Social Science & Medicine 181 (2017) 177–183

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Socio-psychological mediators of the relationship between behavioral health stigma and psychiatric symptoms

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ARTICLE INFO

Article history:
Received 28 October 2016
Received in revised form
22 March 2017
Accepted 23 March 2017
Available online 24 March 2017

Keywords:
Stigma
Substance abuse
Addiction
Mental health
Mental illness
Mediators
Modified Labeling Theory
African American

ABSTRACT

The stigma associated with mental illness or addiction is significantly and positively related to psychiatric symptoms. According to Modified Labeling Theory, several processes should mediate this relationship, including rejection experiences, stigma management (secrecy coping), and social support. In the first comprehensive test of this theory, we examined a serial mediation model on three waves of data from 138 adults receiving outpatient behavioral health treatment.

Participants were recruited from outpatient behavioral health clinics in a large northeastern city in the United States and completed interviews that assessed stigma, rejection experiences, stigma management, social support, and psychiatric symptoms. There was a direct effect between stigma and psychiatric symptoms and an indirect effect in which perceived rejection, secrecy coping and social support sequentially and longitudinally intervened in the stigma and psychiatric symptom relationship. Higher perceptions of stigma predicted more rejection experiences, which marginally increased secrecy coping and decreased social support. In turn, decreased social support increased psychiatric symptoms. We provide support for Modified Labeling Theory and the clinical utility of specific mediators in the relationship between stigma and psychiatric symptoms among adults in behavioral health treatment living in urban settings.

1. Introduction

Stigma has a pervasive and continuing impact on the lives of individuals who have mental illness and/or addiction challenges. Stigma refers to a discrediting attribute or status that is carried by an individual (Goffman, 1963; Link and Phelan, 2001) that may increase experiences of rejection and/or discrimination, and ultimately limit opportunities for health and well-being (Link and Phelan, 2001). Stigma may be internalized, to varying degrees, by individuals if they believe the negative biases about their group (Glass et al., 2013b; Hatzenbuehler et al., 2013; Link and Phelan, 2001; Livingston and Boyd, 2010). In this paper, public stigma refers to social and cultural stereotypes related to group membership; felt or experienced stigma refers to specific experiences of rejection and discrimination that result from group membership; and self-stigma occurs when an individual internalizes and accepts societal views and incorporates them into one's belief system and values (Livingston and Boyd, 2010).

Modified Labeling Theory (MLT; Link et al., 1989) provides a framework for understanding the mechanisms through which stigma affects health and well-being, with a particular focus on psychiatric symptoms. Modified Labeling Theory consists of a five-step model – Beliefs, Official Labeling/Internalization, Response, Consequences, and Vulnerability – that was developed to describe how labeling affects individuals diagnosed with a mental illness (Link et al., 1989). As shown in Fig. 1, a person not yet diagnosed with a mental illness or addiction becomes aware of socially- and

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http://dx.doi.org/10.1016/j.socscimed.2017.03.049
0277-9536/

culturally-constructed beliefs about mental illness or addiction, and thus may perceive individuals who experience these challenges as devalued by society (Step 1; Beliefs). This public stigma reflects an awareness of societal and cultural views of those with mental illness and/or addiction. When an individual receives a diagnosis of a mental health or substance use disorder, the individual is assigned a formal label (Step 2; Official Label and Internalization), and may internalize the negative stereotypes related to that label because the person is now part of the stigmatized group. An official label provides the individual with an opportunity to connect public social and cultural stereotypes about the group to the self, which may result in internalization of the negative attributes associated with the label (Link and Phelan, 2001). For those so labeled with mental illness or addiction, internalized stigma has been associated with decrements in quality of life, self-esteem, self-efficacy, empowerment, and social support (Boyd Ritsher et al., 2003; Corrigan et al., 2006; Link and Phelan, 2001; Link et al., 2001; Link et al., 1997). Research also indicates that internalized stigma exacerbates psychiatric symptoms (Boyd Ritsher et al., 2003; Glass et al., 2013b; Link et al., 1997; Livingston and Boyd, 2010; Lysaker et al., 2007), and a recent meta-analysis showed that increased internalized stigma is related to greater psychiatric symptoms and poor treatment outcomes (Livingston and Boyd, 2010). In addition, higher internalized stigma for alcohol abuse was related to an increased risk for persisting alcohol use disorder and internalizing psychiatric symptoms (Glass et al., 2013b).

Individuals who are assigned a formal label and internalize the stigma associated with that label may have a heightened awareness for, or more experiences of, rejection or discrimination due to stigma (Hamilton et al., 2014). For example, experienced stigma in the form of rejection and discrimination has been found to predict depressive symptoms one year later among men with co-occurring mental illness and addiction (Link et al., 1991). Experienced stigma may lead to various coping responses, such as an attempt to keep one's labeled status secret or hidden (Step 3; Response). The strategies individuals use to cope with or manage experienced stigma, or stigma management, may reduce, buffer, or exacerbate the impact of stigma (Link et al., 1989; Link et al., 1991). A key stigma management strategy is secrecy, in which one attempts to hide a stigmatized status. For individuals in treatment for substance use disorder, high use of secrecy was negatively associated with indicators of well-being and also related to high internalized stigma (Luoma et al., 2007). In addition, secrecy has been found to mediate the relationship between social stigma, internalized stigma, and mental health recovery (Chronister et al., 2013). Importantly, given the paucity of longitudinal research on Modified Labeling Theory, we know little about the specific pattern of, or the relative impact of, these mediators in the stigma – symptom relationship.

Maladaptive coping strategies may make it less likely that the labeled person receives social supports and other resources that are critical for symptom reduction (Step 4; Consequences). Social support has long been established as a buffer of varying forms of stress (Berkman et al., 2000; Broadhead et al., 1983; Cohen and Wills, 1985; Kessler et al., 1985; Milner et al., 2016), although other studies have reported inconsistent findings depending on the type of perceived or received supports (i. e. Brondolo et al., 2009). Research has also shown that high internalized stigma is related to lower social support among individuals diagnosed with an alcohol use disorder (Glass et al., 2013a). These findings suggest that social support may be a critical resource that can reduce the negative effects of stigma on health outcomes, specifically psychiatric symptoms. Finally, with diminished social supports, the person with mental illness or addiction may be at increased risk for further psychiatric symptoms or relapse (Step 5; Vulnerability).

Although several studies have examined components of Modified Labeling Theory (i.e., Kroska and Harkness, 2006; Link et al., 1989; Glass et al., 2013b), none to date have examined rejection-related experiences, secrecy coping, and social support as sequential mediators of the relation between public stigma and psychiatric symptoms. Further, there is a dearth of longitudinal studies on stigma, as most research has been cross-sectional (Livingston and Boyd, 2010). The few longitudinal studies that do exist often examine changes in stigma as a predictor of well-being, as indicated by self-esteem and recovery-related outcomes (Livingston and Boyd, 2010). To date, a comprehensive longitudinal test of the patterns of relations for the constructs in Modified Labeling Theory (Link et al., 1989) has not yet been conducted (Glass et al., 2013b). Such a test is essential to identify the theoretical socio-psychological processes through which stigma operates so as to affect long-term outcomes of individuals with a mental illness or addiction label, and to advance theory, research, and practice on stigma.

1.1. The present study

The present study analyzes longitudinal data to examine public stigma (Time 1) and its relationship to psychiatric symptoms (Time 3) as sequentially mediated by rejection experiences, secrecy coping and social support (Time 2) among low income, mostly minority adults who have been labeled with mental health and/or substance use disorders. This analysis examines longitudinal patterns among the constructs in Modified Labeling Theory (Link et al., 1989) for individuals in outpatient treatment for mental illness and/or addiction, thus providing the basis for subsequent examination of causal pathways among these constructs. We hypothesize that public stigma will be internalized and will predict rejection experiences, which will be related to more use of secrecy coping. Secrecy coping, in turn, will be related to lower social support, which will predict higher psychiatric symptoms over time. In addition, since we expect that gender, race, and psychiatric treatment will influence mediators and outcome variables, we control for these effects.

2. Method

2.1. Participants

The present study included 138 participants receiving mental health and/or addiction treatment who were available for three

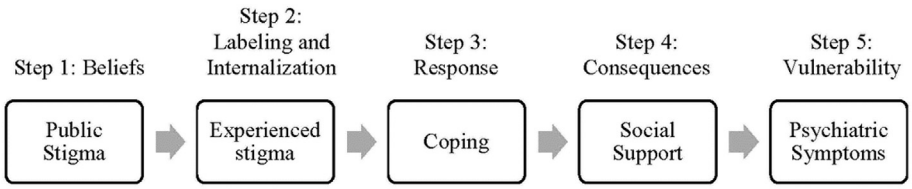

Fig. 1. Modified Labeling Theory.