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Demographic and clinical features related to perceived discrimination in schizophrenia

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ABSTRACT

Perceived discrimination contributes to the development of internalized stigma among those with schizophrenia. Evidence on demographic and clinical factors related to the perception of discrimination among this population is both contradictory and scarce in low- and middle-income countries. Accordingly, the main purpose of this study is to determine the demographic and clinical factors predicting the perception of discrimination among Mexican patients with schizophrenia. Two hundred and seventeen adults with paranoid schizophrenia completed an interview on their demographic status and clinical characteristics. Symptom severity was assessed using the Positive and Negative Syndrome Scale; and perceived discrimination using 13 items from the King's Internalized Stigma Scale. Bivariate linear associations were determined to identify the variables of interest to be included in a linear regression analysis. Years of education, age of illness onset and length of hospitalization were associated with discrimination. However, only age of illness onset and length of hospitalization emerged as predictors of perceived discrimination in the final regression analysis, with longer length of hospitalization being the independent variable with the greatest contribution. Fortunately, this is a modifiable factor regarding the perception of discrimination and self-stigma. Strategies for achieving this as part of community-based mental health care are also discussed.

1. Introduction

People with schizophrenia usually experience two main problems: the symptoms of the disorder itself, and discrimination from others, which in turn interferes with their service use (Angermeyer et al., 2017; Corrigan and Rüsch, 2002) and therefore their likelihood of recovery. Moreover, even when patients manage to control their symptoms though proper treatment (including negative ones, such as abulia) and are motivated and able to work, they still have great difficulty finding a job due to employment discrimination (Daumerie et al., 2012; Rüsch et al., 2005).

Moreover, due to their awareness of other people's discrimination, patients may show diminished self-esteem (Vass et al., 2015) and develop a subjective, internal experience of stigma or self-stigma (Quinn et al., 2015; Ritsher et al., 2003), with all the personal suffering and other harmful consequences this entails (Brohan et al., 2010).

According to the INDIGO cross-sectional survey in 27 countries (Thornicroft et al., 2009), both experienced and anticipated discrimination are a global pattern among people with mental illness. Approximately half of them experienced negative discrimination in making friends and from family members, while over a third had difficulty finding or keeping a job, and in intimate or sexual relationships. Anticipated discrimination affected a higher percent (55% seeking a close relationship, and 64% applying for work, training, or education).

Interestingly, it is also true that not everyone with a mental disorder who is aware of negative social attitudes towards them suffers from self-stigma (Rüsch et al., 2006), which has prompted efforts to understand factors related to the perception of discrimination and the development of internalized stigma among patients with schizophrenia. This could help identify vulnerable patients and design and implement effective preventive and therapeutic interventions to target specific groups; for which it would obviously be necessary to consider country and cultural

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differences (Krajewski et al., 2013).

Nevertheless, there is a dearth of evidence on this particular area of knowledge, since it is usually produced in high-income countries where social determinants related to mental health outcomes may differ from those in low- and middle-income countries, while incongruent findings regarding the way certain factors are related to the perception of discrimination and the development of self-stigma are extremely common. For example, whereas some studies suggest that people with mental illness with lower incomes and more unemployment are more likely to experience a sense of devaluation and discrimination than people with better social outcomes (Cechnicki et al., 2011), other authors cite current employment, usually related to high educational attainment, as a significant demographic predictor of high internalized stigma (Krajewski et al., 2013).

Inconsistent results regarding clinical factors related to the perception of discrimination and the development of self-stigma have also been reported. A number of studies, including some on low- and middle-income countries, suggest that patients with more severe symptoms and/or longer duration of illness are more likely to experience self-stigma (Boyd et al., 2014; Holubova et al., 2016; Thornicroft et al., 2009), whereas other authors suggest that socioeconomic variables, rather than symptoms or social functioning, are related to the perception of discrimination among patients with schizophrenia (Dickerson et al., 2002). In their study on the association between self-stigma and socio-demographic, socioeconomic and psychosocial variables in six European countries, Krajewski et al. (2013) present initial evidence on between-country differences in both the occurrence and mechanisms whereby self-stigma operates, specifically regarding the probable different impact of socio-cultural context on the relationship between perceived discrimination and the internalization of stigmatizing experiences.

In this context, the aim of the present study is to determine the demographic and clinical factors that predict the perception of discrimination among Mexican patients with schizophrenia.

2. Method

2.1. Participants

This research used data from 217 participants over 18 with a DSM-IV (American Psychiatric Association, 1994) diagnosis of paranoid schizophrenia, who were receiving specialized psychiatric treatment at the *Schizophrenia and Psychotic Disorders Clinic* at the outpatient department of the Ramón de la Fuente National Institute of Psychiatry (*Instituto Nacional de Psiquiatría Ramón de la Fuente Muñíz* (INPRF)), a highly specialized mental health center in Mexico City. Patients were not included if they had a concomitant medical or neurological illness according to the clinical interview or medical records or if they were agitated at the time of the evaluation for the study.

Patient recruitment included a non-probabilistic sample approach: all patients took part voluntarily after receiving a full explanation of the procedures for the study and gave their written informed consent. The study was approved by the INPRF Research Ethics Board.

2.2. Assessment procedures

A diagnosis of paranoid schizophrenia was undertaken using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) (First et al., 1997) and confirmed by consensus by two clinicians from the *Schizophrenia and Psychotic Disorders Clinic*.

The demographic and clinical variables analyzed in this study were obtained through clinical face-to-face interviews with the patient and their relatives. Questions on demographic status included sex, age, years of education, marital and employment status; while clinical variables were linked to schizophrenic features during illness evolution, including age at onset, duration of untreated psychosis (DUP) – defined as the time from the onset of psychotic symptoms to the first contact with a psychiatric facility to receive specialized treatment (Larsen et al., 1998)–, previous psychiatric hospitalizations and the number and total length of hospitalizations.

Symptom severity at the time of the study was assessed using the five-factor model (positive, negative, cognitive, excitement and depression/anxiety dimensions) of the *Positive and Negative Syndrome Scale* validated in the Mexican population (Fresan et al., 2005) by previously trained clinicians. For the assessment of *Discrimination*, the Spanish version of King's Internalized Stigma Scale (ISS) was used (Flores-Reynoso et al., 2011; King et al., 2007). This version comprises 13 of the 28 self-report items of the ISS scored on a five-point Likert agreement scale, and refers to *the perception of negative reactions of other people toward the illness, including acts of discrimination by health professionals and employers* (King et al., 2007). We chose not to include the remaining two dimensions of the ISS, *Disclosure* and *Positive Aspects*, since they refer to the management of illness to avoid discrimination and the acceptance of illness, and the aim of this study is related to the perception of discrimination.

2.3. Statistical analyses

All analyses were performed with the statistical package SPSS version 20.0. Descriptive statistics of all variables were calculated. Bivariate linear associations between demographic and clinical variables with the total score for *Discrimination* were subsequently determined through the Pearson correlation coefficient. This analysis was used to identify the variables of interest to be included in a multiple linear regression analysis. The β-coefficients were used as an effect size measure of the variables with the highest association with the *Discrimination* score. All analyses were deemed significant at $p \leq 0.05$.

3. Results

3.1. Sample description

Table 1 shows the demographic and clinical features of the 217

Table 1
Demographic and clinical features of the simple.

	n	%	
Gender			
Male	146	67.3	
Female	71	32.7	
Marital status			
Single	179	82.5	
Married	38	17.5	
Occupational status			
Unemployed	86	39.6	
Housewife activities	39	18.0	
Student	29	13.4	
Employed	63	29.0	
Psychiatric hospitalizations			
No	93	42.9	
Yes	124	57.1	
	Mean	**S.D**	**Range**
Age	37.4	10.8	18–65
Years of education	11.7	3.2	2–21
Age of illness onset	24.5	8.0	9–51
Duration of untreated psychosis (weeks)	85.7	163.3	6–1776
Number of psychiatric hospitalizations	1.7	1.6	1–15
Mean length of hospitalization (weeks)	6.1	5.2	1–32
PANSS score			
Positive dimension	15.5	5.6	8–38
Negative dimension	16.8	5.0	7–35
Cognitive dimension	14.2	3.8	7–29
Excitement dimension	5.8	2.3	4–14
Depression/Anxiety dimension	7.0	2.7	4.16
Total score	59.3	15.9	34–119