

Stigma, social function and symptoms in schizophrenia and schizoaffective disorder: Associations across 6 months

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Abstract

Research suggests stigma is a barrier to self-esteem and the attainment of resources in schizophrenia. Less clear is the association of stigma experiences with symptoms and social function both concurrently and prospectively. To assess this, symptoms were measured using the Positive and Negative Syndrome Scale, social function was measured using the Quality of Life Scale and stigma experience was assessed using the Internalized Stigma of Mental Illness Scale among 36 persons with schizophrenia at two points, 6 months apart. Correlations found stigma was associated with concurrent levels of positive and emotional discomfort symptoms and degree of social contact. When initial stigma levels were controlled for, stigma at 6 months was predicted by baseline levels of positive symptoms. Greater initial stigma predicted greater emotional discomfort at follow-up. Results suggest internalized stigma is linked with social function and symptoms. Positive symptoms may make some persons with schizophrenia more vulnerable to ongoing stigma experience.

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1. Introduction

Population surveys indicate that, despite increased awareness of the nature of schizophrenia spectrum disorders (Swindle et al., 2000), many among the general public hold stereotyped beliefs about persons with these conditions including expectations of violent and disorderly behavior, and an inability to sustain employment or

make informed decisions (Markowitz, 1998; Link et al., 1999; Pescosolido et al., 1999; Phelan et al., 2000). A matter of great importance, stigma may incline persons in the general public to seek social distance from those with schizophrenia (Angermeyer and Matschinger, 2003; Martin et al., 2000) and represent a barrier to meeting basic needs (Link et al., 1989; Wahl and Harman, 1989). Stigma can interfere, for instance, with obtaining work (Bordieri and Drehmner, 1986; Link, 1987), housing (Page, 1983) and/or negotiating with the legal system (Sosowski, 1980). Stigma may also possibly encourage persons to embrace self-fulfilling prophecies of failure (Ritsher et al., 2003; Ritsher and Phelan, 2004;

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Thompson, 1988; Warner et al., 1989; Wright et al., 2000) and has been suspected to be connected to suicide in schizophrenia (Siris, 2001).

While stigma against the mentally ill has been linked to decrements in role function and morale, it remains less clear whether stigma is linked with symptoms and interpersonal relations. Do certain symptoms or patterns of social function increase vulnerability to accepting stigmatizing beliefs? For instance, with heightened levels of positive or affective symptoms, do persons tend to be more accepting of stigma? Considering the converse: as persons increasingly internalize stigma, are they more likely to experience increases in symptoms or decrements in psychosocial function?

We suggest there are several reasons to speculate that stigma may influence and be influenced by symptoms and social relations over time. For one, stigma may drive persons away from society and incline them towards non-adherence to medication (e.g. Katschnig, 2000; Freudenreich et al., 2004; Lloyd et al., 2005). Such behavior can lead to a number of problems, both for the individual and in terms of others' perceptions. Torrey (2004) proposes that, while there is not a linear relationship between medication noncompliance and violent behavior, treatment non-adherence is related to violent behavior and such behavior perpetuates stigma of those with severe psychiatric disorders. Thus, perhaps as persons internalize stigma, they withdraw and with greater stress and fewer supports experience exacerbations in their symptoms. It is also possible to imagine that, as symptoms and/or social dysfunction reach a certain level, they may identify persons with schizophrenia as mentally ill to others, making them vulnerable to stigma. Perhaps too as persons become more symptomatic they despair and are more likely to accept negative beliefs about themselves. Therefore, as symptoms and dysfunction worsens perhaps, there is also greater internalization of stigma.

Research to date on the association of clinical features of illness and stigma has been limited and equivocal, however. Dickerson et al. (2002) found stigma experiences linked to socioeconomic factors but not with positive or negative symptoms. Ertugrul and Ulug (2004) compared groups of persons with schizophrenia who had more severe vs. less severe stigma experience and reported the more severely stigmatized group had more severe symptoms. Penn et al. (2000) found that negative symptoms predicted the experience of discriminatory behaviors.

One limitation of this research has been its cross sectional nature. Furthermore, while measures of stigma assess stigma exposure, they do not necessarily assess

the extent to which persons internalize or accept stigmatizing beliefs. To address these issues, we have assessed stigma using an instrument, which includes a measure of internalization of stigma and resulting alienation along with symptoms and social function at two points in time. We reasoned this approach would allow us to assess concurrent relationships at two separate times and to see effects between time points, controlling for baseline. Specifically, we examined two hypotheses: (a) would measures of symptoms and social function predict levels of stigma 6 months later, controlling for baseline stigma level and (b) would levels of stigma predict symptoms and social function 6 months later, controlling for baseline symptoms and social function.

2. Materials and methods

2.1. Participants

Thirty-three males and three females with SCID (Spitzer et al., 1994) confirmed DSM-IV diagnoses of schizophrenia or schizoaffective disorder were recruited from a comprehensive day hospital at a VA Medical Center for a larger survey of the prevalence of anxiety symptoms in schizophrenia. All participants were receiving ongoing outpatient treatment and were in a post acute or stable phase of their disorder, defined as no hospitalizations or changes in medication or housing in the last month. Participants with history of mental retardation documented in a chart review were excluded. Participants had a mean age of 46.9 (S.D.=9.7), a mean educational level of 12.8 (S.D.=1.8) and a mean of 11.1 (S.D.=7.2) lifetime hospitalizations with the first occurring on average at the age of 23.7 (S.D.=7.2). Eighteen were Caucasians, 17 African American and one Latino. Twenty had schizophrenia and 16 had schizoaffective disorder. Nineteen were never married, 13 were divorced and four were married.

2.2. Instruments

2.2.1. Internalized Stigma of Mental Illness Scale

Internalized Stigma of Mental Illness Scale (ISMIS; Ritsher et al., 2003) is a 29-item paper and pencil questionnaire designed to assess subjective experience of stigma. It presents participants with first person statements and asks them to rate on a four-point Likert scale how much they agree or disagree. Items are summed to provide five scale scores: alienation, which reflects feeling devalued as a member of society, stereotype endorsement, which reflects agreement with negative stereotypes of mental illness, discrimination experience,

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