2004; Kessler et al., 2005; Slade et al., 2009). Ergo, from a statistical perspective, a significant number of people currently have or will have an MI at

some point in their lives, as well as very likely to know someone who has an MI. Despite the prevalence of MIs, stigma remains a ubiquitous experience to those living with one. *Stigma* is a process of distinguishing and labeling human differences, wherein dominant cultural beliefs link certain differences to undesirable characteristics

This article was published Online First July 10, 2023.

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The authors have no conflicts of interest, financial or otherwise, to disclose. Materials and analysis codes for this study are not available.

Our positionality statements follow: Acknowledging that identity can influence scientific practice (Roberts et al., 2020), the authors wish to provide information on their backgrounds. With respect to gender, two of the authors self-identify as women, and one author identifies as a man. With respect to race, one author identifies as mixed (European/Indigenous), one as White/European, and one as Chinese.

Arianna M. Gibson played a lead role in conceptualization, data curation, formal analysis, investigation, project administration, and writing—original draft and an equal role in methodology, validation, and writing—review and editing. Brittany L. Lindsay played a supporting role in conceptualization, supervision, and validation and an equal role in methodology and writing—review and editing. Andrew C. H. Szeto played a supporting role in conceptualization, methodology, validation, writing—review and editing, and supervision.

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(Link & Phelan, 2001). Status loss, discrimination, and unequal outcomes in stigmatized individuals occur as a consequence of this distinction, which can be further propelled by a lack of social, economic, and political power. Some consequences of MI stigma include housing instability, decreases in mental health, and difficulty gaining employment (Hipes et al., 2016; Mejia-Lancheros et al., 2021). Furthermore, when individuals with an MI begin to anticipate and expect stigma from those around them, they may begin withdrawing from social and occupational settings, ultimately isolating themselves from others (Link et al., 1987). This act of withdrawal and isolation can cause a lack of help-seeking behaviors for mental health care to avoid stigmatizing labels (i.e., label avoidance; Sheehan et al., 2017).

One goal of stigma research is to understand who is likely to perpetrate stigma and to effectively tailor stigma reduction programs to individuals with these indicators (P. W. Corrigan, 2004; Szeto et al., 2015). Several moderating factors have been investigated in this context, including personality traits (Szeto et al., 2015), authoritarian beliefs and benevolence (Zurick, 2016), gender (Dey et al., 2020), and lack of knowledge of MI (Ay et al., 2006). More recently, two promising factors have been suggested as playing a role in stigma endorsement: familiarity and relationship quality (P. W. Corrigan & Nieweglowski, 2019; Ran et al., 2022). Familiarity describes a continuum of the overall closeness between individuals of differing relationship types (P. W. Corrigan & Nieweglowski, 2019), while relationship quality describes the degree of negative versus positive attributes within a relationship (Islam & Hewstone, 1993; Ran et al., 2022).

### Familiarity and Stigma

P. W. Corrigan and Nieweglowski (2019) recently examined the relationship between familiarity and stigma in 26 peer-reviewed studies and found that 19 studies supported a negative linear relationship between familiarity and stigma, such that those with higher familiarity with individuals with an MI were less likely to endorse stigmatizing attitudes. However, five studies found significant relationships in the opposite direction: High familiarity was positively correlated with greater stigma (Batastini et al., 2014; Broussard et al., 2012; P. W. Corrigan et al., 2005; Phelan & Basow, 2007; Wolkenstein & Meyer, 2009).

Considering these findings, a u-shaped curvilinear relationship was proposed to explain how familiarity (x-axis) and public stigma (y-axis) are related (see Figure 1 in P. W. Corrigan & Nieweglowski, 2019, p. 44). The left half of the curve (e.g., individuals with no experience with MIs, acquaintances, coworkers, and friends) is a downward slope where, as familiarity increases, stigma decreases until the inflection point (e.g., extended family) is reached. At this point, or where the right half of the curve begins, familiarity increases further (e.g., service providers and nuclear family), and stigma increases alongside it. The authors proposed that burden (i.e., the responsibilities of taking care of those with MIs) and associative stigma (i.e., stigma extending to those who are in contact with people with an MI) are two possible mechanisms explaining the increase of stigma seen within high-familiarity groups. The burden may manifest as challenges with finances, work, depression, or anxiety as a reaction to relatives with an MI, which is then further exacerbated by associative stigma.

A more recent study investigated the relationship between knowledge of MIs, various aspects of contact (quality, quantity, and familiarity), and MI stigma (Ran et al., 2022). The stakeholder groups that were examined (i.e., community residents, mental health workers, and family members) supported the aforementioned theoretical framework (P. W. Corrigan & Nieweglowski, 2019), finding that community residents and family members had similarly higher stigma scores compared to mental health workers. In addition, it was found that positive relationship quality had the strongest link to less stigmatizing attitudes, demonstrating that relationship quality also plays a critical role (Ran et al., 2022). That is, relationships characterized by equality, support, and friendliness were shown to have lower stigmatizing attitudes. The findings from this study ultimately suggest that familiarity and relationship quality have significant implications on the endorsement of stigmatizing attitudes and that testing additional stakeholder groups to determine differences is a worthwhile endeavor.

### Microaggressions

MI microaggressions present an interesting connection within the conundrum of familiarity and stigma. *Microaggressions* are “the everyday verbal, nonverbal, and environmental slights, snubs, and insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership” (Sue, 2010, p. 24). Microaggressions are distinguished from traditional discrimination in that they represent a particular type of behavior that is often more covert, common, and sometimes ambiguous but remains a stressful occurrence for the target due to the ubiquity and deniability of the act (Williams, 2020). Seminal research on microaggressions initially focused on racism (e.g., Pierce, 1970; Sue et al., 2007) and sexism (e.g., Capodilupo et al., 2010; McCabe, 2009; Solórzano, 1998), later extending to additional structurally marginalized communities, such as the two-spirit, lesbian, gay, bisexual, transgender, queer and/or questioning, intersex, asexual, and additional sexual/gender identities (e.g., Nadal, 2023; Nadal et al., 2016) and disabled populations (e.g., Dávila, 2015; Harris, 2017). It is only within the last decade that the term microaggressions has been used within the MI literature (e.g., Gonzales, Davidoff, Nadal, et al., 2015; Peters et al., 2017). Qualitative explorations of MI microaggressions have identified seven major themes from the recipients’ perspective, including invalidation, assumption of inferiority, fear of MI, shaming of MI, being perceived as a second-class citizen, defining a person by their disorder, and misuse of terminology (Gonzales, Davidoff, DeLuca, et al., 2015; Peters et al., 2017). These themes encompass experiences of being minimized, made to feel *less than* or incompetent, the denial of individual agency, and the invisibility of not being acknowledged as a person that has opinions of merit.

Although there are commonalities among all microaggressions, it is important to note the impact of intersectionality on the presentation of microaggressions (Nadal et al., 2015). Unique combinations of race, ethnicity, gender, sexuality, class, and other idiosyncratic characteristics will result in different experiences of all forms of stigma, including microaggressions. Recent research on intersectionality in microaggressions has found that individuals with marginalized intersectional identities (e.g., Latine transgender youth) experienced increased microaggressions compared to those

with only one structurally marginalized trait (e.g., Latine cisgender youth; Abreu et al., 2023), and they are more negatively impacted by these experiences (Barrita et al., 2023).

The concept of microaggressions has been scrutinized as simply being a less severe form of prejudice and discrimination (Barber et al., 2020); however, these experiences present unique tribulations for the recipient, including feelings of frustration, loss of self-esteem, self-stigmatization, and alienation (Gonzales, Davidoff, Nadal, et al., 2015; Peters et al., 2017). More commonly understood forms of stigma, such as overt discrimination and stereotyping, are often easier to spot and have more immediate consequences, while microaggressions serve to diminish individuals over time with repeated exposure to subtle exclusions (Jana & Baran, 2020). For example, refusing to rent a home to an individual with an MI is a very clear act of discrimination with evident impact (i.e., lack of housing). In comparison, microaggressions toward that same person could include speaking more slowly because you think that they will get confused or avoiding asking them to do certain tasks because it might be too difficult for them. Initially, these behaviors may appear to be well-intentioned; however, they stem from limiting beliefs about individuals with MIs that take away from their autonomy and question their intelligence and abilities (Gonzales, Davidoff, Nadal, et al., 2015). Recipients of microaggressions may leave these interactions unsure of what the perpetrator meant and confused as to why they feel upset by the comment because these acts are so elusive and ambiguous (Sue, 2010). Due to their subtlety, microaggressions may not always be identified or corrected by recipients or bystanders (Sue et al., 2007). This is problematic because without intervention, microaggressions can have a cumulative impact, in that repeated occurrences of microaggressions elicit symptoms similar to severe trauma (Nadal, 2018).

Given the nature of microaggressions and the concealability of MIs, familiarity and relationship quality would appear to be factors that impact the expression of microaggressions. Some preliminary studies have found that MI microaggressions are often perpetrated by close contacts and authority figures (Gonzales, Davidoff, Nadal, et al., 2015; Peters et al., 2017). For example, Peters et al. (2017) found that individuals with an MI (i.e., recipients of microaggressions) perceived *higher* microaggression tendencies by those who had more interpersonal contact with them (i.e., those closer to them). Another study with the *perpetrators* of MI microaggressions, however, found that the more interpersonal contact one had with persons with MIs (e.g., family members), the *less* they reported committing microaggressions (Zurick, 2016). Due to these conflicting findings in the literature, further research is needed to understand what contexts microaggressions are occurring in, as well as *who* microaggression reduction programs should be targeting (i.e., close contacts or not). Although P. W. Corrigan and Nieweglowski's (2019) theory was created for stigmatizing attitudes, it might also help explain these conflicting findings in the microaggression literature as well (i.e., the relationship could be curvilinear). To explore this potential explanation, one objective of the present study was to determine how varying levels of familiarity and relationship quality influence the endorsement of microaggressions.

### The Present Study

The present study aimed to experimentally test the aspects of P. W. Corrigan and Nieweglowski's (2019) theory on public stigma,

as well as expanding it to (a) incorporate the possible importance of relationship quality and (b) examine its applicability to microaggressions. The study focused on three stakeholder groups that fit within distinct areas under the proposed curve: coworkers (left; low familiarity), cousins (middle; moderate familiarity), and romantic partners (right; high familiarity). The study utilized a 2 (quality: positive, negative)  $\times$  3 (familiarity: coworker, cousin, romantic partner) between-subjects factorial design. The research questions addressed in this study were twofold: (1) *How does an individual's level of familiarity with persons with MI and the quality of their relationship affect endorsement of MI stigma?* and (2) *Is MI microaggression endorsement affected differently by familiarity and relationship quality compared to stigmatizing attitudes?* Several hypotheses and exploratory questions (i.e., queries that did not have enough research to develop concrete hypotheses) were explored.<sup>1</sup>

### Stigmatizing Attitudes Hypotheses

*Hypothesis 1a:* Familiarity will have group differences in stigmatizing attitudes (i.e., composite scores on the AQ-27; P. Corrigan et al., 2003) where those in the high-familiarity (romantic partner) and low-familiarity (coworker) conditions will have similar stigmatizing attitudes, which will be statistically higher than those in the moderate-familiarity (cousin) condition (P. W. Corrigan & Nieweglowski, 2019; Ran et al., 2022).

*Hypothesis 1b:* Familiarity will show a convex (u-shaped) curvilinear relationship with stigmatizing attitudes following Hypothesis 1a differences (P. W. Corrigan & Nieweglowski, 2019).

*Hypothesis 2:* Negative relationship quality conditions will have higher levels of stigmatizing attitudes compared to positive relationship quality conditions (Ran et al., 2022).

*Exploratory Question 1:* Is there an *interaction* between familiarity and relationship quality that affects the endorsement of stigmatizing attitudes?

### Microaggression Hypotheses

*Hypothesis 3:* Negative relationship quality conditions will have higher levels of microaggressions compared to positive relationship quality conditions (Ran et al., 2022).

*Exploratory Question 2:* Is P. W. Corrigan and Nieweglowski's (2019) theory applicable to MI microaggressions? The analyses used for all previous tests on stigmatizing attitudes (Hypothesis 1a, Hypothesis 1b, and Exploratory Question 1) will be repeated with microaggressions as the dependent variable. These exploratory analyses will subsequently be referred to as Exploratory Question 2a (Exploratory Question 2a; main effect of familiarity), Exploratory Question 2b (Exploratory Question 2b; curvilinear trend), and Exploratory Question 2c (Exploratory Question 2c; interaction).

<sup>1</sup> In preregistration, the hypotheses were presented and/or worded differently but were edited here to increase clarity in the reporting of results. The content of the hypotheses has not been changed.

The present study was registered with AsPredicted (No. 79637) prior to data collection on November 12, 2021.

## Method

### Participants

Participants were recruited using an online Research Participation System (RPS) at the University of Calgary and received 0.5-course credit as remuneration. Inclusion criterion required enrollment in a participating psychology course(s). To determine an adequate final sample size, an a priori power analysis was conducted using G\*Power 3.1 ( $f = 0.25$ ,  $1 - \beta = .95$ ,  $\alpha = .05$ ,  $N = 251$ ). A total of 300 participants were recruited. Fifty-eight of the recruited participants were excluded from the sample for not consenting ( $n = 10$ ), failing both attention checks ( $n = 5$ ), failing at least one of the manipulation checks ( $n = 32$ ), or having a very short or very long study duration<sup>2</sup> ( $n = 11$ ). Those who were removed did not differ in terms of gender,  $\chi^2(4) = 1.91$ ,  $p = .753$ ; sexual orientation,  $\chi^2(6) = 5.82$ ,  $p = .444$ ; ethnicity,  $\chi^2(11) = 9.92$ ,  $p = .538$ ; or age,  $t(162.6) = -1.60$ ,  $p = .113$ . The final sample included 242 participants, ranging from 17 to 37 years old ( $M = 20.01$ ,  $SD = 2.82$ ; 50% women). The sample was diverse in terms of gender, ethnicity, sexual orientation, academic major, and year of study (see Table 1). Personal experience and familiarity with MI varied across participants. About 34% of the sample indicated that they have an MI (unspecified;  $n = 82$ ),

62% had a family member with an MI ( $n = 151$ ), 54% had a friend with an MI ( $n = 131$ ), 36% had a coworker with an MI ( $n = 87$ ), and 14% work in a job that involves serving and/or treating those with an MI ( $n = 35$ ). Of those who knew someone with an MI, 30% lived with someone with an MI ( $n = 73$ ). No participants indicated that they had zero familiarity with MI; however, about 9% of participants noted having only observed individuals with an MI on television ( $n = 21$ ).

### Materials

#### Vignettes

The study included six between-subject conditions, which were manipulated using vignettes (see Supplemental Materials). The vignettes portrayed a gender-neutral character with symptoms of depression and anxiety that was in one of three relationship types (coworker, cousin, or romantic partner), which were portrayed as either positive or negative in quality. The participants were provided with instructions that asked them to imagine that they were personally in a relationship with the vignette character, with the relationship type corresponding to their condition. The vignettes were written in the second-person point of view (i.e., addressing the reader using “you”) to further elicit this experience beyond the descriptions in the vignette.

The vignettes were researcher-created, following suggestions for increasing validity in vignettes (Gould, 1996). The symptomology depicted within the vignette aligned with the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* criteria for depression and anxiety (American Psychiatric Association, 2013) while more general aspects (setting, tone, extraneous content) were inspired by existing vignettes and clinical case studies of depression and anxiety (Burns & Rapee, 2006; McKeogh et al., 2018). Manipulations of relationship quality were informed by the factors in the Positive–Negative Relationship Quality (PN-RQ) Scale (Rogge et al., 2017). Specifically, the PN-RQ is composed of 16 positive and negative adjectives that assess relationship quality, including good–bad, pleasant–unpleasant, enjoyable–miserable, and full–empty. The vignettes in the present study included these adjectives to manipulate relationship quality, along with others such as “strained” and “difficult” for the negative condition and “healthy” and “interesting” for the positive condition. To increase external validity, efforts were made to have the depicted scenario be realistic to the manipulations while keeping details across vignettes as similar as possible. The vignettes underwent an iterative editing process with the current researchers before feedback was solicited and incorporated from additional colleagues.

**Table 1**  
Participant Demographics

| Demographics       | Response                    | <i>n</i> (%) |
|--------------------|-----------------------------|--------------|
| Gender             | Woman                       | 120 (50%)    |
|                    | Man                         | 116 (48%)    |
|                    | Nonbinary/Genderqueer       | 3 (1%)       |
|                    | Prefer not to disclose      | 3 (1%)       |
| Ethnicity          | White                       | 85 (35%)     |
|                    | South Asian                 | 49 (20%)     |
|                    | Chinese                     | 27 (11%)     |
|                    | Arab/West Asian             | 17 (7%)      |
|                    | Mixed                       | 17 (7%)      |
|                    | Filipino                    | 13 (5%)      |
|                    | South East Asian            | 12 (5%)      |
|                    | Latin America               | 8 (3%)       |
|                    | Black                       | 7 (3%)       |
|                    | Other                       | 6 (2%)       |
| Sexual orientation | Heterosexual                | 189 (78%)    |
|                    | Bisexual                    | 24 (10%)     |
|                    | Gay/lesbian                 | 11 (5%)      |
|                    | Pansexual                   | 4 (2%)       |
|                    | Asexual                     | 3 (1%)       |
|                    | Other/did not disclose      | 10 (4%)      |
| Academic major     | Psychology                  | 86 (36%)     |
|                    | Computer science            | 16 (7%)      |
|                    | Kinesiology                 | 14 (6%)      |
|                    | Biological sciences         | 11 (5%)      |
|                    | Sociology                   | 8 (3%)       |
|                    | Combined degree             | 21 (9%)      |
|                    | Other (35 different majors) | 86 (36%)     |
| Year of study      | First year                  | 83 (34%)     |
|                    | Second year                 | 81 (34%)     |
|                    | Third year                  | 44 (18%)     |
|                    | Fourth year or higher       | 33 (14%)     |

Note. *N*s = 241–242 as some participants did not answer all demographic questions.

<sup>2</sup> Since participation was self-directed (i.e., online and unsupervised), there were extremes in participants' survey duration, ranging from 25 s to 90 hr for completion. Presumably due to participants completing the study without reading its contents (i.e., unreasonably quick durations) or beginning the study but coming back to complete it later (i.e., extremely long durations). For these reasons, only data whose study duration was between 10 min and 3 hr was retained, as data within these parameters were comparable to the modal time of completion within 3 SDs.

### Attribution Questionnaire

A modified version of the Attribution Questionnaire (AQ-27; P. Corrigan et al., 2003) was used to measure public stigma by assessing participants' attitudes and beliefs about persons with an MI. The AQ-27 contains a short vignette about someone with an MI diagnosis and asks 27 items pertaining to this person on a 9-point Likert scale (1 = *not at all* to 9 = *a great deal*), with nine subscales of stereotypes composed of three items each. The questionnaire's character (originally named "Harry") was modified to be consistent with the experimental conditions of the vignettes created for the present study (i.e., the name "Harry" was replaced with either *coworker*, *cousin*, or *romantic partner*). Following previous research (Martínez-Hidalgo et al., 2018; Reynolds et al., 2022), the present study used a total measure mean score (with the help and avoidance items reverse-coded), with higher scores indicating greater stigmatizing attitudes (range = 1–9). This measure had good internal consistency in previous studies ( $\alpha = .89$ ; Reynolds et al., 2022), consistent with the present study ( $\alpha = .87$ ).

### Mental Illness Microaggressions Scale–Perpetrator Version

The Mental Illness Microaggressions Scale–Perpetrator Version (MIMS-P; Gonzales, Davidoff, DeLuca, et al., 2015) was used to assess MI microaggression endorsement from the perpetrator's perspective. The MIMS-P has 17 items rated on a 4-point Likert scale (1 = *strongly disagree* to 4 = *strongly agree*) and consists of three subscales: assumption of inferiority, patronization, and fear of MI. Like the AQ-27, this measure's target was modified to correspond with the experimental conditions (e.g., "If someone I'm close to told me" was changed to "If my *romantic partner/cousin/coworker* told me"). Composite mean scores (range = 1–4) were created, with higher scores indicating a greater endorsement of microaggressions. This measure demonstrated good internal consistency in previous studies ( $\alpha = .84$ ; Gonzales, Davidoff, DeLuca, et al., 2015), consistent with the present study ( $\alpha = .85$ ).

### Contact Quantity and Contact Quality Scale

The Contact Quantity Scale (CQNS) and Contact Quality Scale (CQLS; Islam & Hewstone, 1993) assess quantitative and qualitative aspects of contact with a particular group. This was included as a potential covariate in the analyses to control for participants' existing relationships with individuals with an MI. The present study utilized adapted versions of the scales that focus on contact with individuals with an MI (Ran et al., 2022). The CQNS and CQLS consist of five and six questions, respectively, each rated on a 7-point Likert scale (1 = *none at all* to 7 = *a great deal*). The CQNS measures the amount of contact with individuals with an MI (e.g., neighbors, friends), and the CQLS measures the nature of the contact (e.g., as equals, cooperative). Higher scores indicate more quantitative and higher quality contact with individuals with an MI. The CQNS ( $\alpha = .76$ ) and CQLS ( $\alpha = .89$ ) demonstrated good internal consistency in previous studies (Ran et al., 2022), consistent with the present study ( $\alpha = .83$  and  $\alpha = .85$ ). Additionally, a composite mean score including them both ( $\alpha = .89$ ) demonstrated good internal consistency (see the Preliminary Analyses section for composite score explanation).

### Procedure

This study was approved by the University of Calgary's Conjoint Faculties Research Ethics Board (REB21-1314). Participants self-selected for the study on the RPS and completed the survey on *Qualtrics*, an online survey builder and distribution tool. After providing informed consent, participants were randomly assigned to one of the six vignettes described above and were asked to imagine that the vignette character was either their coworker, cousin, or romantic partner. The participants then completed the adapted versions of the AQ-27 and MIMS-P based on their attitudes toward the character in the vignette, followed by the CQNS, CQLS, and the Level of Contact Report<sup>3</sup> (Holmes et al., 1999; experience with MI), which assessed participants' personal experience with MI as a potential control. Last, participants completed other demographic questions (i.e., age, gender, sexual orientation, ethnicity, faculty, major, year of study). In addition to the above measures, attention and manipulation checks were utilized throughout, including questions regarding the familiarity and relationship quality manipulations within the vignette (e.g., "What was your relationship to the character in the vignette?" and "How would you describe the quality of your relationship with the character in the vignette?"). Participants were removed if they answered either of the manipulation checks incorrectly. Following completion of the survey, participants viewed a video debriefing and consented to have their data included in the study.

## Results

### Analysis Approach

All quantitative analyses were conducted using IBM SPSS Statistics (Version 28). The data were cleaned, and assumptions for all relevant analyses were checked. For each of the dependent measures, a 2 (relationship quality: negative, positive)  $\times$  3 (familiarity: coworker, cousin, romantic partner) between-subjects factorial analysis of covariances (ANCOVAs) were used for the primary analysis, using a Bonferroni corrected  $\alpha$  level of  $\alpha = .025$  to control for family-wise error rates (two related dependent measures). In addition, polynomial contrasts (i.e., linear and quadratic) were included in each ANCOVA to assess the trend of familiarity relating to the dependent variables (Hypothesis 1b). Last, all relevant post hoc pairwise comparisons were conducted on significant omnibus results, at a further Bonferroni adjusted alpha of  $\alpha = .008$  (0.025/3 comparisons each). Analyses were conducted both with and without outliers (AQ-27:  $n = 9$ ; MIMS-P:  $n = 1$ ), and no notable differences were seen; therefore, outliers were retained in the reported results.

### Preliminary Analysis

All potential continuous covariates (age, CQNS, CQLS) were assessed for relationships to the dependent variables using Pearson correlations (see Table 2). Gender was assessed with independent-

<sup>3</sup> This measure was initially included as a potential covariate but was ultimately not considered, as the CQNS and CQLS were deemed more appropriate for the study as they assessed more aspects of personal experience with mental illnesses than the Level of Contact Report (LCR). The LCR was also correlated with the CQNS and CQLS ( $r_s = .55$  and  $.41$ , respectively), indicating that they were measuring similar latent constructs (i.e., redundant to include both).

**Table 2**  
*Pearson's Correlations of Dependent Variables and Potential Covariates*

| Measure              | <i>M</i> | <i>SD</i> | 1          | 2          | 3          | 4          | 5          | 6 |
|----------------------|----------|-----------|------------|------------|------------|------------|------------|---|
| 1. AQ-27             | 3.07     | .77       | <b>.87</b> |            |            |            |            |   |
| 2. MIMS-P            | 2.08     | .43       | .51**      | <b>.85</b> |            |            |            |   |
| 3. CQNS              | 3.76     | 1.49      | -.31**     | -.35**     | <b>.83</b> |            |            |   |
| 4. CQLS              | 5.20     | 1.18      | -.38**     | -.46**     | .65**      | <b>.85</b> |            |   |
| 5. Composite contact | 4.55     | 1.20      | -.38**     | -.45**     | .91**      | .90**      | <b>.89</b> |   |
| 6. Age               | 20.01    | 2.82      | -.08       | -.05       | .05        | .04        | .05        | — |

*Note.* Scale reliability (Cronbach's  $\alpha$ ) is reported along the diagonal (bolded) when appropriate. AQ-27 = Attribution Questionnaire; MIMS-P = Mental Illness Microaggressions Scale–Perpetrator; CQNS = Contact Quantity Scale; CQLS = Contact Quality Scale.

\*\*  $p < .001$ .

samples  $t$  tests. Age was not adequately correlated to be considered as a covariate for either variable ( $r_s = -.08, -.05$ ). Results showed no significant difference between women ( $M = 3.04, SD = .75$ ) and men ( $M = 3.07, SD = .76$ ) on the AQ-27, but women ( $M = 2.00, SD = .42$ ) did have significantly lower scores than men ( $M = 2.18, SD = .42$ ) on the MIMS-P,  $t(234) = 3.30, p < .001$ ; therefore, gender was included as a covariate for the MIMS-P analyses.<sup>4</sup>

The CQNS and CQLS had moderate correlations with scores on both the AQ-27 ( $r_s = -.31, -.38$ ) and the MIMS-P ( $r_s = -.35, -.46$ ), respectively. Since the CQNS and CQLS assess different, but related, constructs of contact with individuals with an MI and were highly correlated to one another ( $r = .65$ ), a composite mean score of these two measures was created (i.e., the composite contact score) using raw scores from each item of both measures to be used as a covariate for personal experience with MI. Adjusted marginal means (and standard errors), controlling for the covariate(s) in the models, can be seen in Table 3.

**Table 3**  
*Estimated Marginal Means of Dependent Variables by Familiarity and Relationship Quality*

| Measure                        | Estimated marginal means (standard error) |                               |                                 |                               |
|--------------------------------|-------------------------------------------|-------------------------------|---------------------------------|-------------------------------|
|                                | Coworker                                  | Cousin                        | Romantic partner                | Total                         |
| <b>Stigmatizing attitudes</b>  |                                           |                               |                                 |                               |
| Positive                       | 2.88 (.10)                                | 2.80 (.10)                    | 2.81 (.10)                      | <b>2.83<sub>a</sub> (.06)</b> |
| Negative                       | 3.40 (.10)                                | 3.18 (.12)                    | 3.50 (.12)                      | <b>3.36<sub>b</sub> (.07)</b> |
| Total                          | <b>3.14 (.07)</b>                         | <b>2.99 (.08)</b>             | <b>3.16 (.08)</b>               | <b>3.07 (.77)</b>             |
| <b>Microaggressions</b>        |                                           |                               |                                 |                               |
| Positive                       | 2.00 (.06)                                | 2.17 (.06)                    | 2.12 (.06)                      | 2.10 (.03)                    |
| Negative                       | 1.96 (.06)                                | 2.18 (.07)                    | 2.12 (.07)                      | 2.09 (.04)                    |
| Total                          | <b>1.98<sub>a</sub> (.04)</b>             | <b>2.18<sub>b</sub> (.04)</b> | <b>2.12<sub>a,b</sub> (.04)</b> | <b>2.09 (.43)</b>             |
| <b>Sample sizes (<i>n</i>)</b> |                                           |                               |                                 |                               |
| Positive                       | 44/42                                     | 43/33                         | 44/34                           | <b>105/109</b>                |
| Negative                       | 40/44                                     | 32/44                         | 33/45                           | <b>131/133</b>                |
| Total                          | <b>84/86</b>                              | <b>75/77</b>                  | <b>77/79</b>                    | <b>236/242</b>                |

*Note.* Means with different subscripts are significantly different from each other within that measure (familiarity along bolded rows, quality along bolded columns). A Bonferroni adjusted alpha of  $\alpha = .025$  was used omnibus test;  $\alpha = .008$  for any post hoc follow-ups. Covariates in the models: composite contact score ( $M = 4.52$ ) for both measures; gender ( $M = 1.51$ ) for microaggressions. Sample size notation denotes MIMS-P analysis/AQ-27 analysis. MIMS-P = Mental Illness Microaggressions Scale–Perpetrator; AQ-27 = Attribution Questionnaire.

### Stigmatizing Attitudes Analysis

A  $2 \times 3$  factorial ANCOVA was conducted with the AQ-27 mean scores as the dependent variable and the composite contact score as a covariate (Table 4). There was no significant main effect for familiarity (coworker:  $M_{adj} = 3.14, SE = 0.07$ ; cousin:  $M_{adj} = 2.99, SE = 0.08$ ; romantic partner:  $M_{adj} = 3.16, SE = 0.08$ ),  $F(2, 235) = 1.41, p = .246$ . Relatedly, the planned polynomial contrast assessing the familiarity trend was not significant for either a quadratic trend, contrast estimate ( $c$ ) = .127,  $p = .096$ , or a linear trend,  $c = .015, p = .842$ . A trend analysis on familiarity was also conducted at each level of the quality variable separately, and both the linear and quadratic trends remained not significant (negative:  $p_s = .603, .076$ ; positive:  $p_s = .548, .647$ , respectively). There was a significant main effect of relationship quality, such that those in the negative conditions ( $M_{adj} = 3.36, SE = 0.07$ ) had significantly higher AQ-27 scores than the positive conditions ( $M_{adj} = 2.83, SE = 0.06$ ),  $F(1, 235) = 37.65, p < .001, \omega^2 = 0.11$ . Last, no significant interaction was found between relationship quality and familiarity,  $F(2, 235) = 1.02, p = .362$ .

### Microaggressions Analysis

A second  $2 \times 3$  factorial ANCOVA was conducted using MIMS-P mean scores as the dependent variable for microaggressions, with gender and the composite contact score as covariates (see Table 4). There was a significant main effect of familiarity,  $F(2, 228) = 5.98, p = .003, \omega^2 = 0.03$ . Post hoc pairwise comparisons (adjusted critical  $\alpha = .008$ ) found that the coworker conditions had statistically lower microaggression endorsement ( $M_{adj} = 1.98, SE = 0.04$ ) compared to cousin conditions ( $M_{adj} = 2.18, SE = 0.04$ ) while accounting for relationship quality ( $p = .001$ ). There were no statistically significant group differences between the romantic partner ( $M_{adj} = 2.12, SE = 0.04$ ) and either the coworker ( $p = .017$ ) or the cousin ( $p = .363$ ) conditions; however, the difference between a romantic partner and coworker did reach conventional levels of significance ( $\alpha = .05$ ). Additionally, the planned polynomial contrast assessing familiarity was significant for a downward quadratic trend,  $c = -.104, p = .017$ . As seen in Figure 1, scores increase from coworkers to cousins but then appear to level out. There was neither statistically significant

<sup>4</sup> The nonbinary/genderqueer group was not large enough to be included statistically ( $n = 3$ ), so these participants, along with those who did not disclose their gender ( $n = 3$ ) were removed from the MIMS-P analyses.

**Table 4**

*Follow-Up ANOVAs From MANOVA and Sympathetic Affect ANOVA Results, N = 242*

| Variable               | $F^a$ | $p$                | $\omega^2$ | $R^2$ | $R_{adj}^2$ |
|------------------------|-------|--------------------|------------|-------|-------------|
| Stigmatizing attitudes |       |                    |            | .275  | .257        |
| Familiarity            | 1.41  | .246               | —          |       |             |
| Quality                | 37.65 | <.001 <sup>b</sup> | .11        |       |             |
| Familiarity × Quality  | 1.02  | .362               | —          |       |             |
| Microaggressions       |       |                    |            | .265  | .242        |
| Familiarity            | 5.98  | .003 <sup>b</sup>  | .03        |       |             |
| Quality                | 0.04  | .841               | —          |       |             |
| Familiarity × Quality  | 0.10  | .901               | —          |       |             |

*Note.* Covariates in the models: composite contact score ( $M = 4.52$ ) for both measures; gender ( $M = 1.51$ ) for microaggressions. ANOVA = analysis of variance; MANOVA = multivariate analysis of variance.

<sup>a</sup>  $df_1$ , gender = 1,  $df_1$ , mental illness = 2,  $df_1$ , gender × mental illness = 2,  $df_2 = 235$ , 228, respectively. <sup>b</sup> Denotes statistically significant at Bonferroni adjusted alpha of  $\alpha = .025$ .

main effect for relationship quality (negative:  $M_{adj} = 2.09$ ,  $SE = 0.04$ , positive:  $M_{adj} = 2.10$ ,  $SE = 0.03$ ),  $F(1, 228) = 0.04$ ,  $p = .841$ , nor an interaction between relationship quality and familiarity,  $F(2, 228) = 0.10$ ,  $p = .901$ .

## Discussion

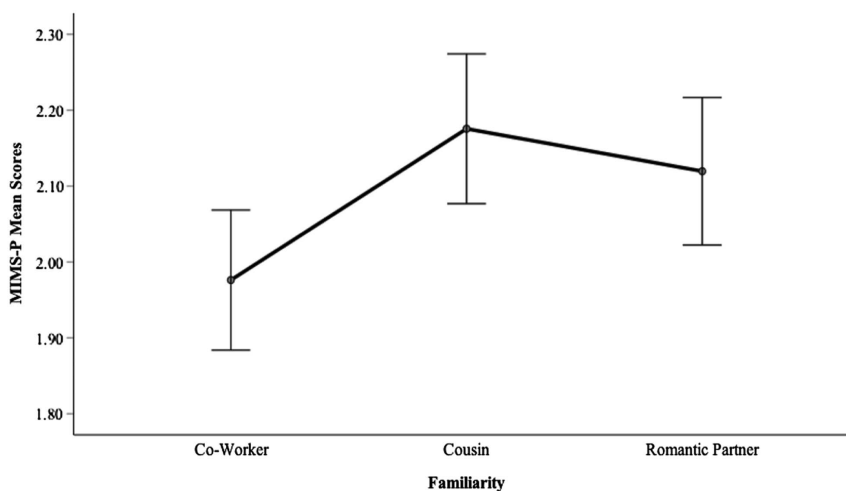
Driven by a recent theoretical framework (P. W. Corrigan & Nieweglowski, 2019), the purpose of the present study was to experimentally explore how different degrees of familiarity and relationship quality affect stigmatizing attitudes and extend upon the limited research on MI microaggressions. For stigmatizing attitudes, Hypothesis 1a and Hypothesis 1b regarding familiarity differences (group differences and curvilinear relationship) were not supported. This lack of support for the theory could be a result of the absence of critical components in the vignettes (e.g., associative stigma and

burden), the methodology utilized (e.g., vignettes, specific relationships chosen), or a third variable is responsible for the relationship between familiarity and stigma which was not captured within the present study (e.g., knowledge of MI; Ay et al., 2006). However, Hypothesis 2 was supported, with participants having more stigmatizing attitudes toward the characters in the negative quality vignettes than those in the positive vignettes. This result aligns with previous findings, which indicate that warm and supportive positive relationships have a lower stigma (Ran et al., 2022).

Regarding microaggressions, Hypothesis 3 was not supported as no significant differences were found between positive and negative conditions. This was an unexpected result, given that previous research has found that positive relationships have lower stigmatizing attitudes (Ran et al., 2022). One interpretation for this finding may be that microaggressions are matched in intention to the quality of the relationship. For example, microaggressions that focus on an individual's commitment to treatment (e.g., ensuring they are taking their medication) might be well-intentioned, while microaggressions that invalidate the individual's experience with an MI (e.g., believing someone is exaggerating about a diagnosis) are ill-intentioned. Perhaps, microaggressions do not differ in *quantity* based on relationship quality but do differ in intention. However, the intentionality of microaggressions is heavily context-dependent (Sue et al., 2007), so research examining these motivations is necessary before any conclusions can be made regarding the relationship between intention and relationship quality.

There was a significant main effect of familiarity in microaggressions (Exploratory Question 2a); however, wherein cousins had statistically higher microaggressions than coworkers (opposite of what was predicted with stigmatizing attitudes), with no other statistically significant differences emerging. The difference between coworker and romantic partner, however, did reach conventional levels of significance ( $p = .017$ ). Further to that, Exploratory Question 2b examined the trend of familiarity in

**Figure 1**  
*Microaggression Scores (MIMS-P) by Familiarity Condition*



*Note.* Error bars represent 97.5% CI of the mean. The composite contact score ( $M = 4.52$ ) and gender ( $M = 1.51$ ) were included as covariates in the model. MIMS-P = Mental Illness Microaggressions Scale-Perpetrator; CI = confidence interval.

MIMS-P scores, which yielded a significant result in opposite concavity than predicted by the theory. Although these results do not align with either Corrigan and Nieweglowski's theory or the general stigma literature, they do partially align with previous literature on microaggressions, which suggests that microaggressions are higher among close contacts (Gonzales, Davidoff, Nadal, et al., 2015; Peters et al., 2017). The results indicate that microaggressions occur more when there is at least a moderate familiarity in a relationship and then begin to level out, suggesting that who is considered a "close contact" in previous literature might include individuals with moderate levels of familiarity. These results could also be explained by the similarity of the depiction of MI symptoms across all familiarity conditions, as symptoms might be more diverse, obvious, and explicit the higher the familiarity with the person, which might not have been represented accurately in these fictitious scenarios.

For both outcome measures, no significant interaction was found (Exploratory Question 1, Exploratory Question 2c). The lack of interaction between familiarity and relationship quality suggests that these variables function separately, such that the effect of one variable is not influenced by the other. Another explanation might be that because relationship quality only significantly impacted stigmatizing attitudes and familiarity with microaggressions, perhaps these relationship variables are only influential to certain manifestations of stigma.

## Implications

The current findings illustrate that stigmatizing attitudes and microaggressions may be functionally different. Although the two constructs were highly correlated, they demonstrated distinctly different presentations based on the relationship variables that were explored. This has significant theoretical implications for future research, as it suggests that stigmatizing attitudes and microaggressions need to be conceptually differentiated from one another and studied as independent constructs. Furthermore, the current findings indicate that the inclusion of relationship quality within P. W. Corrigan and Nieweglowski's (2019) theory might yield a more accurate framework to assess how relationships influence stigma. Additionally, further investigation on the construct of familiarity is necessary to enhance this theory. For instance, defining familiarity as a continuum, rather than distinct relationship types, might represent the nuance of this concept more accurately. The three stakeholder groups that were investigated in the present study were chosen based on categorically assumed levels of familiarity (i.e., one example from each familiarity level: low, moderate, and high). This was a methodological choice to help identify and experimentally test specific levels of familiarity identified in the theory, but it does assume that the initial categorizations by Corrigan and Nieweglowski are accurate for all individuals. In actuality, familiarity is not necessarily defined by a relational label like "coworker" or "parent" but rather by the relative level of closeness between two individuals regardless of that label (e.g., an individual can be much closer with a coworker whom they see every day, compared to their parent who they only see on special occasions). Future studies might choose not to use relationship labels and instead assess how familiar individuals are with one another on a continuum, allowing for these important individual differences.

Practically speaking, different strategies may need to be used to adequately address both stigmatizing attitudes and microaggression reduction. For stigma, intervention programs specific to negative

dyadic interpersonal relationships might aim to increase relationship quality to allow more targeted identification and treatment of these negative beliefs. In terms of microaggressions, close contacts of the individual with an MI should be provided with psychoeducation on appropriate ways to communicate about MI that are not demeaning and invalidating. Studies on racial microaggressions emphasize the importance of education on microaggressions that is carefully framed around the roots of these attitudes as a reduction technique (Foste & Ng, 2022). In addition, psychoeducation has been shown to be effective in decreasing family burden (Fallahi Khoshknab et al., 2014) and increasing the well-being of caregivers (Rosney et al., 2017).

## Strengths, Limitations, and Future Directions

The present study was novel in its methodological approach of using vignettes to experimentally examine the influence of familiarity and relationship quality on stigmatizing attitudes and microaggressions. There are, however, limitations of note in the present study. While the vignettes did allow for an experimental examination of the independent variables, they cannot capture the nuances of an individual's attitudes in reality (Hughes, 1998). Specific to the present study, there is a possibility that participants were randomly assigned to a condition for which they have no frame of reference (e.g., in a romantic partner condition, but having never dated). Despite this being a potential limitation, it is likely that participants have some knowledge of what these relationships might be like from media and observing others in these relationships, so their responses cannot be wholly discounted.

In addition, the present study used symptoms of depression and anxiety to illustrate an MI in the vignette character, which presents a limitation for two reasons. First, depression and anxiety are well-known disorders, and given that increased knowledge and familiarity with MIs decreases stigma (Ay et al., 2006; Ran et al., 2022), other disorders may have different results. Research has found that while there is a baseline level of stigma across different mental disorders, each disorder can be subjected to different stigmatizing beliefs, attitudes, and behaviors (Dauderman, 2018). For instance, Dauderman found that schizophrenia was associated with increased beliefs of dangerousness and fear, while major depressive disorder was associated with coercion and segregation. Therefore, different disorders may also impact the presentation of both stigma and microaggressions. Second, the presentation of MI in the vignettes does not capture intradisorder variation in stigma. Previous research has indicated that individuals with more severe symptom presentation experience higher rates of stigma (Fox et al., 2018). Based on these findings, both the type and the severity of MI will likely impact the presentation of stigma toward the recipient. Future studies assessing both inter- and intradisorder variation in stigma could illuminate whether targeted stigma reduction programs are necessary or if a general approach is more appropriate.

Beyond looking at MI type and severity, further research in this area should prioritize the effects and implications of intersectional identities on the presentation and impact of microaggressions. Specifically, characteristics such as race, ethnicity, social class, sexual/gender identities, and disabilities should be investigated in conjunction with both perpetrators and recipients. For example, being part of other structurally marginalized groups in society (e.g., Black women, transgender youth) alongside having an MI could influence the stigma that is experienced by these individuals (Abreu et al., 2023;

Barrita et al., 2023). Similarly, perpetrators' identities might also influence the perceptions they have toward others with an MI. The influence of these identities can also intersect (e.g., a White disabled woman's perception of a Black able-bodied man with an MI) and adds an additional layer of complexity that needs to be explored.

Future research might also prioritize examining different stakeholder groups (beyond those in the present study) and focusing on how negative relationships specifically influence stigmatizing attitudes. Given that the current findings demonstrate that positive relationships have a lower stigma, further research should clarify what specific factors within negative relationships lead to higher stigma. These factors may be different across levels of familiarity. For instance, P. W. Corrigan and Niewegłowski (2019) suggest that burden and associative stigma are potential factors that lead to stigma increases in high-familiarity groups. The lack of significant differences between familiarity groups in the present study may have been due to the absence of manipulation of these factors. Therefore, future research might address whether burden and associative stigma play a role in stigma increases in high-familiarity groups. Perhaps, negative relationship quality leads to increased sensitivity to these experiences, which ultimately results in higher stigma toward the individual with an MI.

## Conclusion

For those living with an MI, stigma and microaggressions are unfortunate realities with significant impacts on their lives. Findings from the present study indicate a need for adaptations to Corrigan and Niewegłowski's theory and support the argument that stigma and microaggressions are conceptually distinguishable. Future research seeking to disambiguate processes involved in the endorsement of these attitudes requires intentionality and cognizance, such that existing theoretical frameworks on stigma and related concepts undergo regular modifications aligned to current research findings. Moreover, ascertaining other areas where stigma and microaggressions differ will be critical for future investigation of these constructs.

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Received February 22, 2023

Revision received June 8, 2023

Accepted June 12, 2023 ■