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Internalized stigma among psychiatric outpatients: Associations with quality of life, functioning, hope and self-esteem

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ABSTRACT

This study aimed to: (i) determine the prevalence, socio-demographic and clinical correlates of internalized stigma and (ii) explore the association between internalized stigma and quality of life, general functioning, hope and self-esteem, among a multi-ethnic Asian population of patients with mental disorders. This cross-sectional, survey recruited adult patients (n=280) who were seeking treatment at outpatient and affiliated clinics of the only tertiary psychiatric hospital in Singapore. Internalized stigma was measured using the Internalized Stigma of Mental Illness scale. 43.6% experienced moderate to high internalized stigma. After making adjustments in multiple logistic regression analysis, results revealed there were no significant socio-demographic or clinical correlates relating to internalized stigma. Individual logistic regression models found a negative relationship between quality of life, self-esteem, general functioning and internalized stigma whereby lower scores were associated with higher internalized stigma. In the final regression model, which included all psychosocial variables together, self-esteem was the only variable significantly and negatively associated with internalized stigma. The results of this study contribute to our understanding of the role internalized stigma plays in patients with mental illness, and the impact it can have on psychosocial aspects of their lives.

1. Introduction

Stigma is universal and has no boundaries, and is something that can affect anyone. Stigma towards those with a mental illness is no exception; it is widespread and evident across all cultures and societies. The World Health Organization has defined stigma as ‘a mark of shame, disgrace, or disapproval that results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society’ (WHO, 2001). It involves labeling, stereotyping, separation, status loss and discrimination (Link and Phelan, 2001). Stigma is complex and multifactorial and encompasses three interacting levels; individual, social and structural (Corrigan et al., 2005a; Herek, 2007; Herek et al., 2009).

For mental illnesses, structural stigma, also referred to as institutional stigma, exists at the systems or macro level and refers to the rules, policies, and procedures of private and public entities in positions of power that restrict the rights and opportunities of people with mental illness (Corrigan et al., 2005a, 2005b). Social stigma, also known as public or enacted stigma, exists at the group (i.e., meso) level and describes “the phenomenon of large social groups endorsing stereotypes about and acting against a stigmatized group” (Corrigan et al., 2005a, p.179). At the individual or micro level, internalized or self-stigma, can be described as a process whereby affected individuals endorse stereotypes, anticipate social rejection, consider stereotypes to be self-relevant, and believe they are devalued members of society (Corrigan et al., 2005a, 2006; Corrigan and Watson, 2002; Ritsher and Phelan, 2004). Internalized stigma is experienced when a person is aware of the stereotype that describes the stigmatized group, agrees with it and then finally applies it to themself (Corrigan et al., 2009).

The repercussions of stigma are significant for people with a mental illness. Firstly stigma can result in label avoidance, the process by which people are reluctant to be diagnosed with or be seen as seeking treatment for a mental illness, (Corrigan et al., 2004) often resulting in delayed treatment seeking. Internalized stigma has also been shown to be related to poor adherence with psychosocial (Fung et al., 2009, 2008) and pharmacological treatment (Adewuya et al., 2009; Sirey

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et al., 2001). Yanos and colleagues (2008) derived a model relating to the impact of internalized stigma on recovery-related outcomes for people with severe mental illnesses, whereby internalized stigma was related to having an awareness of the psychiatric problem and the meanings attributed to this. They found internalized stigma reduced a person's sense of hope and self-esteem which in turn resulted in negative outcomes related to recovery including social avoidance, depressive symptoms and a preference for using avoidant coping.

Internalized stigma has also been linked to various poor psychosocial outcomes among people with mental illness. These include poor quality of life and life satisfaction (Switaj et al., 2009), difficulty in obtaining employment and/or housing (Wahl et al., 1999), marginalization, rejection, shame and isolation (Shrivastava et al., 2012). Clinically, internalized stigma has also been associated with an increase in symptom severity (Mak and Wu, 2006), positive symptoms (Lysaker et al., 2007; Yanos et al., 2008), negative symptoms (Lysaker et al., 2009, 2007) and depressive symptoms (Lysaker et al., 2007). For other aspects such as insight however, the findings are inconsistent, with some studies showing insight to have a positive correlation with internalized stigma, whilst others finding the correlation to be negative (Hasson-Ohayon et al., 2012; Mashiach-Eizenberg et al., 2013; Mak and Wu, 2006). Overall, internalized stigma is considered a risk factor for poorer mental health prognosis (National Institute of Mental Health, 2008). Given the negative consequences resulting from internalized stigma, there has been increased interest towards identifying ways to help people with mental illness reduce or avoid self-stigma (Ritsher et al., 2003; MacInnes and Lewis, 2008; Lucksted et al., 2011; Yanos et al., 2011) in order to improve outcomes and well-being.

Whilst a recent expansive body of literature has investigated the experiences of people with mental illnesses, the prevalence of internalized stigma among adults with mental illness, its effects on psychosocial outcomes, and the corresponding patterns of relationships between internalized stigma and these outcomes have not yet been fully explored (Drapalski et al., 2013). More specifically, the majority of studies have investigated internalized stigma among patients from one or two diagnostic groups, with only a few studies exploring differences across multiple diagnoses (Drapalski et al., 2013; Oliveira et al., 2015; Chang et al., 2016b).

Several studies have explored the attitudes and stigma towards people with mental illness, however little is known about the extent of internalized stigma experienced by treatment seeking patients with mental illnesses in Singapore, a highly developed country with a multiracial resident population of 3.9 million, comprising predominantly of Chinese (74.3%), Malays (13.3%) and Indians (9.1%). Furthermore little is known about differences in internalized stigma across diagnostic groups, in this multi-ethnic population. This study therefore aimed to determine the prevalence of internalized stigma among a multi-ethnic Asian population of outpatients with schizophrenia or other psychotic disorders, depression, anxiety or obsessive compulsive disorder (OCD), who were seeking treatment at a tertiary psychiatric hospital in Singapore. We also aimed to determine the socio-demographic and clinical correlates of internalized stigma as well as explore the association between internalized stigma and quality of life, general functioning, hope and self-esteem among this patient population. We hypothesized that internalized stigma would differ across the different diagnostic groups and would be negatively associated with quality of life, general functioning, hope and self-esteem.

2. Methods

2.1. Participants and recruitment

This cross-sectional, study recruited adult patients who were seeking treatment at outpatient and affiliated clinics of the only tertiary psychiatric care hospital in Singapore, the Institute of Mental Health (IMH) between May 2014 and September 2015. Inclusion criteria required respondents to be: 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 and having a clinical diagnosis of more than one year of either schizophrenia or other psychotic disorders, depression, anxiety or OCD, as determined by a psychiatrist, using ICD-9 criteria. Patients with intellectual disabilities, patients who were not fluent in English and those patients who had been seeking treatment at IMH for less than one year were excluded. Posters informing attending patients of the ongoing study and its eligibility criteria were placed in the clinic settings along with the phone numbers and email addresses of the study team members. Psychiatrists and other healthcare professionals were also requested to refer eligible patients for the study. On average, the face-to-face, interviewer administered interviews took one hour to complete. Data was captured in real-time via online Computer Assisted Personal Interviewing using an iPad, by trained researchers who were members of the study team. This method allowed interviewers to provide assistance or clarification to the participants where needed, whilst reducing the likelihood of pattern answers. Ethical approval was obtained from the Domain Specific Review Board of the National Healthcare Group, Singapore, prior to the start of the study and written informed consent was obtained from all respondents.

2.2. Measures

2.2.1. Internalized Stigma of Mental Illness

The Internalized Stigma of Mental Illness (ISMI) scale was used to measure internalized stigma and consists of five subscales: alienation, stereotype endorsement, discrimination experience, social withdrawal and stigma resistance (Ritsher et al., 2003). The scale uses a 4-point Likert scale from strongly disagree to strongly agree to rate each of the 29 items, which includes statements such as “Having a mental illness has spoiled my life”, “People without mental illness could not possibly understand me” and “I can’t contribute anything to society because I have a mental illness”. As the stigma resistance subscale has not been included in the ISMI total score in several previous studies, given its relatively weak correlation to the other ISMI subscales and its lack of internal consistency, (Ritsher et al., 2003; Lysaker et al., 2007) the stigma resistance subscale was excluded from analysis. The ISMI has shown a good internal consistency (Cronbach's α=0.94) and good stability over time (test–retest reliability coefficient: ICC=0.78) (Chang et al., 2014) in a sample of psychiatric outpatients in Taiwan, with similar findings in a validation study among a comparable sample (Chang et al., 2016a). The Cronbach's alpha in our sample was 0.93. For the interpretation of scores, a cut-off score of 2.5 was used, which corresponds to the midpoint of the possible range (on a scale of 1–4) where scores of 2.5 and above are reflective of moderate to high internalized stigma. This same cut-off score has been used in several other studies (Lysaker et al., 2007; Ritsher and Phelan, 2004; Boyd et al., 2014; Brohan et al., 2010).

2.2.2. Global Assessment of Functioning

The Global Assessment of Functioning (GAF) scale (Aas, 2010) is a scoring system for the severity of illness in psychiatry. The GAF assesses individual's overall functioning level. Impairments in psychological, social and occupational/school functioning are considered. The scale ranges from 0 (inadequate information) to 100 (superior functioning). Trained raters start at either the top or the bottom of the scale and go up/down the list until the most accurate description of functioning for the individual is reached as per the raters’ judgment. A GAF score in the 91–100 range indicates optimal mental health and coping capabilities while those in the 1–10 range may be considered suicidal and incapable of maintaining minimal personal hygiene.

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