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# THE EFFECTS OF SELF-STIGMATIZATION ON THE FUNCTIONALITY AND SOCIAL DISTANCING OF PEOPLE WITH MENTAL ILLNESS

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## ABSTRACT

**Introduction:** Self-stigmatization levels are usually high in the mentally ill and affect functionality, help-seeking behaviors, treatment adherence and quality of life. **Aim:** This study aims to investigate how self-stigmatization affects the functionality and social distancing of the mentally ill. **Method:** A quantitative cross-sectional study carried out and questionnaires specifically WHODAS, ISMI, SDS, used to collect the data. The study's sample consists of 100 mentally ill people aged 18-65, located in Psychiatric Hospitals in the prefecture of Attica. **Results:** Greater alienation, acceptance of stereotypes, experience of discrimination, social withdrawal and female gender were significantly associated with greater disability. Also, better ephemeral relationships, the experience of discrimination, higher educational attainment and male gender were associated with lower disability. **Discussion:** Self-stigmatization contributes to low functionality and social exclusion of the mentally ill. On the contrary, the existence of interpersonal relationships improves the feeling of acceptance and reduces physical and mental deficits.

## KEYWORDS

Functionality, Internalized stigma, Mental illness, Self-care, Self-stigmatization and Social distancing.

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## INTRODUCTION

The stigma of mental illness is divided into two categories. The first refers to the public / social stigma, which concerns the prejudices and discrimination of the wider society towards people with mental illness. The second concerns self-stigma, i.e. stereotypes, prejudices and discrimination experienced and internalized by

people with a mental illness[1]. Self-stigmatization arises when people with a mental illness are aware of stereotypes and agree with these current beliefs. As a result, they are led to negative emotional reactions and behaviors towards themselves in response to the prevailing prejudices[2-4]. However, as a term it still remains vague. This fact is due to different categories of mental illnesses that exist, the personality of each person, the existing supportive and social network and the degree of empathy they have. The effect of self-stigmatization on one's identity is particularly harmful, as it seems to reduce one's self-esteem, autonomy and confidence in the future[2-6].

The degree of awareness and empathy of people with mental illness is independent of levels of self-stigmatization. In particular, even in cases of low insensitivity, self-stigmatization seems to exist. In mental illnesses, such as schizophrenia, cognitive impairments, distorted perceptual experiences (hallucinations) affect the degree of perception of stigmatization and consequently self-stigmatization. In addition, people with greater severity of psychiatric symptoms are more likely to accept stigmatizing behaviors. An additional element found from the study of Jenkins and Carpenter-Song[5], is that people with schizophrenia received more stigmatizing behaviors when they were in the process of joining a workplace, compared to those who did not work.

However, there is no clear evidence to suggest that self-stigmatization is influenced by the severity of symptoms and cognitive deficits. Self-stigmatization can be related to negative stereotypes and behaviors that the person has internalized long before the diagnosis of mental illness or its relapse. Even if a person experiences severe symptoms and cognitive impairments, he can perceive the association of himself with schizophrenia and may suffer from self-stigma. Therefore, further research will be needed on the relationships between symptoms and self-stigmatization[7].

Research shows that rates of self-stigmatization are high among people with mental illness in both outpatient and inpatient settings in studies conducted in several countries around the world[8-10]. Also, people who were found with significant rates of self-stigmatization, seemed to have increased depression, decreased functionality and increased emotional stress. All the above have as a consequence the negative effect on the recovery of these individuals[10]. In fact, internalized stigma also influences perceptions about seeking help[9]. High levels of self-stigmatization are associated with low levels of self-esteem, functionality and overall quality of life. They also hinder compliance with treatment and consequently, its outcome. In addition, they affect the field of psychosocial rehabilitation of these people, such as finding a job, independent living and socialization[11].

Self-stigmatization is a major problem for the individual, as it affects his self-esteem and self-efficacy[6]. In fact, the negative effects of self-stigmatization persist even when the psychiatric symptomatology has subsided[12]. These people avoid processes that promote their independent living (e.g. finding a job) because they accept stigmatizing behaviors that make them feel incompetent[13]. The same process occurs for the social networking processes of these individuals, with the adverse effect of isolation[14].

Evans Lacko and his colleagues[15] and Yu and his colleagues[16], reported that the negative attitudes of society as a whole were not associated with the self-stigmatization of people with mental illness at the individual level. Therefore, social stigma catalyzes the process of internalization only when the negative attitudes of the audience are experienced and perceived by people with mental illness[15]. The meta-analysis of Yu and his colleagues[16], highlighted the fact that experienced stigma is significantly related to the unfavorable clinical and personal recovery of the individual and well-being.

Beliefs and attitudes towards people with mental illness seem to concern mainly people with psychosis and depression. Attitudes and opinions towards mental illness and consequently stigma seem to vary depending on the categories of mental illness. In schizophrenia, for example, stigma is much more common than in depression[17]. Studies have shown the fact that many people do not wish to socialize with people with schizophrenia, describing

them as "strange"[18] while others maintain social distance from people on the psychotic spectrum based on stereotypes and prejudices around mental illness[19]. This results in individuals internalizing the stigma they experience and withdrawing from social processes and interactions and becoming increasingly isolated[20]. In fact, Jenkins and Carpenter-Song[21], reported that about half of their study participants who had schizophrenia said they took their medication secretly from others because they feared rejection and discrimination.

Therefore, reducing self-stigmatization in people with schizophrenia is important not only to improve self-esteem and self-efficacy, but also to effectively manage the disease.

**Objective**

The purpose of this study is to investigate how internalized stigma affects functionality of mentally ill people at the social, mental and physical level and what effect it has on social distancing and social exclusion in its entirety.

## METHODS

**Ethical considerations**

In order to comply with the rules of ethics and morals, the authors were formally asked for permission to use the questionnaires. The questionnaires were examined by the Ethics Committee of the Department of Nursing of University of Athens and by the respective committees of the hospitals. The researcher obtained informed consent from all participants, who took part in the study voluntarily. They were offered assurance of anonymity and confidentiality of the information provided. Also, they were informed that they could cease completing the questionnaire at any time if they wished to do so. They also took assurance that the collected data would be used only for the study and that their decision to withdraw would in no way compromise the standards of the care provided.

**Description of study scales**

A quantitative cross-sectional study was carried out and questionnaires were used to collect the data. The WHO-DAS scale was used to investigate functionality. This scale measures motor ability, participation, cognition, and self-care (Ustun *et al*, 2010). The ISMI scale was also used to investigate stigma. This scale consists of 29 questions and includes 5 subscales: alienation, acceptance of stereotypes, experience of discrimination, social withdrawal, resistance to stigma (Boyd *et al*, 2014). Finally, the SDS scale was also used to investigate social distancing. This scale includes three subscales: stable relationships, trusting relationships, ephemeral relationships (Economou *et al*, 2010).

**Sample**

The population of the quantitative study consists of mentally ill patients aged 18-65 years, who are located in community structures and rehabilitation units of Psychiatric Hospitals in the prefecture of Attica. The sample size is 100 individuals. Most of them were diagnosed with schizophrenia or some psychotic spectrum disorder (57), emotional and anxiety disorders (38), one (1) with personality disorder and four (4) with Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances. Demographics of the sample are described in Table No.1.

**Criteria for admission to the study**

People who have received the diagnosis of a mental illness according to ICD10

People aged 18-65 People who do not show active psychopathology

People with a good knowledge of the Greek language

Persons with Greek citizenship

**Criteria for exclusion from the study**

People who will declare that they do not wish to participate in the study.

People who will not want to complete the interview process and answer the study questionnaires.

Persons placed under guardianship.

## RESULTS AND DISCUSSION

Quantitative variables were expressed as mean values (Standard Deviation) and as median (interquantile range), while qualitative variables were expressed as absolute and relative frequencies. Variables were first tested for normality using the Kolmogorov-Smirnov criterion. Spearman correlations coefficients (rho) were used to explore

the association of two continuous variables. Multiple linear regression was conducted with WHO-DAS scales as dependent variables, in a stepwise method (p for entry 0.05, p for removal 0.10). Log – transformations of the dependent variables were used in the regression analysis. Internal consistency of the questionnaire was evaluated via Cronbach's alpha. All reported p values are two-tailed. Statistical significance was set at $p<0.05$ and analyses were conducted using SPSS statistical software (version 22.0).

Sample consisted by 100 patients with mean age 49.5 years (SD=13.9 years). Their characteristics are presented in Table No.1. Half of the patients were women. Also, most patients were unmarried (63%), were living with friends or family (59%), had siblings (80%) and they were high school graduates (39%). The descriptive statistics of Descriptive statistics of WHO-DAS, ISMI and SDS subscales are presented in Table No.2. All scales had Cronbach's alpha coefficients greater than.70, indicating acceptable reliability.

All WHO-DAS scales were positively correlated with all ISMI subscales except for "Stigma resistance" (Table No.3). Thus, greater alienation, Stereotype Endorsement, Discrimination Experience and Social Withdrawal was significantly associated with greater disability. Also, better Termporary relationships were significantly associated with lower disability (except for Participation and Cognition subscale). On the contrary, stable and trusting relationships had no significant association with patients' disability.

Alienation was significantly and negatively correlated with temporary relationships, rho=-.39; p<.001 (Table No.4). Also, Stereotype Endorsement and Discrimination Experience were significantly and negatively correlated with all SDS subscales. Social Withdrawal was significantly and negatively correlated with stable, rho=-.25; p=.013 and temporary relationships, rho=-.26; p=.009.

When multiple linear regression was conducted (Table No.5) it was found that only discriminant experience was significantly associated with Motor ability (β=0.047; p<.001). Patients' greater educational level was associated with lower disability regarding participation and cognition (b=-0.058; p=.050), while greater Alienation was associated with greater disability in the aforementioned sector (b=0.024; p=.002). Participants with siblings had significantly less disability regarding selfcare (b=-0.225; p=.026). Overall, women reported significantly greater disability compared to men (β=0.141; p=.046) and having more Stereotype Endorsement was significantly associated with greater disability (β=0.043; p<.001).

Also, multiple linear regression revealed that educational level was the only factor that was significantly associated with stereotype endorsement subscale, β=-0.038, 95% CI: -0.064;-0.013, p=0.003, and with social withdrawal, β=-0.031, 95% CI: -0.060;-0.002, p=0.035. Moreover, having siblings was significantly associated with lower score in trust relationships, β=-0.122, 95% CI: -0.207;-0.037, p=0.006.

**Discussion**

In the present study, the relationship between internalized stigma, functioning and disability, as well as social distancing, was studied in a sample of 100 people with a psychiatric diagnosis in three psychiatric hospitals in Attica. All participants were taking some psychiatric medication (mainly antipsychotics, antidepressants and anxiolytics). These patients were either undergoing psychosocial rehabilitation or were at the end of their hospitalization after a relapse of the disease and the need for pharmaceutical regulation.

Studies from the international literature have highlighted the fact that both stigma in all its manifestations and forms – social stigma, internalized stigma – is second nature to mental illness [6-11]. In addition, mental illness, according to the World Health Organization (2016), emerges as the third leading cause of disability and general burden after cardiovascular disease and cancer. The stigma that accompanies mental illness concerns not only the patient himself, but also his family network, with results such as reduced social activity and reduced social network for both the individual and the whole family[22]. In Greece, a country in which the role of the family and the wider social network

continues to play an important role in supporting or rejecting and excluding a person with mental illness, the study of stigma parameters seems to be important in determining the outcome of the disease itself, the functioning of the individual and finally, social inclusion or exclusion.

Functioning as a concept includes the ability to perform the activities that people enjoy at work, at home, and in social life, self-care, maintaining interpersonal relationships and social adjustment[23]. The gender differences between the survey participants appeared to be insignificant. The majority of them continue to live with people from their family environment, do not have a partner and have not created their own family, confirming in a way the framework of previous studies on the difficulty of maintaining interpersonal relationships and adaptation. Also, the educational level and studies of the participants seemed to be in line with the results of previous studies. Specifically, 66 out of 100 were elementary, middle and high school graduates, while 29 continued in tertiary education and only 5 continued at postgraduate or doctoral level. Both cognitive deficits created due to the disease and social exclusion due to stigma seem to be a significant obstacle to the education, professional and psychosocial rehabilitation of these people[6,9,15]. All of the above is confirmed in this study, as only one in four reported working in some context.

The results show that greater alienation, internalization of stereotypes about mental illness, existence of some experience of discrimination and social withdrawal, lead to significantly greater impairment of functionality and consequently greater rates of disability. Of all mental illnesses, schizophrenia is the one with the most significant cognitive, emotional and functional deterioration[24]. Similar studies, such as that of Clark[25], refer to low rates of functioning and maintenance of daily life skills and social roles in people with schizophrenia and other psychotic spectrum disorders. Among the factors affecting functioning, symptoms of the disease appeared to be, as well as social, cultural, social and environmental factors, including stigma and self-stigmatization[26]. In the current study, ephemeral relationships, within a context of socialization and interaction between people, appeared to be associated with lower rates of disability in contrast to stable relationships, which did not seem to play a significant role in participants' functioning.

Educational attainment seemed to contribute to lower rates of disability in terms of social participation and cognitive ability. Educational attainment was associated with higher social functioning and better disease outcomes in people with mental illness[27]. A study among people with schizophrenia found that higher educational attainment was associated with the absence of negative symptoms and consequently higher functionality[28]. Finally, McGurka and Meltzer[29], who also found in their study a positive correlation between higher educational attainment and higher functioning, explained the fact that high academic level delayed the onset of the disease, so functioning skills were already at a high level, helping these individuals to remain socialized to a significant extent.

In terms of gender, women recorded significantly greater disability compared to men. Greater internalization of stereotypes was also associated with greater disability. The results of the study are consistent with those of Capar and Kavak[27], with women showing lower rates of functionality. On the contrary, Erol *et al*[30], found no statistically significant differences in the functioning of mentally ill people between the sexes.

Participants with siblings and therefore a direct family support framework recorded significantly lower rates of disability relative to self-care levels. In contrast, participants who experienced greater alienation and isolation recorded greater disability.

The study of social distancing has so far been researched at the level of the general population, its attitudes and perceptions of mental illness. The results of this study come to some extent to reinforce data from the global literature, on the consequences of social exclusion – mainly from people in the wider society and not from the immediate social and family network – on the levels of internalization of stigma and discrimination and impairment of

functioning of people with mental disorder, regardless of diagnosis. On the contrary, the existence of social and interpersonal relationships enhances the feeling of social participation and acceptance, thus improving the functionality of the individual. As has been demonstrated by previous literature, social distancing and exclusion cause or intensify both physical and mental problems in individuals, affecting emotional, cognitive, and overall well-being[31].

In addition, the possibility of including people with psychiatric disorder in education significantly reduces their sense of disability. The level of education seems to contribute to the improvement of one's functioning on two levels. It helps to better study and understand the disease in a psycho educational context, due to which it has more powerful tools for its management (symptoms, aesthetics, pharmaceutical compliance)[31].

The contribution of this study lies in the fact that it attempts to investigate not only the functional, physical, cognitive, mental and social consequences that the nature of the disease and the stigma experienced by people with mental illness and their families can have. How they perceive and exploit for the benefit or at the expense of the social group of the mentally ill the experience of mental illness itself. In Greece, research has focused much more on the attitudes and perceptions that exist in various population groups of the general population about mental illness. In contrast, there is limited study and research on the experience of discrimination in people with psychiatric disorders. Engaging and researching these uncharted paths seems to be important, as by studying the same topic from two different perspectives we can analyze it comprehensively and find possible proposals for the sole purpose of accepting the social empathy of people with mental disorder. Reduce or eliminate all those parameters related to stigma and self-stigma that lead to a second parallel illness with mental disorder to burden and render the person disabled.

**Strengths and limitations**

However, this research has some limitations. The sample is not representative for the entire Greek population, as it concerns a population of people living in the capital. Social stereotypes and prejudices in the province of Greece as well as gender segregation are much more pronounced in small societies. Thus, this sample concerns people in an urban area in which the possibilities for support and psychosocial rehabilitation and care may be much greater than in the province, but also there is even a rudimentary mitigation of stereotypes and discrimination that apply to mental illness. It is important to explore an even larger part of the Greek population both in the big cities and in the province as the framework of support to the community is not so extensive there. In addition, the sample includes people with different psychiatric diagnoses and different levels of functionality. Therefore, this makes it difficult to be able to help more especially in each disease category according to its needs. This is because each category of mental illness has a different prognosis, different stigma and therefore different needs.

**Table No.1: Sample characteristics (N=100)**

| S.No | Characteristics | N (%) |
|---|---|---|
| **Gender** | | |
| 1 | Men | 49 (49.0) |
| 2 | Women | 50 (50.0) |
| 3 | Other | 1 (1.0) |
| 4 | Age, mean (SD) | 49.2 (13.9) |
| **Family status** | | |
| 5 | Unmarried | 63 (63.0) |
| 6 | Married | 14 (14.0) |
| 7 | Divorced | 13 (13.0) |
| 8 | Widowed | 5 (5.0) |
| 9 | In a relationship | 5 (5.0) |
| **Place of Birth** | | |
| 10 | Attica | 67 (67.0) |
| 11 | Out of Attica | 26 (26.0) |
| 12 | Abroad | 7 (7.0) |
| **Living status** | | |
| 13 | Alone | 37 (37.0) |
| 14 | With friends/ family | 59 (59.0) |
| 15 | In care unit | 4 (4.0) |
| 16 | Siblings | 80 (80.0) |
| **Number of siblings** | | |
| 16 | Mean (SD) | 1.94 (1.62) |
| 17 | Median (IQR) | 1 (1 - 2) |
| 18 | Children | 29 (29.0) |
| **Number of children** | | |
| 19 | Mean (SD) | 2.14 (1.27) |
| 20 | Median (IQR) | 2 (1 - 2) |
| **Educational level** | | |
| 21 | Primary school | 10 (10.0) |
| 22 | Middle school | 17 (17.0) |
| 23 | High school | 39 (39.0) |
| 24 | University | 29 (29.0) |
| 25 | M.Sc/ PhD holder | 5 (5.0) |
| 26 | Employed | 23 (23.0) |

**Table No.2: Descriptive statistics of WHO-DAS, ISMI and SDS subscales**

| S.No | | Minimum | Maximum | Mean (SD) | Median (IQR) | Cronbach's alpha |
|---|---|---|---|---|---|---|
| | **ISMI** | | | | | |
| 1 | Alienation | 6 | 22 | 12.8 (4) | 13 (10 - 15) | 0.80 |
| 2 | Stereotype Endorsement | 7 | 24 | 14.4 (4.2) | 15 (12 - 17) | 0.78 |
| 3 | Discrimination Experience | 5 | 19 | 11.2 (3.6) | 11 (8.5 - 14) | 0.81 |
| 4 | Social | 6 | 24 | 13.2 (4.2) | 13 (9.5 - 17) | 0.82 |

| | Withdrawal | | | | | |
|---|---|---|---|---|---|---|
| 5 | Stigma Resistance | 5 | 17 | 10.8 (2.5) | 11 (9 - 13) | 0.73 |
| **WHO-DAS** | | | | | | |
| 6 | Motor ability | 0 | 83.3 | 33.5 (21.9) | 33.3 (16.7 - 50) | 0.81 |
| 7 | Participation and cognition | 0 | 75 | 32.2 (22.4) | 37.5 (12.5 - 50) | 0.74 |
| 8 | Self care | 0 | 91.7 | 20.3 (24.3) | 8.3 (0 - 33.3) | 0.88 |
| 9 | Total disability score (WhoDas) | 0 | 75 | 29.5 (20) | 27.1 (13.5 - 45.8) | 0.90 |
| | **SDS** | | | | | |
| 10 | Stable relationships | 5 | 25 | 17.4 (4.8) | 18 (14 - 21) | 0.70 |
| 11 | Trusting relationships | 5 | 23 | 15 (4.9) | 16 (12 - 18.5) | 0.71 |
| 12 | Termporary relationships | 4 | 20 | 13.3 (4.4) | 13.5 (10 - 16.5) | 0.71 |

**Table No.3: Spearman correlation coefficients of WHO-DAS subscales with ISMI and SDS subscales**

| **S.No** | | | **Motor ability** | **Participation and cognition** | **Self-care** | **Total disability score (WhoDas)** |
|---|---|---|---|---|---|---|
| 1 | Alienation | rho | 0.50 | 0.43 | 0.43 | 0.49 |
| | | P | <0.001 | <0.001 | <0.001 | <0.001 |
| 2 | Stereotype Endorsement | rho | 0.53 | 0.48 | 0.46 | 0.55 |
| | | P | <0.001 | <0.001 | <0.001 | <0.001 |
| 3 | Discrimination Experience | rho | 0.52 | 0.45 | 0.41 | 0.53 |
| | | P | <0.001 | <0.001 | <0.001 | <0.001 |
| 4 | Social Withdrawal | rho | 0.50 | 0.43 | 0.41 | 0.50 |
| | | P | <0.001 | <0.001 | <0.001 | <0.001 |
| 5 | Stigma Resistance | rho | 0.16 | 0.19 | 0.12 | 0.17 |
| | | P | 0.115 | 0.060 | 0.233 | 0.097 |
| 6 | Stable relationships | rho | -0.19 | -0.17 | -0.17 | -0.18 |
| | | P | 0.060 | 0.090 | 0.092 | 0.072 |
| 7 | Trusting relationships | rho | -0.18 | -0.13 | -0.18 | -0.16 |
| | | P | 0.067 | 0.207 | 0.072 | 0.120 |
| 8 | Temporary relationships | rho | -0.28 | -0.13 | -0.30 | -0.26 |
| | | P | 0.004 | 0.210 | 0.002 | 0.010 |

**Table No.4: Spearman correlation coefficients between ISMI and SDS subscales**

| S.No | | | **Stable relationships** | **Trust relationships** | **Temporary relationships** |
|---|---|---|---|---|---|
| 1 | Alienation | rho | -0.17 | -0.17 | -0.39 |
| | | P | 0.096 | 0.086 | <0.001 |
| 2 | Stereotype Endorsement | rho | -0.35 | -0.35 | -0.45 |
| | | P | <0.001 | <0.001 | <0.001 |
| 3 | Discrimination Experience | rho | -0.31 | -0.26 | -0.39 |
| | | P | 0.002 | 0.008 | <0.001 |
| 4 | Social Withdrawal | rho | -0.25 | -0.17 | -0.26 |
| | | P | 0.013 | 0.096 | 0.009 |
| 5 | Stigma Resistance | rho | -0.14 | -0.19 | -0.03 |
| | | P | 0.178 | 0.057 | 0.784 |

**Table No.5: Multiple linear regression analysis results with WHO-DAS scales as dependent variables**

| **S.No** | **Dependent variable** | **Independent variable** | **b+** | **95% CI++** | **P** |
|---|---|---|---|---|---|
| 1 | Motor ability | Discrimination Experience | 0.047 | 0.031 ; 0.064 | <0.001 |
| 2 | Participation and cognition | Educational level | -0.058 | -0.115 ; -0.001 | 0.050 |
| | | Alienation | 0.024 | 0.009 ; 0.039 | 0.002 |
| 3 | Self-care | Siblings (yes vs no) | -0.225 | -0.422 ; -0.028 | 0.026 |
| 4 | Total disability score (WhoDas) | Gender (women vs men) | 0.141 | 0.002 ; 0.279 | 0.046 |
| | | Stereotype Endorsement | 0.043 | 0.025 ; 0.062 | <0.001 |

+regression coefficient; ++95% Confidence Interval

## CONCLUSION

Elements that should be given to both the interventions of the state and the interventions of mental health workers are the interventions to reduce stigma as the elimination of stereotypes even nowadays seems to be a difficult road for many social categories of people. The existence of stigma and the internalization of all those stereotypes against people with mental illness seem to be indeed a second disease with which these people face and which significantly hinders functional parts on a physical level such as self-care, mobilization and personal hygiene and pharmaceutical compliance as well as the empowerment in society as a whole through the continuation of education to find work creating social networks or family.

As shown by the present research, self-stigma contributes to the low functionality and social exclusion of the mentally ill to a significant extent. It is therefore necessary to make an effort to reduce it, for the benefit of patients, through effective interventions, such as acceptance and commitment therapy, group psycho education in the context of cognitive therapy, or the recently proposed Narrative Augmentation and Cognitive Therapy[11]. An equally important goal is to inform and raise awareness of society about mental illness in order to reduce as much as possible the stigma that it is also a primary cause of self-stigmatization. In any case, all of the above, except for a broader duty of the state, are an additional duty for every mental health worker.

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## CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

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