Routledge
Taylor & Francis Group

Journal of Human Behavior in the Social Environment

ISSN: 1091-1359 (Print) 1540-3556 (Online) Journal homepage: www.tandfonline.com/journals/whum20

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To cite this article: Andreia A. Manão, Ana Carvalho, Patrícia M. Pascoal & Ana Filipa Beato (27 Apr 2026): Stigma and discrimination through the lens of people with lived experience of mental health conditions with diverse gender identification and age frames: A qualitative study, Journal of Human Behavior in the Social Environment, DOI: 10.1080/10911359.2026.2657908

To link to this article: https://doi.org/10.1080/10911359.2026.2657908

Published online: 27 Apr 2026.

JOURNAL OF HUMAN BEHAVIOR IN THE SOCIAL ENVIRONMENT
https://doi.org/10.1080/10911359.2026.2657908

Stigma and discrimination through the lens of people with lived experience of mental health conditions with diverse gender identification and age frames: A qualitative study

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ABSTRACT

Stigma against people with lived mental health experiences (PWLE) worsens their psychological and physical health and poses a global public health problem. Age and gender may influence stigma experiences, but findings vary. This qualitative study explores PWLE experiences across ages and genders, examining perceptions of who the discrimination agents are. Understanding age and gender intersectionality aids in reducing mental health-related stigma with a nuanced approach. A total of 182 adults ($M = 35.6$, $SD = 13.4$) with self-identified mental health conditions answered an open-ended question. We performed a reflexive thematic analysis. Three themes were developed: (1) Rationalizing discrimination - i.e., socially shared stereotypes used to justify discrimination; (2) This is what we get when we mess with them - i.e., patterns of lived experiences of social discrimination, harassment, and exclusion in different contexts; and (3) The perks of being a wallflower - i.e., internalized stigma related to patterns used by PWLE and circumstances to avoid exposure to stigma and discrimination. Older PWLE reported using coping strategies to prevent stigma. The age-gender of a PWLE seemed to influence how others perceive their mental health conditions. Findings suggest that PWLE face mental health stigma rooted in rationalization, leading to maladaptive coping strategies, such as hiding their condition. Prevention efforts should consider age-gender intersectionality.

KEYWORDS

Mental health; PWLE; stigma; social discrimination; reflexive thematic analysis

Introduction

Mental health plays a crucial role in overall well-being, affecting both individuals and society (World Health Organization [WHO], 2022). For example, it significantly impacts global health, as those with severe mental health conditions are at a higher risk of premature death compared to the general population, largely due to preventable physical diseases (Lancet, 2022). Globally, mental health conditions are highly prevalent, with about one in eight people living with a mental health condition (WHO, 2022). In Europe, Portugal has the second-highest prevalence of mental health conditions, with more than one-fifth of the Portuguese population coping with a psychiatric disorder (Almeida et al., 2013). While this statistic is from 2013, recent research suggests a decline in mental health among people in Portugal following the COVID-19 pandemic (Vieira & Meirinhos, 2021). This decline underscores the need to further explore the experiences of people with lived experiences of mental health conditions (PWLE) in Portugal, as they may have specific nuances that were not previously recognized or addressed, such as the experience of stigma related to mental health status and its intersection with age and gender.

Despite growing awareness and advocacy (Ma et al., 2023), along with recommendations from established institutions to reduce stigma surrounding mental health (e.g., Organisation for Economic Co-operation and Development, 2021; WHO; 2022), this stigma continues to impact PWLE, who frequently manage both their mental health condition and the associated stigma (Thornicroft et al., 2022). Stigma

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about mental health conditions refers to a negative disposition that includes three components: stereotypes, which are negative beliefs about PWLE (e.g., perceiving them as being weak or dangerous); prejudice, which encompasses negative emotional reactions (e.g., anger, fear); and discrimination, which refers to the behavioral manifestation of such prejudice (e.g., avoidance or withholding help) (Corrigan & Watson, 2002).

Misconceptions about mental health, such as the belief that PWLE are dangerous or incapable, are deeply ingrained in societal attitudes (Hinshaw & Stier, 2008) and remain a critical global public health problem (Lancet, 2022) that negatively impacts PWLE lives. For example, when people from the general population were asked to describe mental health conditions such as schizophrenia, bipolar disorder, and autism, many participants used pejorative labels like "mad" or "lunatic" (Durand-Zaleski et al., 2012). However, when asked directly to describe PWLE (not the condition itself), participants used more compassionate feelings, such as "sorrow." While this response appears compassionate, it can also be viewed as a form of benevolent discrimination that can also be harmful (Eagly & Diekman, 2005) because it reinforces the socially subordinate position of PWLE.

According to the *Modified Labelling Theory* (Link et al., 1997), PWLE often perceive that others hold negative views about their conditions, leading them to fear stigma and keep their condition secret to avoid mistreatment. However, this concealment can lead to psychological distress, inauthenticity, reduced sense of belonging, and limited access to healthcare and supportive relationships (Elliott & Doane, 2015; Murphy & Mackenzie, 2025). Experiences of stigma are frequent (e.g., Gaiha et al., 2020) and can reduce PWLE self-esteem, limit social and professional opportunities, worsen their symptoms, and hinder the recovery process (Del Rosal et al., 2021). It can also affect PWLE families and friends, who may,among other experiences, feel shame and fear of association with a PWLE due to stereotypes about mental health conditions and reduce their empathy toward PWLE (Dobener et al., 2022; Samari et al., 2022). Families and friends may also experience hopelessness (Ebrahim et al., 2020) and feel powerless to fight against discrimination and stigma themselves, which contextualizes stigma's negative impact as systemic and not merely individual.

The intersection of demographic factors such as age and gender can influence stigma, but findings remain inconsistent. While some studies suggest that younger people stigmatize less than older ones due to having greater mental health literacy (Almeida et al., 2023) or due to having more chances to have previous contact with PWLE (Evans-Lacko et al., 2012), other studies indicate that young people stigmatize more due to peer pressure (Bradbury, 2020). In terms of gender, studies show that men stigmatize more than women (e.g., Bradbury, 2020), while other studies suggest the opposite (e.g., Lauber et al., 2004). Nevertheless, the majority of research addresses stigma primarily from the stigmatizer's perspective, with scant attention paid to the perspectives of those who face stigma. Among the few studies that explore the experiences of those who are stigmatized, a qualitative study conducted in Mexico revealed that individuals with schizophrenia felt their reintegration into society was influenced by gender, with being female serving as a facilitator for finding employment (Ponting et al., 2020). It is essential to acknowledge a gap in the literature concerning whether the age and gender of PWLE are linked to people's experiences of stigma, as establishing if people from different age groups perceive different experiences in relation to their gender broadens our view of the experience of stigma and may open venues for more advanced approaches and theoretical comprehension of lived experiences of stigma in different social groups using an intersectional perspective.

The current body of literature on mental health stigma mainly consists of quantitative studies based on questionnaires evaluating stigma (e.g., Fang et al., 2021; Nohr et al., 2021), and this method of data collection, although informative, does not allow for specifying the nuances and experiences of the stigma perceived by PWLE, since stigma seems to be contextually dependent (Reinka et al., 2024). Additionally, the conceptualization of mental health stigma and its scientific knowledge and implications appear unclear (Fox et al., 2018). Few studies have allowed PWLE to share their perspectives on the stigma they experience through qualitative research methods (for an exception, see: Gronholm et al., 2024; Lewis et al., 2025). An example of a qualitative study is Subu et al. (2021) work, where PWLE in Indonesia reported feeling ostracized by others, including family. Some believed others avoided them due to the misconception that mental health conditions are contagious, leading PWLE to feel ashamed of their condition, exacerbating their suffering. This use of qualitative methods is particularly significant because it can provide valuable insights that may create awareness, reduce stereotypes, and thus help shape healthcare practices and policies. As Stutterheim and Ratcliffe (2021) state, qualitative studies are a type of participatory method

that provides significant opportunities for meaningful community engagement, promoting empowerment, and addressing power imbalances to reduce mental health stigma.

This exploratory, qualitative, cross-sectional, online study aims to innovate the scientific literature by disseminating the voices of PWLE of varying ages and genders, exploring how they experience stigma in their daily lives and how they perceive and understand the agents involved in discrimination. Therefore, consolidating the intersectionality of age and gender supports a diversity mission aimed at reducing mental health-related stigma through a nuanced approach. This study is designed to address the research question: "What are the lived experiences of stigma and discrimination among people with lived experiences of mental health conditions (PWLE)?"

Materials and methods

Participants

A total of 182 Portuguese adults aged 18–64 ($M = 35.6$, $SD = 13.4$) who self-identified as having mental health conditions took part in this exploratory, qualitative, cross-sectional, online study. Regarding gender, 147 self-identified as women (80.8%), 31 as men (17%), 2 as non-binary people (1.1%), and 2 stated "I prefer not to say" (1.1%).

Regarding the status of mental health conditions, 119 participants reported currently experiencing these problems (65.4%), while 63 reported having experienced mental health conditions in the past (34.6%). The mental health conditions identified by the participants have undergone summative content analysis (codification) and are presented in Table 1.

Dataset generation

This study is part of a larger project focused on understanding and reducing mental health-related stigma. The current study employed a cross-sectional, qualitative design and was approved by the relevant ethics committee. The survey was set up and hosted on the secure platform Qualtrics (Provo, UT, USA). The research team asked other researchers and laypeople to test it to ensure the language was simple and concise. They were also asked to assess its usability and functionality in various web browsers. Subsequently, the fourth author and other research team members distributed the survey link using a non-probabilistic snowball-like method. This online data-generating approach was used to gather answers from people in diverse, geographically dispersed locations (Braun et al., 2017) and facilitate quick data generation. Importantly, the use of open-ended responses aimed to enable participants to express their experiences in their own words, aligning with the exploratory nature of the research question and the focus on subjective meaning-making. Additionally, this dataset generation method may promote both disclosure and participation due to the social comfort of answering outside of a face-to-face context, as its flexibility is particularly suitable for PWLE (Braun et al., 2021).

Table 1. Frequency of codes regarding the mental health conditions (summative content analysis).

Codes (n)
Anxiety disorders ($n = 119$)
Mood disorders ($n = 90$)
Burnout ($n = 27$)
Neurodevelopmental disorders ($n = 16$)
Substance-related and addictive disorders ($n = 6$)
Trauma -and stressor-related disorders ($n = 5$)
Eating disorders ($n = 4$)
Personality disorders ($n = 3$)
Sleep-awake disorders ($n = 2$)
Obsessive-compulsive and related disorders ($n = 2$)
Psychotic disorders ($n = 1$)

The study announcement was posted between January and July 2024 on social media by the fourth author, on the project website, and on university student platforms, outlining the study's objectives, inclusion criteria (described below), and the survey link. The link directed participants to a landing page containing the study's general description, information about the authors (e.g., as having clinical experience), the study's objective, and informed consent details (e.g., no monetary compensation). Participants were required to review the informed consent form carefully and either provide explicit consent to participate or contact the research team with any concerns they could have. We provided a list of free mental health services, namely helplines, and the research team's contact information for participants who might find it helpful or necessary to seek professional assistance. This list of mental health resources was available at the beginning and end of the questionnaire. The survey included questions about sociodemographic characteristics, such as age and gender.

Additionally, after answering if they had ever, or not, experienced stigma or discrimination related to their mental health condition, people were invited to openly write and share their experience by answering the following open question: "Can you briefly describe the experience, namely, how these behaviors were manifested and who were the agents?"

The present study had several inclusion criteria, namely: (1) understanding Portuguese, (2) being at least 18 years old, and (3) self-reporting a current or past mental health condition. There was no specific requirement for the number of participants, as qualitative studies can often yield rich data with smaller samples (Braun et al., 2021; Sim et al., 2018). All IP addresses and geolocalizations were removed from the database, and only the research team was granted access to the password-protected database. This study was approved by the relevant ethics committee.

A total of 185 PWLE responded to the study protocol. However, two participants were excluded (1.1%) because they did not report a mental health condition per se (e.g., indicating 'marital problems'), and one participant was excluded (0.5%) for not answering the open-ended question. Therefore, 182 responses were included in the analysis.

Data analysis

We used summative content analysis (Coe & Scacco, 2017; Hsieh & Shannon, 2005) to understand participants' mental health conditions, followed by reflexive thematic analysis (Braun et al., 2021) to explore patterns of meaning in the answers to the research question. Reflexive thematic analysis is subjective and, therefore, is inevitably influenced by our clinical psychology training, experience in public and private mental health settings across different age groups and social backgrounds, and our shared interest in stigma-related content. This can be seen as an advantage, as these experiences may help us identify data patterns and draw meaningful conclusions with clinical implications.

We used an inductive approach, involving the development of broader generalisations from specific data content (Alhojailan, 2012), with the first author coding the data in semantic and latent ways. The third and fourth authors met with the first author to discuss the data in a colaborative process aimed at enriching our reflections (Braun et al., 2021). The process continued until a coherent and representative data report was agreed upon. The meaning of the answers was thoroughly understood using a data-driven and contextual approach to critically understand people's specific contexts (Braun & Clarke, 2022). We divided participants into two age groups: (1) 18–44 years and (2) 45–64 years, as in other studies (e.g., Yap et al., 2021).

For the reflexive thematic analysis, we excluded the responses from people who reported never experiencing stigma or discrimination. However, we did analyze answers from people who reported not experiencing it because they actively avoided it because stigma avoidance is associated with the experience of internalized stigma, which is another form of stigma related to mental conditions (Corrigan et al., 2010).

Despite Braun and Clarke's (2024) advise against separating the "Results" and "Discussion" sections, they reckon that specific journals may require it (Braun et al., 2021). So, we will follow the journal's instructions and incorporate distinct sections for "Results" and "Discussion."

In the "Results" and "Discussion" sections, themes will be presented in bold font, subthemes will be underlined, and quotes will be italicized. Each quote will be accompanied by a brief anonymous description:

participant's age, gender, mental health condition, and whether the participant reported currently experiencing mental health conditions (marked with an "[C]") or had experienced it/them in the past (marked with an "[P]").

Results

Participants wrote direct, informative, and rich responses about their life experiences of stigma and discrimination, although some elaborated more than others.

The participants' answers reflected an array of agents who stigmatized them. It is noteworthy that family was mentioned as an agent, but also as a safe context/setting where symptoms could be expressed or talked about and work as a comfort zone for some people (e.g., *Fortunately, I always had people around me* [family] *who encouraged and helped me*; 52 years old, woman, burnout [P]).

The codes regarding the agent of discrimination are presented in Table 2.

As a result of our reflexive thematic analysis, we established three interconnected themes: (1) **rationalizing their discrimination**, (2) **this is what we get when we mess with them**, and (3) **the perks of being a wallflower**. The first theme had three subthemes, whose underlying pattern refers to justifications that people use to support discrimination: (1) a different class, (2) a burden in the system, and (3) you reap what you sow. In the second theme, we created two subthemes that shared a pattern of social discrimination, harassment, and exclusion: (1) growing harassment and (2) it's not that bad!. In the third theme, we developed two subthemes that shared a common underlying meaning of strategies and circumstances to avoid stigma and discrimination exposure: (1) the mask becomes part of the face, and (2) passing as if I was normal, that is great!.

Figure 1 presents the final thematic map. Table 3 presents quotes and a brief description of each code. Where appropriate, some of the participants' sentences were slightly adjusted to ensure that the literal translation did not lose clarity. However, this was done in a way that preserved the original meaning. We will describe the subthemes developed in the text, along with the patterns developed.

Table 2. Codes regarding the agents of discrimination.

Agents	Examples quotes
Authorities	– *[. . .] police officers* (34 years, woman, depression [C])
Bosses	– *When I asked for a few days off work because I couldn't work, they pressured me and accused me of not going to work because I didn't want to because I wasn't trying hard enough to put up with the work* (40 years, woman, depression, anxiety and stress [C])
Family members	– *[. . .] mostly from people who are close to me, such as my family* (23 years, woman, anxiety [C])
Health professionals	– *I have experienced stigma and discrimination from a psychologist* (26 years, men, autism [C])
Peers	– *When I was in a very serious depression with suicidal ideation, I had some "friends" at the time who told me to slit my wrists vertically* (26 years, woman, depression and anxiety [C])
School colleagues	– *[. . .] from my school colleagues* (22 years, woman, anxiety and attention deficit hyperactivity disorder [C])
Teachers	– *Some teachers thought I was pretending to have panic attacks* (22 years, woman, anxiety [P])
Work colleagues	– *Perhaps in professional terms, because I refused to work too much outside of my working hours, and this was seen by my colleagues as a lack of willpower* (30 years, woman, anxiety and burnout [P])

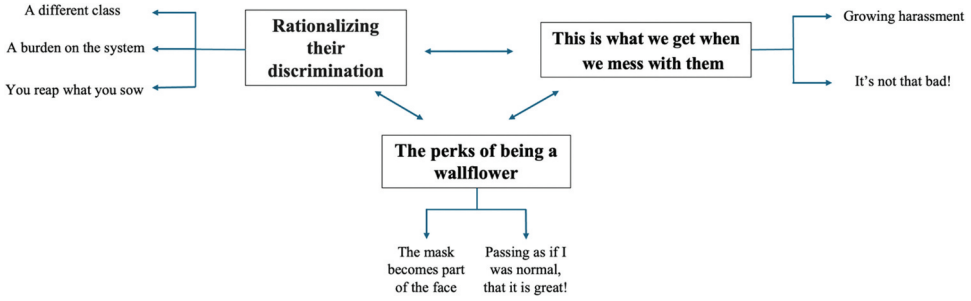

Figure 1. Final thematic map.

Table 3. Description of the reflexive thematic analysis.

Themes	Subthemes	Codes	Description	Examples quotes
Rationalizing their discrimination	A different class	Bad manners	This refers to the belief that PWLEs are often seen as having bad manners and being unpredictable.	– *Being seen as [. . .] rude by both friends and close family* (20 years, woman, social anxiety disorder [C])
		Madness	This refers to the belief that mental health conditions are seen as madness.	– *I have a family where there is a stigma that psychologists are for crazy people, that people with mental illnesses are crazy* (31 years, woman, borderline personality disorder, paranoid schizophrenia, depression, anxiety, and panic attacks [C])
		Inferiority	PWLE are often seen as inferior and weak when compared with people without mental health conditions.	– *My friends . . . I felt that they saw me in an inferior way, that they undervalued my problem, and that I was different from them* (30 years, man, anxiety and burnout [P])
		Condescending pity	This refers to the common belief that PWLEs have a reduced capacity to perform tasks or understand communication, so people often feel pity for them.	– *My family and doctors are paternalistic and think I have a diminished capacity to perform tasks and understand what people say to me* (53 years, man, depression and anxiety [C]) – *[...] Discrimination revolves around treating me and my son, who has autism, as poor children* (53 years, woman, depression and anxiety [P])
	A burden on the system	Laziness	This refers to people's beliefs about mental health conditions being an excuse for being lazy.	– *I suffer from stigma from my employer. When I asked for a few days off work because I couldn't work, they pressured me and accused me of not going to work because I didn't want to, because I wasn't trying hard enough to cope with the workload* (40 years, woman, depression, anxiety and stress [C]) – *When I'm on long-term sick leave, I'm seen as someone who doesn't want to do anything* (41 years, woman, generalized anxiety, depression and burnout [P])
		Incompetence	This refers to people misinterpreting behaviors associated with attention deficit disorder as signs of a lack of intelligence.	– *My schoolmates thought I was stupid [. . .]* (21 years, woman, attention deficit hyperactivity disorder [C])
	You reap what you sow	Age-related misconception	This refers to the misconception that young people do not experience mental health conditions.	– *[. . .] They [my family] say that I'm too young to have that kind of thing* (23 years, woman, anxiety [P])
		Responsibility of the person	PWLE stated that there seems to be a misconception about PWLE being completely responsible for their mental health conditions.	– *They think that depression goes away if you think positively, and when you don't get better, it's because you don't work hard* (34 years, man, depression and anxiety [P])
		A trend	This refers to the belief that mental health conditions are now fashionable.	– *When I was 18, I suffered a nervous breakdown [. . .] my family often comments that it's "fashionable" for young people to suffer from anxiety and mental health problems* (22 years, man, depression, anxiety, burnout, and trauma [C])
		Problem devaluation	This refers to the belief that the mental health condition of PWLE is not significant and that the person is overreacting.	– *They devalued my problem* (52 years, man, anxiety [C]) – *Both friends and family think it's no big deal and that it's just drama* (19 years, woman, depression and anxiety [C])
This is what we get when we mess with them	Growing harassment	Work-related discrimination/ harassment	This refers to the imposition of work-related tasks on PWLE despite them having the capability and certification to handle more challenging tasks.	– *I was given fewer challenging tasks by the head of service, despite having a certificate of ability to return to work* (37 years, woman, bipolar disorder [C])
		Distrust in the person with mental health conditions	PWLE reported that others lacked belief in their abilities due to their mental health condition	– *My work colleagues lack confidence in me* (58 years, woman, depression and anxiety, [C])

(*Continued*)

Table 3. (Continued).

Themes	Subthemes	Codes	Description	Examples quotes
		Disregarded in decision-making	PWLE expressed they often feel excluded from giving opinions.	– *Being ignored and excluded from decision-making or opinion by health professionals and family members* (42 years, woman, depression [C])
		Social exclusion	This refers to the experience of being intentionally excluded from social activities.	– *I have a son with mild cognitive impairment associated with autism spectrum disorder; I experienced depression and great anxiety at a certain period in my life. The stigma happens when [. . .] they [teachers] limit our presence at school events, for example, because it will disturb others* (53 years, woman, depression and anxiety [P]) – *Two relationships did not happen because they did not want to be involved with someone with mental health conditions* (20 years, woman, borderline personality disorder, [C])
		Mental health conditions as a manipulative tool used by other people	This describes the use of a person's mental health conditions by others to undermine their credibility and damage the child's relationship with the other parent.	– *My problem was used as a tool/strategy for parental alienation* (46 years, man, anxiety [C])
		Punishments due to the symptom's expression	Some participants reported that other people react negatively when PWLE symptoms manifest.	– *I was called dumb* (21 years, woman, attention deficit hyperactivity disorder [C]) – *I suffered from discrimination at school—I had difficulty sitting still and keeping quiet for so long. I received scoldings and punishments from teachers that I considered unfair* (64 years, woman, attention deficit hyperactivity disorder [C])
	It's not that bad!	Symptoms devaluing	This refers to the minimization or dismissal of a person's psychopathologic symptoms by others.	– *Some family members ignored and misunderstood me. They thought I was overly sensitive. They said: "Just think positive, and everything will be fine!" (45 years, woman, anxiety and burnout [P])*
		Lack of empathy	This refers to the experiences of the PWLE with other people who lacked empathy.	– *On the part of my previous partners, there was a lack of empathy and an inability to understand my avoidance behavior* (26 years, woman, panic disorder [C])
The perks of being a wallflower	The mask becomes part of the face	Symptoms concealment	Some participants indicated that they hide their mental health conditions to protect themselves from stigma and discrimination.	– *I never felt stigma because I disguised it well* (49 years, woman, depression [P]) - *I have never been stigmatized because I'm very careful in choosing the people I talk to about my depression and anxiety* (46 years, woman, depression and anxiety [C])
		Internalized stigma	Some participants report that although they do not feel stigmatized or discriminated against by other people, they do feel a sense of stigma themselves about their own condition.	– *I don't think I felt stigma or discrimination [by others]. Perhaps I still feel some stigma about my problem* (45 years, woman, depression, anxiety, and burnout [P])
	Passing as if I was normal, that is great!	Low severity of the symptoms	This refers to the lack of experience of stigma due to the mild nature of some people's mental health conditions; these symptoms often go unnoticed, making them "invisible" to other people.	– *I never felt stigma because my depression was slight [. . .]* (56 years, man, depression [P])
		Symptoms in a safe environment	Experiencing acute distress after a violent incident is a typical and understandable response, given the context and severity of the situation. For this reason, some participants indicated that they did not feel stigmatized by these acute situations.	– *I have never been stigmatized because I've had symptoms at times of serious illness and family loss* (59 years, woman, anxiety and burnout [C]) hich wasn't my fault (43 years, woman, anxiety [P])

Rationalizing their discrimination

This theme encompasses the arguments, beliefs, and rationales that PWLE perceive to exist about their place in society, their characteristics, values, and responsibilities. As indicated by the participants, other people perceive them to belong to a different class due to their inability to conform to the established social norms. This is attributed to their perceived lack of social skills, unpredictability, and laziness. As a result of these perceived characteristics, PWLE are often regarded with condescension and pity. These characteristics that render PWLE less capable also mean that they lack the profiles that contribute to the capitalist system, being a burden to the system. However, they are also seen as responsible for their condition because they are following fashions and are overreacting, as described in the subtheme you reap what you sow.

This is what we get when we mess with them

Participants revealed that some people engage in tangible actions directly related to PWLE mental health. This phenomenon occurs in various contexts, e.g., some people exploit the PWLE conditions as a means of workplace harassment, while others employ them as a strategy for parental alienation, as shown in the subtheme growing harassment. These behaviors are predicated on the assumption that their conditions are not severe. Other people also tend to minimize or dismiss the PWLE psychopathological symptoms, indicating a lack of empathy toward them, as shown in the subtheme it's not that bad!.

The perks of being a wallflower

In this theme, participants discussed strategies to avoid stigma and discrimination. In the subtheme, the mask becomes part of the face, they discussed active efforts to conceal their condition. Furthermore, the participants recounted their personal experiences of internalizing stigma related to their condition and employing strategies to prevent others from experiencing the same feelings toward them. Other participants noted that, due to the moderate nature of their symptoms, their visibility is limited to acceptable contexts, allowing them to be perceived as ordinary people, free from the burden of stigma or discrimination, which is exemplified in the subtheme passing as if I was normal, that is great!.

Reflexive analysis of participants' answers considering age, gender and the intersection of age-gender

Participants aged 18–44 reported a significant experience of stigma and discrimination. Conversely, although those aged 45–64 reported that they did not always experience stigma and discrimination, they had a significant use of coping strategies to manage or avoid these experiences.

Notably, the patterns of the theme **rationalizing their discrimination**, subtheme you reap what you sow, were predominantly reflected in the answers of people aged 18–44.

Regarding patterns of gender and experience of stigma, men reported that they are targeted for discrimination because they are perceived as responsible for their condition, follow mental health conditions fashions, and their problems are not considered serious. This falls under the theme **rationalizing their discrimination**, subtheme you reap what you sow.

Participants who identified as women reported that they are discriminated against due to the overreacting to the problem and because they are seen as crazy and rude, which also falls under the theme **rationalizing their discrimination**, subthemes you reap what you sow and a different class. Also, women reported patterns of being discriminated against in the work context, which falls into the theme **this is what we get when we mess with them**, subtheme growing harassment.

Regarding the intersection of age-gender among participants who identified as men, answers from those aged 18–44 predominantly indicated a theme of **rationalizing their discrimination**, specifically within the subtheme you reap what you sow. Those participants reported patterns of facing stigma and discrimination due to the invalidation of their mental health conditions by others, highlighting that society often holds men in this age range more accountable for their mental well-being. Conversely, a clear pattern was developed among the answers of men aged 45–64, meaning that others hold condescending attitudes toward men in

this age frame. This is captured under the theme **rationalizing their discrimination**, in the subtheme a different class.

Regarding the intersection of age-gender among participants who identified as women, the younger group of women (aged 18–44) showed a pattern of answers focused on being perceived as too young to have mental health conditions, portrayed in the theme **rationalizing their discrimination**, subtheme you reap what you sow. Also, their conditions seem to be trivialized by others, reinforcing the notion that they are either invalid or non-existent. This can result in women facing personal attacks related to their condition, such as being attributed negative characteristics directly (e.g., madness). These results align with the theme of **rationalizing their discrimination**, subtheme a different class. Conversely, our analysis of women aged 45–64 uncovered a noticeable trend of feeling marginalized (i.e., socially excluded) in various contexts stemming from their mental health conditions.

In comparing the experiences of men and women aged 18–44, both groups report feeling invalidated regarding their mental health conditions by others. However, men in this age group seem to perceive that society holds them responsible for their conditions, while women seem to experience judgment as too young to have problems or that their conditions are dismissed as mere "madness."

When examining the responses of men and women aged 45–64, it appears that men in that age group often face condescending attitudes from others. On the other hand, women in the same age group tend to experience a greater sense of others isolating them due to their mental health conditions.

When comparing men aged 18–44 with women aged 45–64, it becomes evident that there is a pattern of answers regarding younger men experiencing minimization of their mental health conditions, while older women seem to face social exclusion as a result of their conditions.

Lastly, when analysing at the responses of women aged 18–44 compared to men aged 45–64, the younger women also report feelings of minimization and personal attacks related to their mental health conditions. Meanwhile, patterns in the answers of men aged 45–64 showed that they seem to encounter condescending attitudes from others.

Discussion

We used a reflexive thematic analysis framework for data analysis to understand the experiences of stigma and discrimination of PWLE in Portugal. We created three themes: (1) **rationalizing their discrimination**, (2) **this is what we get when we mess with them**, and (3) **the perks of being a wallflower**. The findings indicated that the experience of stigma can be intersectional and related to sociodemographic factors such as age and gender, which may contribute to negative perceptions and unjust treatment of these people.

Some participants did not provide detailed answers, but some mentioned they had never experienced stigma or discrimination, without further explanation. Since the mean age of this study's participants was 35.6 years, this absence of stigma and discrimination might be due to the recent implementation of more effective mental health educational programs in Portugal (Gonçalves et al., 2015; Waqas et al., 2020). Indeed, research in Portugal has demonstrated that younger individuals exhibit fewer negative attitudes toward PWLE than their older counterparts (Almeida et al., 2023). This may be attributed to the younger generation's greater mental health literacy (Andrade et al., 2014; Farrer et al., 2008). Additionally, the increased use of technologies (e.g., social media) may have helped normalize mental health conditions (Parrott et al., 2020), as it can increase public awareness of them (Reinka et al., 2024). Other potential explanations may include the difficulty some participants may encounter in disclosing these experiences or their limited awareness of them.

Some participants indicated that they experienced discrimination from their families, while others reported receiving significant support from them. The process of acceptance from family members is important, as it can act as a motivator for therapeutic change (Mahomed et al., 2019) and prevent mental health relapse (Burton et al., 2023). This finding is promising as other studies have shown that families can support recovery by, for example, providing social support, monitoring symptoms, and fostering medication adherence when needed, as well as by legitimising and validating individuals' feelings and perspectives, facilitating engagement in community activities, and assisting with financial management (Chronister et al., 2022). However, attitudes toward mental health from family members have been reported as both facilitators and barriers to PWLE help-seeking (Radez et al., 2021). For example, adolescents may hesitate to

pursue professional assistance due to fears of distressing their families (Wu et al., 2016), making family support a key to help-seeking and mental health improvement. Considering the stigma often faced also by family members of PWLE (Dobener et al., 2022), implementing targeted interventions for them could be vital (Hussain et al., 2024) to boost the chances of improvement for PWLE.

Our analysis indicated that participants aged 18–44 likely encountered stigma and discrimination and used limited coping strategies to manage or avoid it. Conversely, participants aged 45–64 indicated that they frequently employ these coping strategies. This suggests that older people may have learned to conceal their conditions to escape stigma, possibly due to higher levels of internalized stigma (Chronister et al., 2013). This finding is consistent with the *Modified Labelling Theory*, which shows that hiding their condition is a coping mechanism to prevent stigma experiences (Link et al., 1997). This could also indicate that younger participants may not have developed these coping strategies, possibly due to a lack of resources or understanding of their significance.

The you reap what you sow subtheme patterns were predominantly reflected in the answers of people aged 18–44, independently identifying as men or women. This may indicate that the age of PWLE may be a factor that influences how mental health conditions are stigmatized, with younger people potentially being perceived as more responsible for their conditions, as there is less acceptance of these conditions among this age group. Indeed, a systematic review (Radez et al., 2021) indicated that young people are often reluctant to seek professional help, partly due to the belief that their condition is not serious enough (Hassett & Isbister, 2017). This perception should be considered, as it may reduce the likelihood of younger people seeking help early.

Analysis of answers from men aged 18–44 and 45–64 revealed that younger men often feel their mental health conditions are denied or minimized, leading to a sense of blame and delegitimization. Young masculinity is linked to strength and independence (Courtenay, 2000), so vulnerability, which is associated with femininity (e.g., Griffith et al., 2016), may be perceived as failure, contributing to feelings of blame regarding their mental health. In contrast, older men experience overprotection, seen through a paternalistic lens, suggesting diminished competence, which we hypothesize results from their inability to exhibit characteristics typically associated with masculinity, such as emotional repression and "being strong" (Camacho-Ruiz et al., 2026). Due to their perceived lack of competence, others may wish to help them. For women aged 18–44 versus those aged 45–64, younger PWLE women are frequently labeled as mad, leading to perceptions of being exaggerating mental health issues, which may reinforce stereotypes that self-identification drives ulterior motives (Ansell et al., 2024). These trends indicate age-gender implications for mental health stigma, prompting further research in the field.

The first theme, **rationalizing their discrimination**, evidenced patterns of justification used to ground discrimination. Consistent with previous research, explicit stigma persists, with many people holding negative stereotypes about PWLE, like beliefs that they are socially inadequate, less competent, and responsible for their condition (e.g., Corrigan & Watson, 2002). Many people attribute mental conditions to factors like trendiness, personal weakness, or failure rather than recognizing biological or environmental causes (Pescosolido et al., 2010). This can exacerbate stigma, implying that PWLE are to blame for their condition (Hinshaw & Stier, 2008). Curiously, our analysis demonstrates that men are seen as responsible for their conditions, while women are often seen as crazy and rude. This can happen due to gender stereotypes, like, as stated before, the belief that men are supposed to be competent and in control, while women are more likely to be portrayed as emotional (Prentice & Carranza, 2002). In fact, the literature shows that the relationship between stigma stereotypes, mental health conditions and gender intersects (Boysen et al., 2014), which may influence the discriminatory behaviors toward the PWLE. Together, this indicates that societal attitudes toward mental health vary between men and women, suggesting that the gender of PWLE can serve as a context for legitimizing stigmatization.

The second theme, **this is what we get when we mess with them**, demonstrated patterns of harassment that PWLE face, highlighting the impact on their career progression, job security, and overall well-being (Corrigan & Watson, 2002). Literature shows that PWLE may face hostile work environments, including derogatory remarks, isolation, and unfair treatment like bullying or ostracism by colleagues or bosses who see them as less capable (Hansson et al., 2014). This study's participants noted social exclusion, distrust, and disregard in decision-making as common forms of discrimination, highlighting barriers that hinder PWLE

from engaging in community life and accessing resources (Rüsch & Thornicroft, 2014). As such, PWLE may face verbal, physical, and emotional harassment due to stigma (Rüsch et al., 2005). Consequently, the fear of harassment can worsen their mental health and make it harder to seek professional help, exacerbating the condition and increasing treatment costs (Brohan et al., 2012; Hansson et al., 2013). As stated by the study participants, it is important to note that even healthcare providers may discriminate against PWLE (Jauch et al., 2024), highlighting the risk of health professionals acting as vehicles for promoting stigma.

Finally, the third theme, **the perks of being a wallflower**, focused on patterns of concealment strategies that PWLE may use to avoid stigma, which may be associated with internalized stigma (Chronister et al., 2013). However, employing concealment strategies may have negative consequences, as they can lead to a rebound effect: the act of hiding one's condition can result in increased psychological distress (Elliott & Doane, 2015), a central factor in the development and maintenance of mental health conditions. Additionally, it heightens psychological processes such as worry and increased vigilance (Pachankis, 2007), which, in turn, may perpetuate and exacerbate conditions such as anxiety and depression (e.g., Vîslă et al., 2022). Moreover, the act of concealing one's mental condition may contribute to the perpetuation of stigma, as a reduction in the disclosure of mental health may result in a lessening of the normalization of these conditions (Bersani & Chiaie, 2021), underlining the maladaptive side of these strategies.

To conclude, this study allows us to disseminate the voices of PWLE and highlights the pervasive nature of stigma and discrimination they face, as well as its intersection with age and gender. By understanding their real-life experiences, we can better inform public policies and design targeted interventions to uphold their rights, dignity, and citizenship (Stutterheim & Ratcliffe, 2021). Further research and intervention, such as peer support, mental health services, anti-stigma campaigns, contact-based programs, community engagement initiatives, institutional guidelines, and public policies, are needed to improve mental health literacy and foster acceptance of PWLE (Waqas et al., 2020; Wong et al., 2018).

Limitations and future studies

A study limitation is the inability to confirm if participants had a formal mental health diagnosis. Additionally, we lack information on the history and progression of their clinical conditions, which could have allowed for a more biographical and narrative data contextualization. In terms of the age-gender analysis, we do not know whether it represents people's real experiences of stigma and discrimination or if their perceptions about it evolve with age. Future studies should consider these aspects. Developing research about the experiences of stigma and discrimination of PWLE with greater intersectionality (e.g., exploring ethnicity and income; Siena et al., 2024) and in different socio-cultural contexts is also recommended.

Contributions and conclusions

This study shows that PWLE experiences an atmosphere of legitimation of mental health stigma by recognizing that there is a system of coherent rationalization about mental health and actions that result in fewer opportunities that can only be overcome by using maladaptive coping strategies, such as concealment of their mental health status. It innovates by showing that experiences of stigmatization may be different for PWLE in different age frames and genders, calling attention to the need to develop prevention and mitigation strategies that consider these specificities and nuances to erase the stigma and its impact. Awareness and prevention need to consider the multiple sources of stigmatization and emphasize the role of family members as safe havens.

Acknowledgments

The authors would like to thank all who participated in this study.

Author contributions

All authors have read and agreed to the published version of the manuscript.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This study is funded by La Caixa Foundation (LCF/PR/SR22/52570002) and by Fundação para a Ciência e Tecnologia (FCT), under HEI-Lab R&D Unit (UIDB/05380/2020, https://doi.org/10.54499/UIDB/05380/2020).

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Data availability statement

The data presented in this study can be available at the request of the corresponding author.

Ethical approval

The study was conducted following the Declaration of Helsinki and approved by the Ethical and Deontological Committee for Scientific Research of the School of Psychology and Life Sciences (CEDIC) of Lusófona University in Lisbon.

Informed consent statement

Informed consent was obtained from all subjects involved in the study.

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