



Internalized stigma in schizophrenia: Relations with dysfunctional attitudes, symptoms, and quality of life

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ABSTRACT

Internalized stigma refers to the process by which individuals with mental illness apply negative stereotypes to themselves, expect to be rejected by others, and feel alienated from society. Though internalized stigma has been hypothesized to be associated with maladaptive cognitions and expectations of failure, this relationship with dysfunctional attitudes has not been fully examined. In the present study, 49 individuals with schizophrenia or schizoaffective disorder completed the Internalized Stigma of Mental Illness Scale (ISMI; Ritscher et al., 2003) in addition to measures tapping defeatist performance beliefs, beliefs regarding low likelihood of success and limited resources, negative symptoms, depression, and quality of life. Consistent with prior research, internalized stigma was correlated with depression and quality of life but not with negative symptoms. Further, internalized stigma was correlated with both measures of dysfunctional attitudes. After controlling for depressive symptomatology, the relationship between internalized stigma and beliefs regarding low likelihood of success and limited resources remained significant, and though the correlation between defeatist performance beliefs and internalized stigma was no longer significant, it was of a similar magnitude. Overall, these data suggest that dysfunctional attitudes play a role in internalized stigma in individuals with schizophrenia, indicating a possible point of intervention.

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1. Introduction

Individuals with mental illness who are highly stigmatized face serious challenges across multiple domains, including social isolation, income loss, difficulty obtaining housing and employment, depression, loss of quality of life, and reduced access to medical care (e.g., Bordieri and Drehmer, 1986; Druss et al., 2000; Farina and Felner, 1973; Katschnig, 2000; Link et al., 1987, 1989; Lloyd et al., 2005; Page, 1977). In fact, “mental illness” is regarded as one of the most highly rejected status conditions, clustering more often with drug addiction, prostitution, ex-convict status, and alcoholism rather than with conditions such as cancer, diabetes, or heart disease (e.g., Albrecht et al., 1982; Angermeyer and Dietrich, 2006; Tringo, 1970).

The current literature delineates three levels of stigma: structural, social, and internalized. While structural (i.e., institutional) stigma exists at the systems level and social stigma exists at the group level, internalized or self-stigma exists at the individual level and describes the process by which affected individuals endorse stereotypes about mental illness, expect social rejection, apply these stereotypes to themselves, and believe that they are

devalued members of society (Corrigan et al., 2005, 2006; Ritscher and Phelan, 2004). Further, internalized stigma may be characterized by maladaptive behavior, identity transformation, and acceptance of diminished expectations for oneself on the basis of mental illness (Caltaux, 2003; Livingston and Boyd, 2010).

Surveys have shown that individuals with schizophrenia and other forms of serious mental illness report high levels of internalized stigma (Ritscher and Phelan, 2004), and research has shown that internalized stigma is associated with decreased self-esteem and self-efficacy, hopelessness, demoralization, depression, reduced feelings of empowerment/mastery, poor quality of life, impairments in vocational functioning, and reduced motivation to work towards recovery goals (e.g., Link et al., 1989, 2001; Livingston and Boyd, 2010; Lysaker et al., 2007; Ritscher et al., 2003; Ritscher and Phelan, 2004; Yanos et al., 2010, 2008). Further, individuals with high levels of internalized stigma are less likely to pursue employment and independent living opportunities (e.g., Link, 1982) and less likely to utilize mental health services (Fenton et al., 1997; Sirey et al., 2001a, 2001b). Because internalized stigma obstructs recovery and wellness goals and inhibits individuals with schizophrenia from pursuing appropriate services and treatments, a thorough understanding of internalized stigma and its correlates is necessary.

One aspect of internalized stigma that has not been fully explored is the role of dysfunctional attitudes. From a social-cognitive

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perspective, Corrigan and Calabrese (2005) have proposed that internalized stigma consists of negative self-statements and schemas that surface through exposure to stereotypes present in one's culture. A frequently studied type of dysfunctional belief is defeatist performance beliefs, which are "overly generalized negative conclusions regarding [one's] own task performance (Beck et al., 2009, p. 152). For example, "If you cannot do something well, there is little point in doing it at all" or "People should have a reasonable likelihood of success before undertaking anything." Research has found that, compared to healthy controls, individuals with schizophrenia are more likely to endorse defeatist performance beliefs (Horan et al., 2010). Beck et al. (2009) have also highlighted the role of negative expectancy appraisals in schizophrenia, which refer to beliefs about reduced future likelihood of pleasure, acceptance, success, and perception of limited cognitive resources necessary to perform tasks associated with daily living. These beliefs regarding low likelihood of success and limited resources are significantly correlated with defeatist performance beliefs, diminished experience of negative symptoms, and depressive symptoms in schizophrenia (Couture et al., 2011) and may be associated with the development of maladaptive behaviors, such as social avoidance and isolation. In line with Beck's cognitive model of schizophrenia (Beck et al., 2009), the selection of maladaptive behaviors then limits opportunities to challenge the negative beliefs, which ultimately reinforces the dysfunctional beliefs and attitudes. Thus, while research has found a relationship between internalized stigma and negative beliefs about one's capability (i.e., self-efficacy, empowerment) (Corrigan et al., 2006; Ritsher et al., 2003), the relationship between internalized stigma and other forms of dysfunctional attitudes (e.g., beliefs about likelihood of pleasure, acceptance, and success) has not been empirically examined and warrants further exploration. This distinction is important because these other forms of dysfunctional attitudes encompass more than beliefs about capability. In other words, an individual with mental illness may report high levels of self-efficacy, but generalized beliefs about low likelihood of pleasure or acceptance may preclude one from social engagement.

Further, though internalized stigma has been shown to be associated with a number of psychosocial outcomes, its relationship with symptoms in schizophrenia remains unclear. Research has shown that internalized stigma increases avoidant coping and active social avoidance (Yanos et al., 2008), which suggests a possible connection to negative symptom domains of asociality and anhedonia. Rector et al. (2005) proposed that stigma may be a cognitive factor in the development of negative symptoms. In the only study to investigate the relationship between internalized stigma and negative symptoms, Lysaker et al. (2007) found that positive but not negative symptoms were associated with internalized stigma. Because this study utilized the Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987), which only includes seven negative symptom items, further exploration using a more thorough negative symptom assessment is warranted. Additionally, the role of depression is important to examine as depressive symptoms have been found to be associated with both internalized stigma (Ritsher et al., 2003; Ritsher and Phelan, 2004) and dysfunctional attitudes (Couture et al., 2011; Grant and Beck, 2009). Elucidating the relationship between internalized stigma and symptoms in schizophrenia could also inform treatment approach and development of interventions for the amelioration of internalized stigma in schizophrenia.

The current study expands on the literature regarding the relationship between internalized stigma and dysfunctional attitudes in individuals with schizophrenia. We hypothesized that defeatist performance beliefs and beliefs regarding low likelihood of success and limited resources would be significantly correlated

with self-reported internalized stigma. Consistent with prior research, we hypothesized that internalized stigma would be significantly correlated with quality of life and depression. Further, we expected that the relationship between internalized stigma and dysfunctional attitudes would remain significant after statistically controlling for depression. Finally, we investigated the relationship between internalized stigma and negative symptoms.

2. Methods

2.1. Participants

Data were taken from a larger project focused on the measurement of beliefs and attitudes proposed by cognitive conceptualizations of negative symptoms in schizophrenia. Participants with schizophrenia or schizoaffective disorder were recruited from outpatient mental health clinics affiliated with a Veterans Administration Medical Center and a division of community psychiatry at a public university. Additional inclusion criteria were age between 18 and 64 years, seen by a mental health provider at the participating clinic at least twice in the last six months, ability to read, and willingness to provide consent. Exclusion criteria were as follows: (1) documented history of neurological disorder or head trauma with loss of consciousness, (2) mental retardation as indicated by chart review, (3) history of significant neurological disease, (4) inability to provide informed consent, and (5) inability to participate due to intoxication or escalation of psychiatric symptoms at the time of the assessment resulting in disruptive or aggressive behavior. Individuals were identified by either chart review or referral by a mental health clinician, yielding a sample of 49 participants who met inclusion criteria and completed the baseline assessment.

Participants were 71.4% male and 87.8% African-American. Participants had a mean age of 49.61 (S.D.=7.15, range 25–64), a mean of 11.18 years of education (S.D.=2.05, range 6–16), and 24.5% were veterans. Overall, 81.6% lived unsupervised in a home/apartment, boarding house or halfway house, 18.4% resided in some type of supervised living arrangement, 93.3% of participants received disability benefits, and 22.4% reported a current job. In terms of diagnosis, 77.6% of participants met criteria for schizophrenia and 22.4% met criteria for schizoaffective disorder. Participants endorsed low to moderate depression on the CDSS (mean Calgary Depression Scale for Schizophrenia score=2.11, S.D.=2.22).

2.2. Measures

2.2.1. Diagnostic and symptom measures

The *Structured Clinical Interview for DSM-IV* (SCID-I; First et al., 1994) was used to establish diagnoses. Interviews were completed by masters' level assessors, and diagnoses were achieved utilizing all available information (e.g., participant report, medical records, treatment providers). To prevent rater drift, interviewers received bi-monthly supervision during which videotapes of study interviews were reviewed. The *Scale for the Assessment of Negative Symptoms* (SANS; Andreasen, 1982) is a 19-item interview measure that assesses the severity of negative symptoms in schizophrenia. The present study utilized the four SANS subscales of Affective Flattening or Blunting, Alogia, Avolition-Apathy, and Anhedonia-Asociality. Items are rated on a 6-point scale, ranging from "not at all" to "severe". The SANS has good inter-rater reliability and internal consistency (Andreasen, 1982). The *Calgary Depression Scale for Schizophrenia* (CDSS; Addington et al., 1990) is a 9-item semi-structured interview measure designed to assess depressive symptoms in people with schizophrenia separate from positive, negative, and extrapyramidal symptoms. The CDSS has good reliability and validity (Muller et al., 2005). The total CDSS score was used in all analyses.

2.2.2. Assessment of internalized stigma

The *Internalized Stigma of Mental Illness Scale* (ISMI, Ritsher et al., 2003) is a 29-item measure of internalized stigma. Sample items include: "I feel out of place in the world because I have a mental illness" and "People discriminate against me because I have a mental illness." Participants rate each item on a 4-point scale ranging from 1 (strongly disagree) to 4 (strongly agree). The ISMI includes five subscales: Alienation, Stereotype Endorsement, Discrimination, Social Withdrawal, and Stigma Resistance. Based on prior findings that the 5-item Stigma Resistance scale shows only weak relations to other ISMI subscales (Lysaker et al., 2007), items from Stigma Resistance were not considered in the current study. A modified total ISMI score was calculated based on the remaining 24 items. The ISMI has good internal consistency, test-retest reliability, and construct validity (Ritsher et al., 2003). In the current sample, the modified total ISMI score showed high internal consistency (Cronbach's alpha=0.90).

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