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Stigma resistance and its association with internalised stigma and psychosocial outcomes among psychiatric outpatients

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ABSTRACT

Studies have suggested that stigma resistance plays an important role in the recovery from mental illness. However, there has been limited research in Asian countries that has examined the benefits of stigma resistance among the mentally ill in Asian populations. Hence, this study aimed to assess the prevalence of stigma resistance and establish the socio-demographic correlates of stigma resistance, as well as its association with internalised stigma and psychosocial outcomes among a multi-ethnic population of 280 outpatients with obsessive compulsive disorder (OCD), schizophrenia, depressive disorders and anxiety disorders in Singapore. Prevalence of stigma resistance measured using the Stigma Resistance subscale of the Internalised Stigma of Mental Illness Scale was 82.9%. ANOVA and logistic regressions were conducted and results revealed that: (i) Stigma resistance was positively associated with being separated/divorced/widowed but negatively associated with depression diagnosis; (ii) Psychosocial outcomes such as self-esteem and psychological health were positively associated with stigma resistance; and (iii) Internalised stigma was negatively associated with stigma resistance. Moving forward, treatments could emphasize on improving the self-esteem and psychological health of patients to increase their stigma resistance for counteracting effects of public and internalised stigma.

1. Introduction

Within the context of mental health, public stigma is characterised by the general population endorsing beliefs that devalue people with mental illness (stereotyping), followed by developing unjustified attitudes towards them(prejudice) and thereafter exhibiting biased treatment which segregates them from the rest (discrimination) (Corrigan and Watson, 2002). According to modified labelling theory (MLT) (Link et al., 1989), societal perceptions influence an individual's beliefs on how people with mental illness are regarded i.e. a person with mental illness who perceives that people stigmatize those with mental illness will develop the belief that he will be discriminated against as well and might exhibit behaviours like secrecy and withdrawal to cope with this discrimination. As such, public stigma may lead people with mental illness to develop internalised stigma - they become aware of the public stigma, agree with it and apply the discriminated attitudes to themselves (Corrigan and Rao, 2012).

For those who have yet to seek treatment, the adverse consequences of internalised stigma include 'label avoidance' i.e. refusing any associations with mental illness which consequently results in treatment delays and/or is a barrier to help-seeking (Corrigan et al., 2014, 2009). For patients undergoing treatment, internalised stigma may impede the effectiveness of the treatment as well as the process of recovery as they immerse themselves in feelings of shame and self-devaluation, and subsequently withdrawing themselves from social activities (Amering et al., 2009). In general, high internalised stigma has been found to be associated with a reduction in hope, empowerment, self-esteem, quality of life (Livingstone and Boyd, 2010; Firmin et al., 2016), readiness to change and poor treatment adherence (Fung et al., 2008; Tsang et al., 2010) as well as increased severity of psychiatric symptoms (Livingstone and Boyd, 2010; Firmin et al., 2016). Given the negative outcomes associated with internalised stigma, efforts to alleviate it are needed.

Stigma resistance in mental health is described as the capacity to resist, counteract or otherwise remain unaffected by mental illness stigmatization (Ritsher et al., 2003). It has been identified to play a beneficial role in fighting against the internalisation process and is likely to facilitate the recovery from mental illness (Sibitz et al., 2011; Brohan et al., 2010b; Firmin et al., 2016). Sibitz et al. (2011) conducted a study among patients with schizophrenia, and found that greater stigma resistance was associated with reduced internalised stigma, greater self-esteem and improved quality of life. Similar conclusions

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were reached in Brohan et al. (2010b)'s study among patients with depression and bipolar disorder.

The stress-coping models of stigma illustrate that a stigmatised individual's wellbeing is challenged when they view the harm due to stigma (primary appraisal) to be exceeding their perceived ability to cope with the stigma (secondary appraisal) (Lazarus and Folkman, 1984). With stigma resistance, the appraisals might be more positive in which the stigmatised individual views stigma to be less harmful and is less affected, therefore, being more confident in their ability to cope with the stigma. This suggests that stigma resistance may help to deflect negative beliefs associated with mental illness (Thoits, 2011) and may act as a buffer against the internalisation of stigma.

While there is currently no individual scale to measure stigma resistance, the Stigma Resistance subscale of the Internalised Stigma of Mental Illness Scale (ISMI; Ritsher et al., 2003) has been commonly used. The Stigma Resistance subscale comprises 5 items that reflect positivity with regard to mental illness e.g. “I can have a good, fulfilling life, despite my mental illness”. Previous research has shown that the Stigma Resistance subscale is psychometrically distinct from internalised stigma and need not be included in the ISMI total score for analysis (Ritsher et al., 2003; Boyd et al., 2014; Chang et al., 2014).

To our knowledge, there has been limited research on the endorsement and associative factors of stigma resistance among Asian populations with mental illness. A recent study among Chinese patients seeking treatment from a psychiatric outpatient clinic at a general hospital in Taipei explored the relationship between internalised stigma, stigma resistance and psychosocial outcomes. The findings revealed that in contrast to those who endorsed internalised stigma, participants with higher stigma resistance reported better psychosocial outcomes, indicating that stigma resistance could be used to counteract the effects of internalised stigma (Lien et al., 2015).

Noting the potential ability of stigma resistance to counter internalised stigma, it would be beneficial to identify the contributing factors to stigma resistance so as to facilitate the development of appropriate interventions to address the issue of internalised stigma. The current study conducted in Singapore, a multi-racial global city with a resident population of 3.9 million comprising 74.3% Chinese, 13.4% Malays, 9.1% Indians and 3.2% Others (Statistics Singapore, 2016), aims to (1) assess the prevalence of stigma resistance among a multi-ethnic population of outpatients with obsessive compulsive disorder (OCD), schizophrenia, depressive disorders and anxiety disorders; and (2) establish the socio-demographic correlates of stigma resistance and its association with internalised stigma, self-esteem, quality of life and hope.

2. Methods

2.1. Study design and participants

This cross-sectional study was conducted from May 2014 to September 2015 at the Institute of Mental Health (IMH) and its affiliated clinics. IMH is the only tertiary psychiatric care hospital in Singapore. Ethical approval was obtained from the Domain Specific Review Board of the National Healthcare Group, Singapore. Participants of this study were adult outpatients seeking treatment at IMH who fulfilled the following inclusion criterion: Singapore citizens or Permanent Residents (PRs), aged 21–65 years, belonging to Chinese, Malay or Indian ethnicity (the three main ethnic groups in Singapore), capable of providing consent, literate in English language, having a clinical diagnosis of schizophrenia, depression, anxiety or OCD as determined by a psychiatrist using ICD-9 criteria and seeking treatment at IMH for more than one year. OCD was examined as a separate diagnosis from anxiety as it is one of the most common mental disorders in Singapore with a lifetime prevalence of 3% (Chong et el, 2012) and therefore, deserves attention. The questionnaire was administered face-to-face by trained interviewers. A total of 280 participants were recruited via direct advertising in the format of posters at the clinics as well as referrals from psychiatrists and other healthcare professionals. Written informed consent was obtained from all respondents prior to the study.

2.2. Measures

2.2.1. Demographic and clinical data

Socio-demographic variables (i.e. age, gender, ethnicity, education level, marital status, employment status) were recorded and clinical data (i.e. diagnosis, age of illness onset, hospitalisation history) were obtained through medical record review by trained researchers who were members of the study team.

2.2.2. Internalised stigma and stigma resistance

The Internalised Stigma of Mental Illness (ISMI) scale uses a 4-point Likert scale consisting of 29 items grouped into 5 subscales – Alienation, Stereotype Endorsement, Discrimination Experience, Social Withdrawal and Stigma Resistance (reverse-scored).

The current study measured stigma resistance using the Stigma Resistance subscale and measured internalised stigma by summing the averages of the remaining four subscales of the ISMI (Ritsher et al., 2003). In the study conducted by Chang et al. (2014), the ISMI (without Stigma Resistance subscale) had demonstrated excellent internal consistency with a Cronbach's alpha of 0.94, while the Stigma Resistance subscale reported a Cronbach's alpha of 0.66. In the current study, Cronbach's alpha for internalised stigma measured by the four subscales and Stigma Resistance subscale was 0.93 and 0.61 respectively. While it may be noted that some studies (Brohan et al., 2010c; Chang et al., 2016) had identified Discrimination Experience as a measurement of perceived stigma instead of internalised stigma, we had still integrated the domain to measure internalised stigma considering the high internal consistency reported (alpha = 0.93).

A cut-off point at 2.5 and above on the mean item score of the Stigma Resistance subscale was applied to define moderate to high (referred to as “high”) stigma resistance, and less than 2.5 for low stigma resistance (Sibitz et al., 2011; Bifftu et al., 2014). The extent of internalised stigma and its subscales were defined using the same cut-off point on its item mean score. This cut-off point has been used in several other studies (Brohan et al., 2010a; Boyd et al., 2014; Kao et al., 2016).

2.2.3. Self-esteem

The Rosenberg Self- Esteem Scale (RSES) contains 10 items which are answered using a Likert scale from strongly agree (1) through to strongly disagree (4). Items 2, 5, 6, 8, 9 are reverse- scored. All item scores are summed and higher scores indicate higher self-esteem (Rosenberg, 1965). The results from the study conducted by McKay, Boduszek and Harvey (2014) supported the unidimensionality of the RSES. The Cronbach's alpha in our study was 0.84.

2.2.4. Quality of life

The World Health Organization Quality of Life –BREF (WHOQOL-BREF) is a 26-item scale which measures overall quality of life (QOL) and general health. It also measures four distinct domains covering physical health (7 items), psychological health (6 items), social relationships (3 items) and environmental aspects (8 items). Participants respond to the items on a 5-point Likert scale. Item 3, 4 and 26 are reversed scored. Mean score of items within each domain are multiplied by 4 to make domain scores comparable with the scores used in the WHOQOL-100. Higher domain scores indicate higher quality of life (WHOQOL, 2004). Studies have indicated support for the psychometric properties of the WHOQOL-BREF in people with mental illness (Mas-Expósito et al., 2011; Su et al., 2014). The Cronbach's alpha in our study for each of the four domains was: physical health, 0.81; psychological health, 0.84; social relationships, 0.63 and environmental aspects, 0.78.