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# Internalized stigma and its psychosocial correlates in Korean patients with serious mental illness



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## ABSTRACT

We aimed to examine internalized stigma of patients with mental illness in Korea and identify the contributing factors to internalized stigma among socio-demographic, clinical, and psychosocial variables using a cross-sectional study design. A total of 160 patients were recruited from a university mental hospital. We collected socio-demographic data, clinical variables and administered self-report scales to measure internalized stigma and levels of self-esteem, hopelessness, social support, and social conflict. Internalized stigma was identified in 8.1% of patients in our sample. High internalized stigma was independently predicted by low self-esteem, high hopelessness, and high social conflict among the psychosocial variables. Our finding suggests that simple psychoeducation only for insight gaining cannot improve internalized stigma. To manage internalized stigma in mentally ill patients, it is needed to promote hope and self-esteem. We also suggest that a relevant psychosocial intervention, such as developing coping skills for social conflict with family, can help patients overcome their internalized stigma.

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## 1. Introduction

Individuals with mental illness suffer from stigma associated with their disorder. Although stigma associated with mental illness is a universal phenomenon, its manifestation may differ by culture (Weiss et al., 2001; Angermeyer et al., 2004; Griffiths et al., 2006; Abdullah and Brown, 2011). Some studies further suggested that stigma in Asian culture is more severe than that in Western culture (Whaley, 1997; Lauber and Rössler, 2007), due to the group-centered nature which is common among Asian populations (Chong et al., 2007; Papadopoulos, 2009; Abdullah and Brown, 2011). In addition, the patterns of stigma vary throughout Asia (Yamamoto et al., 1996; Ng, 1997; Kurihara et al., 2000; Yamada et al., 2001; Chiu et al., 2005) and even between East Asian countries of similar cultures (Kumakura et al., 1992; Hanzawa et al., 2009).

Internalized (or self) stigma refers to the inner subjective experience of stigma, which results from applying a socially negative stereotype to oneself (Link et al., 1989; Corrigan, 1998; Dickerson et al., 2002; Ritscher

et al., 2003; Dinos et al., 2004). According to a systematic review and meta-analysis of internalized stigma among mentally ill patients of diverse psychiatric diagnoses (Livingston and Boyd, 2010), high levels of internalized stigma were associated with various psychosocial (i.e., hopelessness, low self-esteem, low empowerment, reduced self-efficacy, and poor social support) and clinical factors, such as symptom severity, although not with socio-demographic factors. Moreover, previous studies revealed several effects of internalized stigma on individuals with mental illness, including reluctance to seek care (Corrigan, 2004), reduced trust in service providers (Verhaeghe and Bracke, 2011), poor adherence to psychosocial treatment (Fung et al., 2008) or medication (Tsang et al., 2009), increased hospitalizations (Rüsch et al., 2009), barrier to recovery (Ritscher and Phelan, 2004; Muñoz et al., 2011), less improvement in job functioning (Yanos et al., 2010), and poor quality of life (Vauth et al., 2007; Norman et al., 2011; Sibitz et al., 2011). Therefore, mental health professionals must come to understand the characteristics and correlates of internalized stigma to comprehend and manage their patients effectively.

In Korea, the mental health service for patients with serious mental illness is mostly comprised of an inpatient system (Lee, 2011). This system may directly or indirectly affect internalized stigma of patients with mental illness. However, most available studies in Korea have been limited to public stigma towards the

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mentally ill, whereas only a few studies have examined internalized stigma among patients with mental illness (Hwang et al., 2006; Ko et al., 2008; Kim and Jun, 2012). In this cross-sectional study, we aimed to 1) investigate internalized stigma among Korean patients with serious mental illness and 2) identify factors contributing to their internalized stigma among socio-demographic, clinical, and psychosocial variables.

## 2. Methods

### 2.1. Participants

A total of 160 patients (102 patients with bipolar I disorder, 53 schizophrenia, and 5 schizoaffective disorder) were recruited in 2010 and 2011 from the bipolar and psychotic disorder clinic of a university mental hospital. All patients met the diagnostic criteria for their disorder based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (American Psychiatric Association, 2000). Each patient underwent an interview using the Mini-International Neuropsychiatric Interview (Sheehan et al., 1998) by two expert psychiatrists. We excluded any participants with a history of mental retardation or other significant neurological or medical diseases. All 124 inpatients (77.5% of the total patients) participated in the study immediately before their discharge. The other 36 patients (22.5%) were assessed upon visiting our outpatient clinic. There were no significant differences in diagnosis (bipolar vs. schizophrenia spectrum disorder) and socio-demographic data (gender ratio, employment status, education level, current marital status, and living arrangement) between in- and outpatients. The socio-demographic and clinical variables of our whole sample are described in Table 1.

### 2.2. Measures

#### 2.2.1. Internalized stigma

The Internalized Stigma of Mental Illness (ISMI) scale (Ritsher et al., 2003; Ritsher and Phelan, 2004) was developed to assess the subjective experience of stigma on a 29-item questionnaire that uses Likert scales ranging from 1 (strongly disagree) to 4 (strongly agree). The Korean version of the ISMI, which was used in this study, had been previously tested for reliability and validity (Hwang et al., 2006). The ISMI scale consists of 5 subscales: alienation, discrimination experience, stereotype endorsement, social withdrawal, and stigma resistance. Alienation refers to the subjective experience of being devalued as a member of society. Discrimination experience measures the respondent's perception of discrimination in dealing with others. Stereotype endorsement refers to the degree to which the respondent agrees with common stereotypes about mental illness. Social withdrawal measures the avoidance of social situations. Stigma resistance is a (reverse-scored) subscale that measures the ability to remain unaffected by internalized stigma. In agreement with previous studies (Lysaker et al., 2007; Brohan et al., 2010; Mashiach-Eizenberg et al., 2013; Boyd et al., 2014), better internal consistency on the ISMI was obtained in the current study when the stigma resistance subscale was removed. Therefore, we excluded the 5-item stigma resistance subscale and computed the ISMI total score from the remaining 24 items. In our

**Table 1**  
Demographic and clinical characteristics of subjects ( $n=160$ ).

	<i>n</i>	(%)
Female	85	(53.1)
Employed	89	(55.6)
Married	62	(38.8)
Living with others	154	(96.9)
More than 4 hospitalizations	28	(17.5)
Involuntary hospitalizations	140	(90.3)
	<b>Mean</b>	<b>(S.D.)</b>
Age (years)	36.98	(9.93)
Education (years)	14.18	(2.33)
Duration of illness (years)	9.76	(8.32)
Duration of hospitalization(s)/duration of illness	0.117	(0.198)
BPRS	8.54	(7.77)
YMRS <sup>a</sup>	4.66	(6.94)
MADRS <sup>a</sup>	3.90	(4.68)
GAF	63.28	(15.17)

BPRS, Brief Psychiatric Rating Scale; YMRS, Young Mania Rating Scale; MADRS, Montgomery–Åsberg Depression Rating Scale; GAF, Global Assessment of Functioning.

<sup>a</sup> These measures were assessed in bipolar I disorder patients ( $n=102$ ) only.

sample, the ISMI total score revealed a significant degree of internal consistency (Cronbach's  $\alpha=0.89$ ).

#### 2.2.2. Self-esteem and hopelessness

The Rosenberg Self-Esteem Scale (RSES) is a 10-item questionnaire that assesses general self-esteem (Rosenberg, 1965). We used the Korean version of the RSES, which uses a 4-point Likert scale for each item (Lee, 2009). A higher score on the RSES indicates higher self-esteem. The Beck Hopelessness Scale (BHS) consists of 20-items (yes or no questions) that measure negative and pessimistic thoughts about the future. A higher score suggests a higher level of hopelessness (Beck et al., 1974; Shin et al., 1990). Both the RSES and BHS were used in previous studies of internalized stigma (Ritsher et al., 2003; Ritsher and Phelan, 2004; Lysaker et al., 2007; Fung et al., 2008; Yanos et al., 2008, 2010, 2012; Norman et al., 2011; Mashiach-Eizenberg et al., 2013).

#### 2.2.3. Social support and social conflict

The Scale of Social Support (SSS) identifies the extent of social support to which an individual has access, and the Negative Social Interaction Scale (NSIS) identifies the degree of social conflict to which an individual has experienced. Both scales were cited from a Korean article about social adjustment in mental illness (Jung et al., 2008). The SSS is composed of questions that ask how the respondent perceives affection, concern, confidence, and help from family, friends, and health professionals. The SSS is a 6-item questionnaire that uses a 5-point Likert-type scale. A higher score on the SSS indicates a higher level of social support. The NSIS assesses the amount of hostility and conflict that the respondent experiences within their social network. The NSIS is an 8-item questionnaire that uses a 5-point Likert scale (modified form of the NSIS; Rautkis et al., 1995). A higher score on the NSIS indicates a greater perception of social conflict.

#### 2.2.4. Insight, symptom severity, and function

We examined patient insight using Item 1 ("Does the individual believe that he/she has a mental disorder?") on the Scale to assess Unawareness of Mental Disorder (SUMD), which is scored from 1 to 5, with higher scores suggesting a lower level of insight (Amador et al., 1993; Song et al., 2006). To measure cognitive insight of current mental illness, we limited our analysis to "Current illness, Item 1" among 20 items of the SUMD (Lepage et al., 2008; Gilleen et al., 2011). Then, we assessed symptom severity using an 18-item version of the Brief Psychiatric Rating Scale (BPRS; range 0–108; Overall and Gorham, 1962), the Young Mania Rating Scale (YMRS; 11 items, range 0–60; Young et al., 1978), and the Montgomery–Åsberg Depression Rating Scale (MADRS; 10 items, range 0–60; Montgomery and Åsberg, 1979). The YMRS and MADRS were only assessed in relevant cases (Table 1). Psychological, social, and occupational functions were measured by the Global Assessment of Functioning (GAF) scale (American Psychiatric Association, 2000).

### 2.3. Data collection

After obtaining informed consent, two expert psychiatrists and two psychiatric residents collected socio-demographic data of all patients. Through patients' medical records and psychiatric interview, the researchers assessed clinical variables related to patients' current symptom severity and hospitalization (e.g., the number of hospitalizations and whether hospitalization was voluntarily or involuntarily). Then, all patients completed self-report scales to measure the aforementioned psychosocial variables, including internalized stigma. This study was approved by the Institutional Review Board of the Severance Mental Health Hospital and was conducted in accordance with the Declaration of Helsinki.

### 2.4. Statistical analyses

We first performed descriptive statistics on all variables collected from our sample. We also analyzed the correlation between the ISMI, continuous demographic, clinical, and psychosocial variables. To determine which categorical variables were associated with the ISMI, we analyzed the differences of means of the ISMI for each categorical variable using Student's *t*-tests. Variables that were significantly associated with the ISMI were added to hierarchical multiple regression analyses to determine the cross-sectional predictors of internalized stigma. The demographic, clinical, and psychosocial variables were respectively put into the regression analyses sequentially. The ISMI total score was set as the dependent variable. Multicollinearity was not observed among the independent predictors that were included in the multiple regression models. A statistical power analysis was performed, which was expected to require a power of 0.8 based on  $\alpha < 0.05$  for medium effect size (effect size  $f^2=0.15$ ) using G\*power 3 (Faul et al., 2007). The needed sample size was 123–157 when the number of predictors was 11–20; this result of power analysis showed that our sample size (160 subjects) was statistically relevant. The other analyses were conducted using the Statistical Package for the Social Science version 20 (SPSS Inc., Chicago, IL, USA), and the criterion for significance was set at  $P < 0.05$ .

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