A stress-coping model of mental illness stigma: II. Emotional stress responses, coping behavior and outcome

Nicolas Rüscha, Patrick W. Corrigan, Karina Powell, Anita Rajah, Manfred Olschewski, Sandra Wilkniss, Karen Batia

Illinois Institute of Technology, Chicago, USA
Department of Psychiatry and Psychotherapy, University of Freiburg, Germany
Department of Medical Biometry and Statistics, University of Freiburg, Germany
Thresholds Institute, Chicago, USA
Heartland Alliance for Human Needs and Human Rights, Chicago, USA

1. Introduction

Stigma is a stressor for many people with schizophrenia and other mental illnesses and therefore a major clinical and public health issue (Corrigan, 2005; Hinshaw, 2007; Thornicroft, 2006). Yet some individuals with mental illness are demoralized by stigma while others remain relatively unaffected (Corrigan and Watson, 2002; Rüscher et al., 2006b). In part 1 of this two-part paper, we discussed public and personal predictors of stigma stress, that is whether stigmatized individuals feel that the potential harm of stigma exceeds their resources to cope with this threat (Rüscher et al., 2009-this issue). In part 2, we apply the same social–psychological stress-coping model of stigma (Major and O’Brien, 2005) to examine emotional and cognitive reactions to stigma stress appraisal and how these reactions affect broader outcomes for stigmatized individuals (Fig. 1). While...
previous work investigated other stressors and coping in schizophrenia (Betensky et al., 2008; Cooke et al., 2007; Myin-Germeys and van Os, 2007; Roe et al., 2006), we focus here on stigma-related stress and its consequences. This can provide a better understanding of how stigma affects people with mental illness and help to identify targets for interventions that aim to reduce stigma’s negative impact (Knight et al., 2006; Lysaker et al., 2007a; MacInnes and Lewis, 2008).

Reactions to stigma stress can explain why individuals cope more or less successfully with stigma. Stress appraisal leads to two sets of responses (Fig. 1), involuntary emotional reactions and deliberate cognitive coping responses. Two key emotions in the context of stigma are social anxiety and shame (Lazarus, 1993). Social anxiety is a reaction to stigma as a threat in social interactions (Spencer et al., 1999). Likewise, shame is prominent in mental illness (Rüsch et al., 2007b), an emotional correlate of internalized stigma (Rüsch et al., 2006a) and a reaction to being socially exposed and humiliated as a devalued person (Lewis, 1998). This is consistent with findings that shame and social anxiety are consequences of social devaluation among members of the public (Gilbert and Miles, 2000) and of stigmatizing experiences in persons with psychosis (Birchwood et al., 2007).

Coping responses, on the other hand, are conscious and volitional regulation efforts in response to stressors (Miller, 2006). In their classic paper, Crocker and Major (1989) explored three coping mechanisms that can help preserve the self-esteem of stigmatized individuals. First, group members can devalue domains in which their group stereotypically performs poorly, such as work and education in the case of people with mental illness. Negative feedback or failures such as unemployment are then less likely to have a negative impact on the person because these domains become peripheral in the person’s self-concept. The second coping mechanism is to compare oneself primarily with ingroup members, i.e. with other people with mental illness; because other ingroup members are likely to be similarly disadvantaged, ingroup comparisons are usually less painful and self-esteem threatening than comparisons with more advantaged majority outgroup members (i.e., members of the public). Third, a person may choose to attribute negative feedback to discrimination rather than to internal causes such as lack of ability, blaming discrimination instead of blaming the self (Major et al., 2003).

Emotional or cognitive stress responses influence global outcomes. No reaction to stigma is universally beneficial or detrimental (Major and O’Brien, 2005) because one coping response may be helpful in one domain but harmful in another. For example, a person with mental illness may use the coping mechanism of ingroup comparisons to stabilize self-esteem. However, lack of outgroup comparisons may undermine motivation and learning opportunities, resulting in lower academic, vocational or social performance in the long run. Therefore we measured four outcomes, two of which are related to a person’s self-image and two to social performance. First we studied self-esteem and hopelessness as a pair of self-directed outcomes. Self-esteem is of interest because the above-mentioned cognitive coping responses can protect self-esteem (Crocker and Major, 1989; Major et al., 2003) and experiencing stigma is often associated with lower self-esteem (Corrigan et al., 2006; Link et al., 2001; Lysaker et al., 2007b, 2008b; Rüsch et al., 2006a; Wright et al., 2000; Yanos et al., 2008). Hopelessness, as a negative self-directed outcome, is a proxy for demoralization as a consequence of stigma, its relevance being underlined by its association with suicidality (Brezo et al., 2006). Although not assessing stigma stress appraisal, previous studies found aspects of internalized stigma, such as feeling devalued or agreeing with negative stereotypes, and impaired self-experience as reflected by illness narratives to be associated with reduced hope in schizophrenia (Lysaker et al., 2006, 2008a; Yanos et al., 2008). A second pair of outcomes referred to social behavior in the interaction with “normal” majority outgroup members, who are often the source of stigma. Social behavior was measured by a standardized role-play test and a seating distance measure. We examined the hypotheses that first, higher stigma-induced stress appraisal predicts higher levels of emotional stress reactions and cognitive coping responses; and second, that emotional and cognitive stress responses predict broader outcomes.

2. Materials and methods

2.1. Participants

In part 1 (Rüsch et al., 2009-this issue) we reported details of study participants. Briefly, 85 persons with mental illness participated. Twenty-three (27%) participants had schizophrenia, 22 (26%) schizoaffective, 30 (35%) bipolar I or II, and the remaining 10 (12%) recurrent unipolar major depressive disorders. Overall, 33 subjects (39%) suffered from a comorbid current alcohol- or substance-related abuse or dependence.

2.2. Emotional and cognitive responses to stigma stress

Social anxiety and shame were measured as involuntary emotional responses to stigma. Social anxiety was assessed by the fear score of the Liebowitz Social Anxiety scale (Liebowitz,
دریافت فوری
متن کامل مقاله
امکان دانلود نسخه تمام متن مقالات انگلیسی
امکان دانلود نسخه ترجمه شده مقالات
پذیرش سفارش ترجمه تخصصی
امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
امکان دانلود رایگان ۲ صفحه اول هر مقاله
امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
دانلود فوری مقاله پس از پرداخت آنلاین
پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات