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Clinical profiles of stigma experiences, self-esteem and social relationships among people with schizophrenia, depressive, and bipolar disorders

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ABSTRACT

Some mental illnesses and certain mental health care environments can be severely stigmatizing, which seems to be related to decreased self-esteem and a deterioration of the quality of social relationships for people with mental illness. This study aims to identify clinical profiles characterized by clinical diagnoses more strongly associated with the treatment settings and related to internalized stigma, self-esteem and satisfaction with social relationships. It also aimed to analyze associations between clinical profiles and socio-demographic indicators. Multiple correspondence analysis and cluster analysis were performed on a sample of 261 individuals with schizophrenia and mood disorders, from hospital-based and community-based facilities. MCA showed four distinct clinical profiles allowing a differentiation among levels of: internalized stigma, social relationship satisfaction and self-esteem. Overall, results revealed that internalized stigma remains a pervasive problem for some people with schizophrenia and mood disorders. Particularly, internalized stigma and social relationships dissatisfaction and associated socio-demographic indicators appear to be a risk factor for social isolation for individuals with schizophrenia, which may worsen the course of the disorder. Our findings highlight the importance to develop structured interventions aimed to reduce internalized stigma, and exclusion of those who suffer the loss of their social roles and networks.

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1. Introduction

Research has demonstrated that some mental illnesses (e.g., schizophrenia) and certain mental health care environments (e.g., psychiatric hospitals) can be severely stigmatizing. Whereas the stigma of mental illness reflects negative stereotyped beliefs held by the public about persons with mental disorders, internalized stigma (also referred as self-stigma) is an internalized disapproval, which refers to the process of accepting and applying the stereotypes to oneself (Ritsher and Phelan, 2004). It often aggravates feelings of alienation and promotes withdrawal from others. In particular internalized stigma has been found to negatively influence quality of life (QOL) domains related with satisfaction with family and social relationships (Park et al., 2013). This living experience may be exacerbated by the clinical diagnosis since particular cues that signal mental illness may act as a label itself and play an important role in the experience of stigmatization (Corrigan, 2007; Schumacher et al., 2003). In addition to the suffering caused by the intensity of the symptoms (e.g. delusions), individuals with severe mental illness (SMI) suffer from what is called a “second illness”, which is the stigma attached to the disorder (Finzen, 1996).

Consistent with the modified labeling theory on mental illness (Link et al., 1989; Link, 1982), people form negative conceptions of mental illness long before they become psychiatric patients. Such conceptions take on a new relevance when an individual starts a psychiatric treatment due to the stigma that accompanies such labeling. According to this view, a person's beliefs about the devaluation is transformed into a personal expectation of rejection as an employee, neighbor, friend or intimate partner, through the mechanism of internalization, often jeopardizing one's life circumstances.

People with SMI who internalize the negative societal attitudes tend to anticipate discrimination or rejection by others and develop avoidant coping strategies such as withdrawal from social interaction (Yanos et al., 2008). The tendency to use avoidant coping strategies to deal with symptoms and the effects of stigma may, in turn, increase social isolation and lack of engagement in

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rehabilitation and treatment, as an attempt to avoid the status of being a "mental patient" or suffer the stigma that the label entails.

The persistent effects of stigmatization have been previously reported. For instance, in a longitudinal study of men (N=84) with mental illness Link et al. (1997) found that the pervasive effects of stigma remained apparently unaffected by treatment benefits despite of major improvements on symptoms and functioning described by the participants' one-year after entering into treatment.

Likewise, studies investigating internalized stigma in mental illnesses have increased in recent years. For example, research on internalized stigma developed by Yanos et al. (2008) with a sample of persons with diagnoses of schizophrenia spectrum disorders (N=102) found that internalized stigma impacts upon the individuals' hope and self-esteem, thus leading to poor recovery outcomes. Internalized stigma is also associated with demoralization, loss of social support, poor QOL and difficulty obtaining housing and employment (e.g. Link, 1982; Page 1995; Ritsher and Phelan, 2004; Lysaker et al., 2007; Mashiach-Eizenberg et al., 2013).

Results from cross-sectional data involving 27 countries have shown that individuals with schizophrenia often experience discrimination in making or keeping friends, from family members, and in intimate or sexual relationships (Thornicroft et al., 2009). In particular internalized stigma has been shown to negatively influence QOL domains related with satisfaction with family and social relationships (Park et al., 2013). Internalized stigma has also been associated with lowered self-esteem (Lysaker et al., 2008; Yanos et al., 2008; Corrigan et al., 2006), and diminished QOL of those labeled as "mentally ill" (Link and Phelan, 2001; Markowitz, 1998; Rosenfield, 1997). Overall, these results are consistent with findings reported by Livingston and Boyd (2010) in a systematic review and meta-analysis of the current state of research on internalized stigma, which was found to negatively influence various psychosocial variables (e.g. self-esteem, QOL and social support). However, while these authors verified that internalized stigma was positively associated with symptom severity, results regarding other psychiatric variables such as clinical diagnosis and treatment settings were mixed.

Some research suggests that people with schizophrenia report more stigmatizing experiences and that the access to social roles was especially complicated for them, compared to those with depressive disorders (Holzinger et al., 2003). These results are in line with other studies suggesting that rejection experiences were more prevalent among people with psychotic disorders (Lundberg et al., 2008). It has also been found that people with schizophrenia demonstrated lower satisfaction with social relationships than their counterparts with mood disorders (Ritsner et al., 2000). Nevertheless, little is still known whether particular dimensions of internalized stigma may be negatively associated with self-esteem and satisfaction with social relationships (i.e., personal relationships, social support, and sexual activity). Therefore, this is a relevant and unexplored line of inquiry to examine mental health consumers' perspectives with regard to internalized stigma, self-esteem and socialrelationships satisfaction in the hopes of developing healthcare consumer profiles to improve treatment strategies. Hence, this study is supported by the need to bridge the gap regarding the "lack information on the different effects stigma has on persons with different mental disorders" (Rüsch, et al., 2005, p. 536). It seeks for new insights regarding the potential negative effects of the application of a diagnosis (Link et al., 1989) and also sustained by the need to investigate internalized stigma in a more diverse range of treatment settings (West et al., 2011).

The current study sought to identify, among Portuguese consumers with SMI: (1) clinical profiles characterized by clinical diagnoses more strongly associated with the treatment settings as well as related to internalized stigma, self-esteem and satisfaction with social relationships (2) whether clinical profiles are associated with specific socio-demographic indicators.

2. Methods

2.1. Participants

Ethical approval was obtained from all the entities enrolled in this study. After receiving an explanation of the study, individuals who met the inclusion criteria were then referred by the psychiatrist and provided written informed consent.

Two hundred and sixty one inpatients and outpatients diagnosed with schizophrenia (n=147), depressive disorders (n=81) and bipolar disorders (n=33) participated in this study. Participants were receiving professional mental health care in hospital-based services (outpatient psychiatric consultations, short-term and long-term hospitalization) and community-based facilities. Diagnoses were provided by the psychiatrists, who selected individuals based in the following inclusion criteria: (1) adults with a clinical diagnosis according the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994); (2) without neurological disorders or severe cognitive impairments or intellectual disabilities; and (3) under psychiatric treatment and supervision and medically stabilized. The sample consisted of 147 participants diagnosed with schizophrenia (56.3%) and 114 with mood disorders (43.7%). One hundred and forty-five of the respondents were men (55.6%); the mean age was 45.79 (SD=12.21; range=20–79); more than half of the sample was single (59.4%) and 24.9% married; 20.3% completed primary education (4 years), 38.3% had finished the 9th grade; 22.6% finished secondary education and 16% attended university or graduate studies.

2.2. Measures

2.2.1. Internalized Stigma of Mental Illness scale (ISMI)

The Portuguese version of the ISMI scale is a 28-item questionnaire (Oliveira et al., 2015) adapted from the original version (Ritsher et al., 2003), designed to assess the subjective experience of stigma of having a mental illness. The ISMI is rated on a four-point Likert scale (from 1=strongly disagree to 4=strongly agree) with higher scores indicating higher levels of internalized stigma. For the interpretation of scores, we used the 4-category method proposed by Lysaker and colleagues (2007), as followed: 1.00–2.00: minimal internalized stigma; 2.01–2.50: low internalized stigma; 2.51–3.00: moderate internalized stigma; 3.01–4.00: high internalized stigma. The Cronbach's alpha coefficients for the four subscales used in this study were as follows: Stereotype Endorsement 0.73; Discrimination Experience 0.85; Social Withdrawal 0.83 and Alienation 0.86.

2.2.2. Rosenberg Self-Esteem Scale (RSES)

Self-esteem was assessed with the Portuguese version of the RSES (Santos and Maia, 2003), a 10-item scale answered in a 4-point Likert-type scale (1=strongly disagree to 4=strongly agree). The negatively oriented items are reverse coded so that higher scores indicate higher levels of self-esteem. The items were categorized as follows: (1.00–2.00: minimal self-worth; 2.01–2.50: low self-worth; 2.51–3.00: moderate self-worth; 3.01–4.00: high self-worth). The Alpha Coefficient for the self-esteem scale in this sample was 0.88.

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