Research Article

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Effects of Internalized Stigma of Mental Disorder on Quality of Life and Self-Esteem in Panic Disorder Patients

Borjanka Batinic[1*], Elena Lemonis[1] and Goran Opacic[2]

[1]Faculty of Philosophy, University of Belgrade, Serbia

[2]Faculty of Psychology, University of Belgrade, Serbia

*Corresponding author: Batinic Borjanka, MD, Ph.D, Psychiatrist, Assistant Professor, Faculty of Philosophy, Department of Psychology, Clinic of Psychiatry, Clinical Centre of Serbia, Serbia, Tel: +381 11 3662113; Email: doubleb@eunet.rs

Abstract

Background: There is growing evidence of the negative effects of internalized stigma of mental illness (ISMI) on the quality of life (QL) and self-esteem (SE) of patients with mental disorders. There is still however scant data on the degree to which ISMI influences QL and SE in panic disorder (PD) patients.

Aims: To determine the level of ISMI in PD patents and its influence on the QL and SE.

Method: The pilot study sample consisted of 40 PD outpatients, whose average age was 37.88 (SD=9.685) years, with mean illness duration of 6.436 (SD=7.126) years. Assessment instruments included the Internalized Stigma of Mental Illness Scale, the Rosenberg Self-Esteem Scale, the Manchester Short Assessment of Quality of Life and Beck Depression Inventory II.

Results: Patients with PD showed a moderate level of ISMI (M=31.8, SD=9.685). Patients with higher levels of ISMI had significantly poorer QL (r=-0.672), lower SE (r=-0.434), and higher level of depression (r=0.696). The results also indicated that ISMI has an additional negative impact on SE and QL over depression.

Conclusions: ISMI correlated negatively with QL and SE. In order to improve QL and SE in PD patients, we should increase awareness of the burden of ISMI and focus on it as one of the treatment goals.

Keywords: Internalized stigma of mental illness; Quality of life; Self-esteem; Panic disorder patients

Introduction

Since ancient times, when mental illness was connected to "evil spirits" and demonic possession, people suffering from mental illness have faced public stigma. In modern societies, despite advances in the treatment of the mentally ill, psychiatric disorders are still viewed as congenital, untreatable, a sign of personal weakness, uncontrollable and dangerous, despite the fact that less than 3% of mentally ill patients could be categorized as dangerous [1]. Many factors play their part in the persistence of stigma against the mentally ill: the possibility of peculiar and bizarre behaviour which is both undesirable and inconsistent with social norms; the risk of unpredictable behaviour as a result of "being out of one's mind"; the risk of suicide and self-injury; the sensationalism by the mass media in its portrayal of the mentally ill; resistance to psychiatric therapy which is sometimes considered no different to "brainwashing"; the devastating effects of psychosis manifested through functional impairments; and family stigmatization whereby mental illness is seen as "running in the family as a result of bad genes".

There are many different ways in which the general public stigmatizes people with mental illness, and these include labelling, stereotyping, separation, discrimination, etc. Public stigma frequently results in self-stigma as "The product of internalization of shame, blame, hopelessness, guilt and fear of discrimination associated with mental illness" (To experience self-stigma a person must be aware of the stereotypes that describe a stigmatized group of people with mental illness (e.g., "People with mental illness are unpredictable and dangerous"), agree with them ("That's right, people with mental illness are unpredictable and dangerous to other people"), and apply stereotypes to themselves ("I am mentally ill, so I must be dangerous to other people"). These forms the "three A's" of the self-stigmatization process: awareness, agreement, and application [2]. Research suggests that self–stigma leads to decreased self-esteem, depression, delayed seeking of treatment, prolonged course of illness, poor outcome, social withdrawal, reduced self-efficacy and worsening of quality of life [3-12].

It is well documented that people with severe mental illness (e.g., schizophrenia, bipolar disorder) are those who are the most troubled by public and internalized stigma [13,14], but there is a scant data on stigma associated with less severe forms of mental disorders. In our study, we have chosen to research internalized stigma in panic disorder patients who face sudden, unexpected panic attacks, one of the most unpleasant emotional experiences, with a a range of significant physiological and cognitive symptoms. The physical symptoms of panic attacks make some patients believe deeply that they have a life–threatening illness and that their very physical survival is in question, particularly in those with chest pains or with comorbid cardiovascular disease. With each new panic attack, they often expect disaster to occur – leading to a "life with fear" and a "life in fear".

Research indicates that the prevalence of panic disorder among cardiology outpatients, and patients with documented coronary artery disease, ranges between 10% and 50% [15]. Patients with comorbid coronary ischemic disease and panic disorder may really be at increased cardiac risk as panic attacks increase coronary vasomotor tone, an important component of sympathetic hyperactivity, setting off an increase in myocardial oxygen consumption [16,17]. The difficulty in distinguishing between chest pains due to psychogenic and organic causes can lead to patients living on the "edge," with a sense of having no control over their own lives – this in turn can lead to demoralization and depression. Some patients, especially those with symptoms of depersonalization and derealisation, suffer from significant phrenophobia – the fear of insanity, and they can suffer for a long time in secret, avoiding psychiatric consultation because they fear the psychiatrist might diagnose "their madness." They are afraid of ending up in a mental institution, of being "stigmatized", of the possibility of behaving unpredictably, of being rejected, of losing social status and of embarrassing their families. Many fear that others will see their symptoms and judge them as unstable and fragile. Also, some patients with panic disorder are at risk of developing agoraphobia with incapacitating symptoms such as avoiding public places and crowds. In the most severe cases, this can leave them housebound, as the house is the only place where they feel they can tolerate their anxiety. People who cannot independently go into the street, go shopping, go to the dentist or hairdresser, or take their children to school, and who depend on other people to help with day-to-day activities, over time demoralize, lose self-esteem, experience helplessness and become secondarily depressed. Some of them feel disappointed when, after a number of somatic examinations, they are diagnosed with a mental disorder, which receives less sympathy and protection from those they love, feeling that mental illness is seen as a weakness and a defect of personality. All of these facts could influence self-esteem in patients with panic disorder and result in internalization of negative stereotypes about mentally ill people. This could further lead to depression and vice-versa, social withdrawal and decrease in quality of life. We hypothesized that panic disorder patients (with/without agoraphobia) experience internalized stigma, and this experience of self-stigma is negatively correlated with self-esteem and quality of life, and positively correlated with depression.

Method

Sample

The study was undertaken among 40 outpatients who fulfilled the DSM-IV-TR (APA, 2000) criteria for Panic Disorder (with/without Agoraphobia). The patients were recruited at the Clinic of Psychiatry, Clinical Centre of Serbia and the Association of People with Neurosis "Hertz". All patients were undergoing pharmacological and cognitive-behavioural treatment for panic disorder and agoraphobia. Participation was voluntary and anonymous.

Measures

The following measure instruments were applied:

1.Internalized Stigma of Mental Illness (ISMI) scale [18]: The ISMI is a 29-item instrument with 5 subscales for self-rated assessment of the subjective experience of stigma: Alienation, Stereotype Endorsement, Perceived Discrimination, Social Withdrawal and Stigma Resistance. Each item is rated on a 4-point Likert scale, ranging from 1=strongly disagree, to 4=strongly agree, with higher scores indicating higher internalized stigma. The Stigma Resistance subscale consists of 5 reverse coded items. The ISMI has high internal consistency and test-retest reliability. In our sample, the ISMI also showed high internal consistency (Cronbach's alpha=0.93).

2.Rosenberg self-esteem scale (RSE) [19]: The RSE is a ten-item Likert scale, which ranges from 0-30. The higher the score, the higher is the level of self-esteem. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem. The RSE demonstrates excellent internal consistency and test-retest reliability.

3.Manchester Short Assessment of Quality of Life (MANSA) [20]: The MANSA is a short instrument for assessing quality of life, focusing on satisfaction with life as a whole and with life domains (job or sheltered employment, training/education, unemployment/retirement, financial situation, number and quality of friendships, leisure activities, accommodation, personal safety, people with whom the individual lives/or living alone, sex life, relationship with family, physical health and mental health). Its psychometric properties appear satisfactory. The higher the score, the better is the quality of life.

4.Beck Depression Inventory-second edition (BDI-II) [21]: The BDI-II is an assessment of the severity of depression in psychiatrically diagnosed patients. Its internal consistency and test-retest reliability are high. It consists of 21 items, and the maximum total score is 63. Clinical interpretation of total scores uses the following guidelines: 0 to 13 (minimal depression), 14 to 19 (mild depression), 20 to 28 (moderate depression), and 29 to 63 (severe depression).

Statistical analysis

The results were analysed with the SPSS18 statistical package (modules, descriptives and correlations), and AMOS19 (for linear structural equation modelling).

Results

	Minimum	Maximum	Mean	SD
RSE	11.00	30.00	26.63	4.595
BDI	11.00	54.00	14.60	11.991
MANSA	27.00	79.00	56.33	12.272
ISMI	16.00	65.00	31.65	13.147
***Alienation**	1.00	5.00	2.24	1.013
***Stereotype**	1.00	4.00	1.83	0.764
***Discrimination**	1.00	4.20	1.75	0.857
***Soc Withdraw**	1.00	5.00	1.93	0.993
***Resistance**	1.00	5.00	2.85	0.954
*- mean of responses on items that consist of the subscales (1-5)				

Table 1: Descriptive Statistics: Means and standard deviations of all administered instruments. RSE-Rosenberg self-esteem scale; BDI-Beck Depression Inventory II, MANSA-Manchester Short Assessment of Quality of Life; ISMI-Internalized Stigma of Mental Illness scale.

Socio-demographic characteristics of the sample: Gender: male 7 (17.5%), female 33 (82.5%); current age: Mean 37.88 (SD 9.685; Min.

23, Max. 65); education: primary school/secondary education/bachelor degree/university degree-masters and higher: 2/26/8/4; employment status: employment/unemployment/retired: 20/18/2; marital status: single/married/divorced: 12/25/3.Basic information about illness: duration of illness (years): Mean 6.44 (SD 7.126; Min. 0, Max. 30); age at first treatment: Mean 31.31 (SD 9.088; Min. 14, Max. 54); Time between onset of symptoms and treatment (years): Mean 1.50 (SD 2.987; Min. 0, Max. 14). As shown in Table 1, panic disorder patients (with/without agoraphobia) experience a moderate level of internalized stigma of mental illness (ISMI: Mean 31.65, SD 13.147, Min. 16, Max. 65).

In order to confirm the hypothesis that internalized stigma of mental disorder is negatively correlated with self-esteem and quality of life and positively correlated with depression, a correlation analysis was conducted. Results are shown in Table 2. As can be seen in Table 2, the Internalized Stigma of Mental Illness (ISMI) scale has significant correlations with all other instruments. All correlations are in hypothesized directions. The greatest one (0.696) suggests that that subjective experience of stigma has a strong connection with depressive symptoms. The second affected area is quality of life. As expected, a stronger experience of stigmatization was connected with poorer quality of life (612). Further, people with stronger internalized stigma had lower self-esteem. In order to determine whether self-stigmatization has a negative impact on the self-esteem and quality of life over depression, the two two-steps regressions was performed. BDI was included as a predictor in the first step, and ISMI was added to the second.

	BDI	MANSA	ISMI
RSE Rosenberg self-esteem scale	-0.440**	0.212	-0.434**
BDI Beck Depression Inventory	1	-0.556**	696**
MANSA Manchester Short Assessment of Quality of Life			-0.612**
ISMI Internalized stigma of mental illness scale			1
** Correlation is significant at the 0.01 level (2-tailed).			

Table 2: Correlations between applied instruments.

		Beta	
	Model	**RSE**	**MANSA**
Step 1	**BDI**	-0.354**	-0.635**
Step 2	**BDI**	-0.187	-0.496**
	ISMI	-0.315**	-0.262*
**-p<0.001, *-p<0.05			

Table 3: The two step regression: the beta weights of the variables included in model

The result showed that depression is explained about 11.5% of SE variance (R=0.354 adjusted R2=0.114, p<0.001). Inclusion of ISMI in equation increased the proportion of explained variance up to 17.6% (R=0.444 adjusted R2=0.176 p<0.001). Depression was a significant predictor of self-esteem in the first step, but lost predictive power with

the inclusion of ISMI (Table 3).The correlation between depression and quality of life was much higher (R=0.635 adjusted R2=0.396 p<0.001). Despite this high correlation, inclusion of ISMI increased the predictive power of more than 4 percent (R=0.673 adjusted R2=0.438 p<0.001). Depression remains a significant predictor after inclusion of ISMI in equation (Table 3). We can conclude that internalized stigma of mental illness has an additional negative impact on self-esteem and quality of life over depression.

In the next step we tried to analyse specific relations between different aspects of stigmatization measured by the Internalized Stigma of Mental Illness scale (Alienation, Stereotype Endorsement, Discrimination, Social Withdrawal and Stigma Resistance). As can be seen in Table 4, all correlations between self-esteem and subscales of ISMI are statistically significant. The subscale of Stigma Resistance had the greatest correlation with self-esteem. Although the correlation cannot be interpreted in a causal way, we can assume that people with higher self-esteem have stronger resistance to stigmatization. It is interesting that stigma resistance did not correlate with other variables measured in this research. Correlations of self-esteem with other aspects of the ISMI were notably smaller. Correlations of Alienation, Stereotype Endorsement, Discrimination and Social Withdrawal with depressive symptoms and quality of life went in the same direction as the global score. Their size revealed that internalized stigma correlated closely with depressive symptoms and quality of life.

	RSE	**BDI**	**MANSA**
Alienation	-0.415**	0.697**	-0.605**
Stereotype	-0.383*	0.581**	-0.530**
Discrimination	-0.392*	0.659**	-0.535**
Social Withdrawal	-0.378*	0.683**	-0.553**
-Resistance	-0.661**	0.247	0.098
** Correlation is significant at the 0.01 level (2-tailed); * Correlation is significant at the 0.05 level (2-tailed); recoded in reverse direction.			

Table 4: Correlations between subscales of ISMI and self-esteem, depressive symptoms and quality of life

	Stereotype	**Discrimination**	**SocWithdr.**	**Resistance**
Alienation	0.755**	0.756**	0.821**	0.099
Stereotype		0.793**	0.826**	0.076
Discrimination			0.814**	0.220
Social Withdrawal				0.086
** Correlation is significant at the 0.01 level (2-tailed).				

Table 5: Inter-correlations between subscales of ISMI

Different patterns of correlations indicate that resistance is not a part of the same construct as other variables. Inter-correlations between the ISMI subscales give us arguments for this conclusion (Table 5). The correlation of the resistance subscale with self-esteem is much higher than its correlations with other ISMI subscales. All other

cross-correlations are higher than 0.755 and indicate similarity of measured constructs.

Taking into account the results presented earlier, a model of causal relationship between variables was tested by structural equations, modelling that used in the AMOS 19 program. Parameters of model fit, compared with independent and saturated models, are presented in Table 6. As can be seen in Table 6, most of the model fit parameters indicate a good model fit. Chi square is not significant and indicates that there is not a statistically significant difference between data reproduced by the model and empirical data. The NFI and CFI indicate a good model fit. The GFI is a little below the critical values proposed by Hu and Bentler [22] and the RMSEA is a little above the proposed critical value. A graphical representation of the model is given in Figure 1.

Model	GFI	NFI	CFI	RMSEA	CHI	P	CMIN/DF
Default model	0.888	0.904	0.973	0.091	22.510	0.166	1.324
Saturated model	1.000	1.000	1.000	0.435	0.000		
Independence model	0.320	0.000	0.000		234.774	0.000	8.385

Table 6: Fit indices of proposed model. GFI=goodness of fit index; CFI= Comparative Fit Index; NFI=Normed fit index; RMSEA=root mean square error of approximation
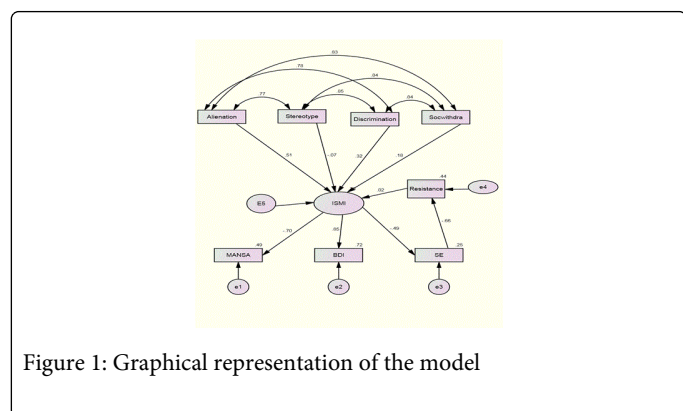

Figure 1: Graphical representation of the model

Discussion

The study results are in concordance with other research on the association between internalized stigma of mental illness, self-esteem, depression and quality of life in mental disorder patients [6,11,12,23]. Panic disorder patients with higher levels of internalized stigma have a significantly poorer quality of life and lower self-esteem. Our results suggest that that subjective experience of stigma has the strongest connection with depressive symptoms. The higher the level of depressive symptomatology, the higher level of internalized stigma. Patients who had longer duration of illness also had higher levels of self-stigma. It would appear that it is difficult for people with panic disorder to separate their panic, agoraphobia and depression from self-esteem. People with panic disorder are also part of the culture which still has highly stigmatizing attitudes toward mental illness. They may view their disorder as a sign of weakness or madness, or defect in character by internalizing stigmatizing ideas widely spread within

society and may start to believe that they are less valued because of psychiatric problems. Self-stigmatization may further leads to depression, delay of treatment seeking, social isolation and diminishment of self-efficacy and quality of life. The high comorbidity of panic disorder and depression is well documented, as is the negative effect of depression on self-esteem and quality of life [24]. We could discuss whether depression leads to self-stigma or self-stigmatization leads to depression. The results showed that internalized stigma of mental illness has an additional negative impact on self-esteem and quality of life over depression. Nevertheless, the interventions that both reduce self-stigma and illness symptoms (panic, depression) are likely to be more efficient in preventing recurrence, relapse and chronic course of panic disorder.

According to our findings, the subscale of ISMI Stigma Resistance had the strongest positive correlation with self-esteem, which is in line with data from literature that persons with psychiatric [12,25-27]. Unexpectedly, Stigma Resistance did not correlate with depression or quality of life. Different patterns of correlations are indicators that Stigma Resistance is not the part of same construct as other variables. As Sibitz et al. [12] suggested the Stigma Resistance subscale is conceptually different to the other subscales and should be considered as a separate construct to self-stigma.

Limitations of the study and further research suggestions

This study has several limitations. Even though we used causal modelling, the inferences about causal relationships should be considered with caution, as we did not have a longitudinal, rather a transactional, research design. Longitudinal or intervention studies could provide us with greater confidence about causal relationships. Also, we are not sure whether our findings can be generalized to other cultures and to other psychiatric nonpsychotic disorders, as we lack a control group of other nonpsychotic disorders. Other relevant clinical data regarding the psychopathological state, comorbidity, and compliance to therapy may reveal a much clearer picture about the impact of stigma experiences, as well as personality traits and social support.

Conclusions

In order to improve quality of life and self-esteem in panic disorder patients and decrease depression and illness duration, we should increase awareness of the burden of internalized stigma on personal well-being and focus on it as one of the treatment goals. Cognitive-Behavioural Therapy (CBT) is a successful approach in managing self-stigma dysfunctional attitudes and may improve self-esteem and quality of life and decrease depression. The CBT approach includes education, symptom and stress management strategies, cognitive restructuring of negative beliefs and exposure to feared stimuli.

Acknowledgement

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