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INTERNALIZED STIGMA AND RECOVERY ATTITUDE AMONG MENTALLY ILL PATIENTS

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***Abstract:* internalized stigma can result in negative feelings about self, maladapted behavior, identity transformation or stereotype endorsement and it can cause significant obstruction to psychological well-being and impairs the attitude toward recovery. The aim of this study: was to examine the relationship between internalized stigma and recovery attitude among mentally ill patients. Design: Descriptive correlational design was utilized in this study. Setting: the study held at the Outpatient Clinics of “Psychiatric Medicine and Addiction Prevention Hospital - Cairo University Hospitals". Sample: A convenient sample of 250 patients with mental illness recruited for this study according to G power analysis. Tools for data collection were: Socio-demographic and clinical data sheet, Internalized Stigma of Mental Illness inventory (ISMI) and Recovery Attitudes Questionnaire (RAQ). Results: Regarding relationship among domains of internalized stigma subscales with recovery attitude, there were no significant statistical correlation between alienation, stereotype endorsement, discrimination experience and social withdrawal subscales with recovery attitude. On the other hand there was a significant statistical weak negative correlation between recovery attitude and stigma resistance subscale. In addition, the study results found that more than one third of the participants had moderate level of internalized stigma and the majority of the participants had positive attitude toward recovery from mental illness. Conclusion: The current study concluded that age, gender, marital status and occupation had no significant statistical difference with internalized stigma and recovery attitude but participants’ diagnosis had significant statistical difference with recovery attitude. Moreover education level, duration of illness and number of hospital admissions had significant statistical difference with internalized stigma. The study also revealed that, those patients with psychiatric illness had positive attitude toward recovery from mental illness despite expressing moderate levels of perceived self-stigma. Recommendations: Longitudinal design is needed and necessary clinical implications concerning creating and refining interventions that address internalized stigma.**

***Keywords:* Internalized stigma, recovery attitude, mentally ill.**

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1. INTRODUCTION

Stigma of mental illness is defined in many ways but can be summarized into three general parts: “absence of adequate knowledge (ignorance), negative attitudes (prejudice), and exclusion or avoidance behaviors (discrimination) which deposits self-stigma resulting in fear of and withdrawal from leading to not seek mental health treatment and social support” **(Ogunsemi, Odusan & Olatawura 2008; Abd-Malik, Kannusamy & Klainin-Yobas, 2012; Papish, et al., 2013).**

More accurately, internalized stigma can be defined as ‘‘a subjective process, rooted within a socio-cultural context, and characterized by negative feelings about self, maladaptive behavior, identity transformation, or stereotype endorsement resulting from an individual’s experiences, perceptions, or anticipation of negative social responses on the basis of their mental illness’’**(Livingston & Boyd, 2010).**

Stereotype settlement takes place when a person accepts the stereotypes as real and usable. The stereotypes then become individually applicable when the person develops mental health difficulties, starts to become aware of him or herself as any person with a mental illness, and receives a mental illness diagnosis or services. If the person concurs that these stereotypes are true, internalizing stigmatizing beliefs begins through endorsing the poor public stereotyping and discriminatory behavior in the direction of persons recognized with mental illness then “self-concurrence” happens, resulting in internalized stigma **(Drapalski, et al., 2013; Uhlmann, et al., 2014).**

Internalized stigma has been associated with a numeral of undesirable outcomes, containing (i.e., hopelessness, low self-esteem, low empowerment, reduced self-efficacy and reduced social support) consequences of internalized stigma on individuals’ schizophrenia, along with a reluctance to look for care, decreased trust in service providers, poor compliance to psychosocial treatment, increased hospitalization rates, obstacles to recovery, decrease willingness to look for help, much less enhancement in occupational functioning and bad quality of lifestyles **(Sibitz, Amering, Unger, Seyringer & Bachmann, 2011; Silverstone, 2011; Drapalski, et al., 2013; Mashiach-Eizenberg, Hasson-Ohayon, Yanos, Lysaker & Roe, 2013; Segalovich, Doron, Behrbalk, Kurs & Romem, 2013).** “As a result of internalized stigma, patient withdraws from society because of negative feelings for example worthlessness and shame” **(Gerlinger, et al., 2013).**

Recovery is not only ‘getting rid’ of problems but also looking beyond a person's mental health problems, identifying and fostering their abilities, interests and dreams. Health professionals often have decreased expectations, while families and friends may be overly protective or pessimistic about what someone with a mental health issue can do and achieve. Recovery is “about looking beyond the imposed limits on people with mental illness to help people achieve their own goals, aspirations and dreams”. “Recovery can be a journey of self-discovery and personal development; mental illness experiences can offer possibilities for change, reflect and discover of fresh values, skills and interests” **(Jacob, 2015).**

“Past study has rarely investigated the connection of social network and social support with the attitudes of people toward their illness, including attitudes toward mental illness recovery and the influence of their acceptance of mental illness societal beliefs and internalized stigma”. Negative attitudes towards disease and perceived stigma can affect the relationship between the individual and their social network. Social exclusion as a consequence of disease affects the attitudes of the individual toward their illness, desire for recovery and internalized stigma **(Cullen, et al., 2017).**

Studies have found that being labeled with a serious mental sickness tends to make stronger core social networks, then again lessens social connections with colleagues and foreigners **(Perry, 2011)** and stigma can cause secrecy which results in a narrower and smaller social network **(Byrne, 2000).** In reviewing factors encouraging recovery in individuals with schizophrenia, **Soundy, et al., (2015)** reported that nearby social connections with family and friends are vital for the recovery process. In the same way, **Leamy, et al., (2011)** identified “connectedness as one of the important processes engaged with recovery among those with mental disorders”. “This study focused on internalized stigma in severe mental disorders and its relation to attitude toward recovery for patients with mental illness”.

Significance of the study

The impacts of mental illness stigma on psychiatric patients include psychological stress, depression and other psychiatric morbidity, distress, marital and relationship complications or problems in their social networks, restrictions from social participation or engagement in social activities and this will influence the recovery attitude of those patients. After reviewing the literature, there is a diminutive body of Egyptian evidences that examine the relationship between the internalized stigma and recovery attitude among mentally ill patients. This suggested a need to examine these variables among patients with mental illness to find out the available alternatives that the psychiatric mental health nurse will apply in caring for those patients and in their follow up in outpatient clinics after discharge.

It is assessed that 33% of individuals with stigma of mental illness experience high levels of internalized stigma that constitute a significant barrier to recovery **(Brohan, Elgie, Sartorius & Thornicroft, 2010; Yanos, Roe & Lysakr, 2011).** “Stigma nearby mentally ill persons may result in delayed treatment or noncompliance of medications, thereby

increasing risks for health problems as relapse that causes hospital readmission, bizarre or disorganized behavior and violence". "Due to a fear of being stigmatized, not all people with mental illness search for health care and treatment" **(Halter, 2008).**

So, it will be beneficial to examine the relationship between internalized stigma and recovery attitude among patients with mental illness as it may guide the health care professionals especially psychiatric mental health nurses to develop psychosocial rehabilitation programs, social skills training programs and planning of public health awareness programs to raise the orientation toward the nature of mental disorders which it will minimize feeling of stigma.

Aim of the study

The aim of the current study was to examine the relationship between internalized stigma and recovery attitude among mentally ill patients.

Research Questions

Q1: What is the relationship between internalized stigma and recovery attitude among mentally ill patients?

Q2: What is the relationship between personal and medical data and the studied variables i.e., internalized stigma and recovery attitude?

2. SUBJECTS AND METHODS

Research Design

Correlational descriptive design was used to describe the relationship among variables in the study.

Setting

This study was conducted at the Outpatient Clinics of "Psychiatric Medicine and Addiction Prevention Hospital - Cairo University Hospitals". The hospital offers inpatient and outpatient services, and consists of 5 floors; the underground floor contains the group psychotherapy room. The ground floor contains the outpatient clinics that include adolescence clinic, gerontology clinic, addiction clinic and psychiatric clinics, ECT & EEG rooms.

Sample

A sample of convenience of 250 mentally ill patients, who visited the Outpatient Clinics of the "Mental Health and Addiction Prevention Hospital- Cairo University Hospitals'' were involved in this research. Criteria for inclusion for this sample were both gender, any age, diagnosed as psychiatric patient with various psychiatric diagnosis, can read and write. All patients with mental retardation, difficulties in communication, addiction and neurological disorders were excluded from the sample.

Tools of Data Collection

Data were collected over a period of 8 months from June 2018 till January 2019, by using ''the socio-demographic and clinical data sheet, internalized stigma of mental illness inventory, and recovery attitude questionnaire''.

1. Socio-demographic and clinical data of participants:

Was developed by the researchers and included, gender, age, educational level, occupation, marital status, diagnosis, duration of illness and number of previous hospital admissions.

2. Internalized Stigma of Mental Illness Inventory (ISMI).

The scale was developed by **Ritsher, Otilingam & Grajales (2003)** and consisted of 29 items. It "was designed to assess an individual's personal experience of stigma related to mental illness. It was categorized into 5 subscales (Alienation, Stereotype Endorsement, Discrimination Experience, Social Withdrawal and Stigma Resistance)". It contained 29 statements. Each statement was rated on the following 4-point Likert scale: 0 = strongly disagree, 1= disagree, 2 = agree, 3 = strongly agree. Higher total scores are indicative of higher levels of internalized stigma.

The scoring system used by Lysaker, Roe & Yanos (2007) was a 4-category method (Score 1.00-2.00 = Minimal to no internalized stigma, Score 2.01-2.50 = Mild internalized stigma**,** Score 2.51-3.00 = Moderate internalized stigma & Score 3.01-4.00 = Severe internalized stigma). The reliability of the tool was measured by Cronbach's alpha test was (0.74) indicating a high degree of internal consistency.

3. Recovery Attitudes Questionnaire (RAQ).

"It was created by a group of consumers, service providers and researchers at the Hamilton County Recovery Initiative" **(Borkin et al., 2000).** It composed of 16 questions designed to identify and think about the participant's own views and attitudes about recovery from associated disorders. The tool was translated into Arabic then back translation was done by the researchers.

Scoring system:

The scale was rated on a 5 points Likert scale design ranged as (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree & 5 = strongly agree). Higher scores indicated a more positive attitude toward recovery. Cut point at 48 was done to identify the positive and negative attitude toward recovery which (16 – 48 means negative attitude toward recovery) and (49 – 80 means negative attitude toward recovery). "The alpha value (Cronbach's alpha) in the original tool was 0.65 for the total score" **(Borkin et al., 2000)** and reliability of the tool in Arabic version was measured by Cronbach's alpha test was (0.62) indicating a moderate degree of internal consistency.

Ethical consideration

A written primary ethical approval was obtained from the Ethical Committee of Scientific research at the Faculty of Nursing, Cairo University. In addition, an official permission to conduct the proposed study was obtained from the head of Psychiatric Medicine and Addiction Prevention Hospital - Cairo University Hospitals. A complete description of the purpose and nature of the study was explained to the participants. All participants were informed that, participation in the current study is voluntary, anonymity and privacy of each participant was protected by allocation of a code number for each one who responded to the questionnaire. Participants were informed that they could withdraw from the research at any moment without stating any excuse, their verbal and written consent was taken but some of them hesitated to sign but agreed to engage in the study.

Procedure

The researchers conducted a thorough review of the relevant literature to ensure the importance of the study and to gain an understanding of past and present researches in this field; a written ethical approval was obtained from the Ethical Committee of Scientific Research at the Faculty of Nursing, Cairo University. In addition, an official permission was obtained from the Head of the Outpatient Clinics of the Mental Health and Addiction Prevention Hospital at Cairo University Hospital. All the tools were revised by a panel of experts consisted of three professors of psychiatric mental health nursing to assure their content validity. A semi structured interview was done with each participant separately after their verbal and written agreement to collect the required data included personal and clinical data, internalized stigma of mental illness inventory (ISMI) then recovery attitude questionnaire. The researchers collected data over a period at 8 months started from June 2018 till January 2019. The interviews with each participant took between 30 min-45min.

Pilot Study

A pilot study conducted in order to test the simplicity of the tools and the time required to respond to each question. A total of 10% of the sample was engaged in the pilot study according to the criteria of selection and they were not involved in the original sample.

Statistical analysis

The collected data was charted, and summarized. Data was computerized and analyzed using appropriate descriptive and inferential statistical tests to answer the research questions; (SPSS) program version 20 was used. Level of significance was at $P < 0.05$.

3. RESULTS

Table (1): Frequency distribution of participants' socio-demographic characteristics (n=250).

Socio-demographic characteristics	No.	%
Age (yrs.):		
- 15<25	47	18.8
- 25<35	102	40.8
- 35<45	59	23.6
- 45<55	31	12.4
- 55<65	11	4.4
Mean ± SD = 33.5±10.2		
Gender:		
- Male	190	76.0
- Female	60	24.0
Education level:		
- can read and write	107	42.8
- Moderate education	97	38.8
- high education	46	18.4
Marital Status:		
- single	123	49.2
- married	103	41.2
- divorced	19	7.6
- widowed	5	2.0
Occupation:		
- Working	116	46.4
- Not Working	134	53.6

Table (1) highlighted that the mean age of the study participants surveyed was (33.5±10.2) and (76%) of them were male. According to education, study findings showed that, (42.8%) of the participants can read and write. Results showed in relation to marital status that (49.2%) were single and according to occupation (53.6%) were not working.

Table (2): Frequency distribution of participants' clinical data (n=250).

Clinical data	No.	%
Diagnosis:		
- Depressive Disorders	21	8.4
- Schizophrenia Spectrum & Other Psychotic Disorders	113	45.2
- Bipolar & Related Disorders	116	46.4
Duration of illness (in months):		
- 0<10	193	77.2
- 10<20	44	17.6
- 20<30	10	4.0
- 30<40	2	0.8
- 40<50	1	0.4
Mean ± SD = 7.6± 7.83		
Number of hospital admissions:		
- None	124	49.6
- Once	72	28.8
- Twice	26	10.4
- three or more	28	11.2

Table (2) stated that (46.4%) of the studied participants had bipolar & related disorders. In relation to duration of illness, (77.2%) of the participants were hospitalized less than 10 months. According to number of hospital admissions, (49.6%) of them didn't hospitalized before.

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Figure (1): Frequency distribution of participants' attitude toward recovery (n=250).

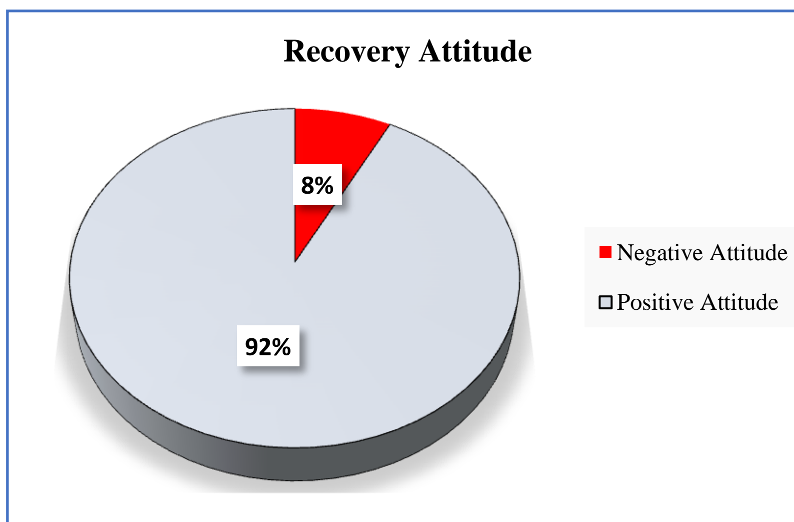

Figure (1) illustrated that, majority (92%) of the participants had positive attitude toward recovery from mental illness while only minority (8%) of participants had negative attitude toward recovery from mental illness.

Table (3) Comparison between male and female participants in relation to their internalized stigma and recovery attitude (n=250).

Variables	Gender	Mean	Std. Deviation	Independent t test	
				t	P
Internalized stigma	Male	75.03	13.49	1.72	0.41
	Female	71.55	14.29		
Recovery attitude	Male	59.62	7.84	1.02	0.73
	Female	60.81	8.09		
Statistically significant at p < 0.05*					

Table (3) showed that there was no significant statistical difference between male and female patients as (t=1.72; p=0.41) regarding internalized stigma and also there was no significant statistical difference between male and female patients when (t=1.02; p=0.73) in relation to recovery attitude.

Table (4) Correlation between participants' age, internalized stigma and recovery attitude (n=250).

Variables		Recovery Attitude	Internalized Stigma
Age	r	-.012	-.015
	p	.856	.810
Correlation is significant at p < 0.05 *			

Table (4) represented that there was no significant statistical correlation between age, internalized stigma and recovery attitude toward mental illness (r= -.015; p= 0.810) and (r= -.012; p= 0.856) respectively.

Table (5) Comparison between internalized stigma, recovery attitude and participants' diagnosis (n=250).

Variables	Diagnosis						One way ANOVA	
	Depressive Disorders		Schizophrenia Spectrum & Other Psychotic Disorders		Bipolar & Related Disorder			
	Mean	SD	Mean	SD	Mean	SD	F	P
Internalized stigma	71.3	14.62	75.67	13.45	73.28	13.82	1.37	0.26
Recovery attitude	63.9	10.57	57.74	7.81	61.3	6.84	9.32**	0.000
Highly statistically significant at p < 0. 001**								

Table (5) revealed that there was no significant statistical difference (F= 1.37; p= 0.26) in relation to internalized stigma and participants' diagnosis. In contrast, there was highly significant difference when (F= 9.32**; p= 0.00) in relation to recovery attitude and mentally ill patients' diagnosis.

Table (6) Relationship between participants' internalized stigma and recovery attitude toward mental illness (n=250).

Variables		Recovery Attitude
Internalized Stigma	r	-0.08
	P	0.19
Correlation is highly significant at p < 0.01*		
Correlation is significant at p < 0.05 *		

Table (6) showed that there was no significant statistical correlation as (r= -0.08; p= 0.19) between recovery attitude and internalized stigma.

Table (7) Relationship between participants' internalized stigma subscales and the recovery attitude toward mental illness (n=250).

Domains		Alienation	Stereotype endorsement	Discrimination Experience	Social withdrawal	Stigma resistance	Internalized stigma
Recovery attitude	r	0.002	-0.09	0.06	-0.04	-0.26**	-0.08
	p	0.97	0.14	0.38	0.56	0.00	0.19
Highly statistically significant at p < 0.001**							

Table (7) showed that, there was no significant statistical correlation as (r=-0.08; p=0.19) between recovery attitude and internalized stigma scale scores. Regarding relationships among domains of each scale with recovery attitude, there were no significant statistical correlation among alienation, stereotype endorsement, discrimination experience and social withdrawal (r=0.002; p=0.97), (r= -0.09, p=0.14), (r=0.06; p=0.38), (r= -0.04; p=0.56) respectively. While there was significant statistical weak negative correlation when (r=-0.26**; p=0.00) between recovery attitude and stigma resistance subscale.

4. DISCUSSION

The aim of the current study was to examine the relationship between internalized stigma and recovery attitude among mentally ill patients. As regard socio-demographic and clinical data among studied participants, the current study revealed that less than half of the studied participants aged between 25-35 years old with no significant correlation with internalized stigma and recovery attitude. These findings could be attributed to that middle age of the studied participants who had profound and concentrated view of different problems; they usually seek medical assistance to recover from their disease because they were the family's heart and the main source of funding.

These results are supported by **Gaber & Wadie (2016)** who revealed that "over half of their studied respondents between the ages of 26 to 35 without significant association to self-stigma, medication discontinuation and medication compliance". **Singh, Mattoo & Grover (2016)** studied "stigma and its correlates in schizophrenic patients attending a general hospital psychiatric unit" and they find no significant correlations between different stigma results and age of onset, current treatment duration, and positive and negative syndrome score.

The present study results revealed that over three quarters of participants were male while almost one quarter was female. The results added that there wasn't significant statistical difference in internalized stigma and recovery attitude according to participants' gender. These outcomes could be viewed by high flow of men may be due to preventing themselves from occupational deterioration or losing their jobs because they are their family's main source of income. These findings were compatible with **Abd-El Monem, Khalil, Osman & Gaber (2014)** who found out that, there was no statistically significant relationship between stigma and gender.

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Regarding marital status, about half of the participants within the current study were single, while less than half were married. High numbers of unmarried participants may be due to the effect of internalized stigma and feel of failure later on their life, some of them didn't inform their spouse about their disease before marriage, some adult women needed privacy about their information obtained because they will be impacted by adverse effects of mental illness and also some men who are scared of being rejected. Also, the results showed that there was no significant statistical difference between internalized stigma and recovery attitude toward mental illness according to the participants' marital status. These results were contradicted by "**Gaber & Wadie (2016)** who reported that marital status and self-stigma were significantly associated".

Concerning level of education of the participants, the current study results indicated that less than half of the participants can read and write while minority have high education. Regarding the relationship between education level, internalized stigma and recovery attitude, the current study revealed that there was a significant statistical difference in internalized stigma according to participants' educational level. On the other hand, there was no significant difference in the recovery attitude among mental illness according to the participants' educational level. In contradiction, the current study wasn't consistent with "**Mohamed & Sayed (2016)** who found that there was no significant statistical relationship between level of education, internalized stigma and adherence to treatment". Similarly, it wasn't consistent with "**Abd-El Monem, Khalil, Osman & Gaber (2014)** who stated that no significant statistical relationship existed between stigma and education level.

Regarding occupation, more than half of the participants were unemployed this result was consistent with **Mohamed & Sayed (2016)** who found that 61.8% of patients with schizophrenia and 60 % of patients with bipolar disorder were not working. Unemployment may be associated with internalized stigma, feel of rejection, prejudice and discrimination. Some participants were house wives and some male patients left their jobs due to their disease symptoms and disturbed relationships with their peers.

The current study results declared that there was no significant statistical difference in recovery attitude and internalized stigma according to participants' occupation. It was noticed that, the current study findings weren't consistent with **Gaber & Wadie (2016)** who reported that more than half of the participants were working and (47%) weren't working. Regarding the relationship between and internalized stigma occupation, the study results were supported by **Kim et al., (2015)** who reported that "there was no association between occupation and self-stigma among mentally ill patients". On the other side, the current study wasn't consistent with "**Abd-El Monem, Khalil, Osman & Gaber (2014)** who reported that, a significant statistical relationship has been found between stigma and job"**.**

As regard clinical data of the studied participants, there was significant statistical difference in internalized stigma according to participants' number of hospital admissions. This result wasn't supported by "**Gaber & Wadie (2016)** who found that "no statistical correlation was found between self-stigma and number of admission". However, there was no significant statistical difference in the recovery attitude among mental illness according to the participants' number of hospital admissions and this result was supported by "**Gaber & Wadie (2016)** who reported that, no statistical correlation was found between number of hospital admissions and compliance to treatment".

Regarding the relationship between participants' diagnosis and studied variables, there was no significant statistical difference in internalized stigma according to participants' diagnosis. While there was significant statistical difference in the recovery attitude among mental illness according to the participants' diagnosis. These findings were supported by "**Abd-El Monem, Khalil, Osman & Gaber (2014)** who reported that "no significant statistical relationship has been found between participants' diagnosis and stigma".

Considering the relationship between participants' duration of illness, there was significant statistical difference in internalized stigma according to participants' duration of illness. But there was no significant statistical difference in the recovery attitude among mental illness according to the participants' duration of illness. These results were consistent with "**Gaber & Wadie (2016)** who reported that, duration of the disease was positively associated with self-stigma. Also these results were supported by "**Kamaradova, et al. (2016)** who reported that "there's a positive association between duration and onset of the disease and experiencing self-stigma".

In relation to internalized stigma and the attitude toward recovery, the present study proved that, there was no significant statistical correlation between recovery attitude and internalized stigma. This may be due to presence of spiritual items in this tool which affect our culture like "to recover requires faith, hope & courage". These findings were contradicted by "**Kamaradova, et al. (2016)** who studied "Connection between self-stigma, adherence to treatment, and discontinuation of medication. Patient preference and adherence" and revealed that, a significant correlation was found between self-stigma and adherence to treatment. Moreover, "**Dimitropoulos, McCallum, Colasanto, Freeman & Gadalla (2016)** revealed a positive correlation between better attitude toward recovery, greater self-esteem and self-efficacy" "and negatively correlated with greater internalized stigma and perceptions of others that devalue patients' families".

In conclusion, the current study showed no significant statistical correlation between domains of internalized stigma subscale such as alienation, stereotype endorsement, discrimination experience and social withdrawal with recovery attitude. On the other hand, there was significant statistical weak negative correlation between recovery attitude and stigma resistance subscale. Moreover, the study results found that more than one third of the participants had moderate level of internalized stigma and the majority of the participants had positive attitude toward recovery from mental illness.

In a study done by "**Sedlackova, et al. (2015)** who found that, the overall self-stigma rating was significantly negatively correlated with compliance to treatment. The higher the degree of self-stigma, the lower the adherence to treatment. Adherence to treatment correlated negatively with alienation, social withdrawal but their correlation between adherence to treatment and stigma resistance is consistent with the current results as they reported that "adherence to treatment was correlated negatively with stigma resistance subscale".

5. CONCLUSION

The current study concluded that age, gender, marital status and occupation had no significant statistical difference with internalized stigma and recovery attitude but participants' diagnosis had significant statistical difference with recovery attitude. Moreover education level, duration of illness and number of hospital admission had significant statistical difference with internalized stigma. The study also revealed that, those patients with psychiatric illness had positive attitude toward recovery from mental illness despite expressing moderate levels of perceived self-stigma.

6. RECOMMENDATIONS

- Longitudinal design is needed and necessary clinical implications concerning creating and refining interventions that address internalized stigma.

- The effect of internalized stigma on broader effects associated to mental health recovery and quality of life additionally needs to be investigated.

- A guide to the recovery concept and the creation of a recovery-oriented system of care need to be one of the key segments of any strategy to combat the stigma of mental illness.

- The cultural and the social stigma aspects of stigma should be taken into account in the developing of the recovery concept and on the recovery-oriented care system.

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