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Stigma-related stress, shame and avoidant coping reactions among members of the general population with elevated symptom levels

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Abstract

Background: It is unclear whether mental illness stigma affects individuals with subthreshold syndromes outside clinical settings. We therefore investigated the role of different stigma variables, including stigma-related stress and shame reactions, for avoidant stigma coping among members of the general population with elevated symptom levels.

Methods: Based on a representative population survey, general stress resilience, stigma variables, shame about having a mental illness as well as avoidant stigma coping (secrecy and social withdrawal) were assessed by self-report among 676 participants with elevated symptom levels. Stigma variables and resilience were examined as predictors of avoidant stigma coping in a path model.

Results: Increased stigma stress was predicted by lower general stress resilience as well as by higher levels of perceived stigma, group identification and perceived legitimacy of discrimination. More shame was associated with higher perceived legitimacy. Lower resilience as well as more perceived stigma, group identification and perceived legitimacy predicted avoidant coping. Stigma stress partly mediated effects of resilience, perceived stigma and group identification on avoidant coping; shame partly mediated effects of perceived legitimacy on coping. Stigma stress and shame were also directly and positively related to avoidant stigma coping. Analyses were adjusted for symptoms, neuroticism and sociodemographic variables.

Conclusions: Stigma may affect a larger proportion of the population than previously thought because stigma variables predicted secrecy and withdrawal among members of the general population with elevated, but overall mild symptom levels. Avoidant stigma coping likely has harmful effects, potentially exacerbating pre-existing psychological distress and undermining social networks. This highlights the need to reduce public stigma as well as to support individuals with subthreshold syndromes in their coping with stigma stress and shame reactions.

1. Introduction

1.1. Public stigma, shame, and stress coping reactions

The desire for social distance from people with mental illness has not decreased among members of the general public during the last decades [1]. Many people with mental illness, including common mental disorders such as depression, frequently experience discrimination [2]. Stigma is a broad concept and comprises negative stereotypes, prejudice (agreeing with the stereotypes incl. emotional reactions) and discriminating behavior. While stigma often unfairly prevents people from reaching important life goals due to discrimination by powerful

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others [3], it can also have internal consequences for the cognitive and emotional functioning of individuals with mental illness, two of which are relevant for the purposes of this study: shame and stress-coping reactions.

Shame is an aversive emotion based on a global negative self-evaluation and is associated with avoiding eye contact and the impulse to hide [4]. Shame about having a mental illness can be considered as the emotional side of self-stigma [5,6] which occurs when people with mental illness agree with public stereotypes and apply them to themselves [7]. Stress-coping models of mental illness stigma are based on the assumption that stigma does not affect individuals with mental illness as passive recipients. Its effects depend in part on individuals' perceptions of stigma-related harm and of personal resources to cope with this threat [8,9]. Stigma stress occurs when perceived harm due to stigma exceeds one's perceived coping resources and is associated with emotional reactions such as shame and anxiety as well as broader outcomes like reduced self-esteem and hopelessness [6,10].

If stigma can be a stressor, coping reactions are important. In a set of classic studies, Bruce Link and his colleagues investigated secrecy and social withdrawal as coping orientations in response to perceived stigma [11]. Although these coping reactions may help to avoid discrimination and its consequences in the short term, they usually have negative long-term consequences such as unemployment and demoralization [12] and are therefore an important outcome in itself. The choice between secrecy/withdrawal on the one hand and disclosure on the other hand is a key concern for many people with mental illness. Supporting them with their disclosure decisions is a focus of recent interventions to reduce stigma-related stress [13,14].

As shown by social psychological research, stigma's impact is further influenced by two factors, group identification and perceived legitimacy. First, if persons with mental health problems do not believe they have many things in common with people with mental illness, they are less likely to be affected by negative stereotypes about this group [15,16]. On the other hand and especially if individuals think highly of their own group, group identification may be a resource. A second factor is whether someone believes that discrimination against people with mental illness is fair, referred to as perceived legitimacy [17]. Among people with mental illness, perceiving stigma as fair was associated with reduced empowerment [18], impaired social performance [19] as well as with increased shame [20] and self-stigma [21].

Current diagnostic systems of mental disorders use a categorical yes-or-no approach and do not reflect the dimensional continuum between the extremes of perfect mental health and severe mental illness. Likewise, most stigma research so far has examined samples classified as either the general public without mental illness or as people with diagnosed mental illness. These dichotomies are unsatisfactory for two reasons. First, they are at odds with the concept that an artificial boundary between mental health and mental illness sets people with mental illness apart as a separate group, facilitating stigma [3], and at odds with recent findings that a continuum model of mental health may decrease stigmatizing attitudes [22]. Second, subthreshold depressive, anxiety and psychotic syndromes that do not fulfill diagnostic criteria are very common in the community and their negative clinical, social and economic consequences are well documented [23–25]. It appears likely that stigma's pernicious effects extend to that group, but we are not aware of previous research on this issue. We have therefore conceptual and empirical reasons to study the role of stigma variables for avoidant coping in a community sample, considering elevated symptom levels as a proxy of subthreshold syndromes. If stigma variables and shame lead to social withdrawal and secrecy in that group, stigma would affect a larger proportion of the population than previously thought.

1.2. Aims and hypotheses

The aim of this study was to assess general stress resilience and stigma variables (perceived public stigma, group identification, perceived legitimacy of discrimination) as predictors of avoidant stigma coping (secrecy and social withdrawal). We also examined stigma stress and shame as potential mediators of predictor effects on stigma coping (see Fig. 1). We expected (i) that lower general stress resilience as well as higher levels of perceived public stigma, group identification and perceived legitimacy would predict more avoidant stigma coping; and (ii) that stigma stress and shame would not only be positively related to avoidant coping, but also mediate effects of predictor variables on stigma coping.

2. Material and methods

2.1. Participants

All data were collected in the epidemiological survey of the ZInEP-study on the prevalence of common mental disorders in the Canton of Zürich, Switzerland [26,27]. By telephone, a sample of 9829 young to middle-aged Swiss participants completed a screening interview. General psychopathology was assessed by the Symptom Checklist 27 (SCL-27 [28]), yielding a global severity index with higher mean scores from 1 to 5 reflecting higher symptom levels. A 75th percentile cutoff of SCL-27 scores was used to divide the total sample into low and high scorers; from the high scorers a random subsample (n = 900) was drawn. This paper is based on those 676 high scorers for whom stigma data were available (for details see Ajdacic-Gross et al. [26] and Oexle et al. [29]). These 676 participants had a mean age of about 30 years, were 41% (n = 280) male and had on average mild symptom levels (M = 2.1, SD = 0.4). Compared to the n = 224 without stigma data (age M = 29.0, SD = 7.1; n = 90/40% female), the 676 participants with stigma data were slightly older (M = 30.1, SD = 6.6; T = −2.13, p = .03), included a higher proportion of women (chi-square 22.9, p < .01), but had very similar symptom levels (T = 0.01, p = .99). For other means and standard deviations