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Relationship between Internalized Stigma and Social Function among Schizophrenic Patients

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Abstract: Schizophrenia is still one of the most serious psychiatric conditions with tremendous economic and social costs for the individuals and community. Internalized stigma is a recovery barrier from schizophrenia and has been related to diminished self-esteem and functioning impairment in schizophrenia. **Aim of this study:** assess the relationship between internalized stigma and social function among schizophrenic patients. **Method**: descriptive design was used to conduct the research on 200 patients with schizophrenia or schizoaffective disorder who attend in-patient department and out-patient clinics at Mansoura University Hospitals throughout six months. **Results:** 20% of the patients reported moderate to severe levels of internalized stigma and most of the patients had low scores on social function scale, a statistically significant negative correlation was revealed between internalized stigma and social function. **Conclusion:** The findings show that the patients' social functioning decreases with the increasing levels of internalized stigma. Based on the present results we recommended that future intervention for preventing and decreasing internalized stigma may help to promote social function.
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Key Words: Schizophrenia, Internalized stigma, Social function.

1. Introduction

Schizophrenia is a severe psychiatric condition with a broad range of symptoms, including distortions of thinking, perception, cognitive, psychomotor abnormalities, avolition and apathy, communications and emotional problems **(Carpenter & Tandon, 2013).** Schizophrenia affects about 1% of the world's population **(World Health Organization [WHO], 2018).**

Schizophrenia is a serious mental disorder that linked to disability and poor quality of life. Due to the nature of the disorder, people with schizophrenia have to deal with the symptoms of illness; furthermore, they have to confront negative consequences that come along with stigma associated with the illness. Among the various mental illnesses, evidence proposes that patients with schizophrenia feel more stigma than other psychiatric disorders such as depression and eating disorders **(Singh, Mattoo, & Grover, 2016).** However, stigma is one of the major stressors individuals diagnosed with a mental illness face, as it provides the message that they are not valued members of society **(Rusch, Zlati, Black, & Thomicroft, 2014).** Individuals with schizophrenia are regularly exposed to societal discrimination and can therefore internalize their own group negative attitudes, often leading to self-stigma or internalized stigma **(Seifu, 2018).**

Internalized stigma undermines hopes for achieving goals, diminishes self-worth feelings and has been related to not pursuing opportunities that encourage independence and employment. Stigma internalization often leads to social isolation and detachment making them to see themselves as humiliated, less loved, beaten, subsequently hopeless and depressed **(Corrigan & Rao, 2012).** Society not only stigmatizes people with schizophrenia, it also seems to stop interact with them and engage with them in social relationships. Attempts by patients to cover up their mental disorders for fear of being stigmatized leads to their isolation from social environments **(Yıldız, 2011).**

Internalized stigma encompasses decreased self-esteem and is frequently came with self-blame **(Corrigan, Rafacz, & Rusch, 2011),** as well as impaired social functioning and lowered empowerment **(Livingston & Boyd, 2010).** Individuals with mental illness are likely to constringe their social networks and opportunities in anticipation of rejection due to stigma, which contributes to isolation, unemployment, lowered income, and reduced quality of life **(Watson, Corrigan, Larson, & Sells, 2007)**.

In schizophrenia, due to the problems stemming from the nature of the disorder and its positive symptoms, a devastating reduction in the functioning, personal care, and professional, social, and academic life of patients can occur **(Kaya & Öz, 2019).** Problems in global social functioning lead patients to experience difficulties in establishing consistent behaviors in interpersonal relations, in fulfilling social and professional responsibilities, and in adhering to their medical treatment **(Gülseren et al., 2010)**.

Social functioning has a significant impact on prognosis of schizophrenia patients. Schizophrenia patients with serious functional deficit have higher relapse rate, and functional deficit is as an important prognosis factor. So, is important to evaluate social functioning to predict prognosis and determine effective treatments **(Bae, Lee, Park, Hyun, & Yoon, 2010).**

Significance of the study:

Internalized stigma is usually associated with low quality of life, can cause tremendous pain to people with schizophrenia and may undermine vocational functioning. Stigma has been deemed as the most important hurdle to the appropriate treatment and rehabilitation of those suffering from mental illness **(Seifu, 2018).** Internalized stigma is a significant problem in schizophrenia, including far reaching consequences on patients, treatment and overall outcome. Social functioning impairment is a descriptive trait of schizophrenia that may often emerge as a result of internalized stigma in addition to the impairment originating from the direct effects of the schizophrenia. Therefore, it is important to conduct this study to assess relationship between internalized stigma and social function among schizophrenic patients.

Aim of the study:

To assess the relationship between internalized stigma and social function among people with schizophrenia**.**

2. Subjects and Method:-

Study Design:-

This study was designed as a descriptive study.

Setting:-

The study was carried out at in-patient and out-patient clinics of Psychiatric Department at Mansoura University Hospitals.

Study Sample

A convenient sample of 200 patients with Schizophrenia or Schizoaffective disorders fulfilling the following inclusion criteria:

Inclusion criteria:

1. Patients with schizophrenia or schizoaffective disorder according to patient's records.
2. Age From18 to 60 years old.
3. Both sexes.
4. Able to communicate.
5. Willing to engage in the study.

Exclusion criteria:

1. Patients having terminal illness.
2. Patients having sensory impairment.
3. Patients with substance related disorders.

Tools of data collection: Three tools were utilized for data collection

Tool (I): Socio-demographic and clinical characteristics sheet:

- Socio-demographic characteristics of the patients included: patient's age, sex, educational level, marital status, occupation, and adequacy of income.
- Clinical data of patients such as age at illness onset, duration of mental illness, and family history of mental illness.

Tool (II): Internalized Stigma of Mental Illness Inventory-9 item version (ISMI-9)

It was developed by **Ritsher, Otilingam, & Grajales (2003).** It is a nine items one dimensional short form of the original English-language version of the ISMI-29. The ISMI-9 is a self-report instrument designed to measure internalized stigma of mental illness (self-stigma of mental illness) among people with psychiatric disorders. Items are estimated on a Likert scale of 4 points, ranging from 1 (Strongly disagree) to 4 (Strongly agree). A higher score indicates more severe internalized stigma of mental illness. The total ISMI _9 score was obtained by adding the scores of 9 items ranging from 9 to 36 points, when this score divided 9 items; Minimal to no internalized stigma (1.00-2.00); Mild (2.01-2.50); Moderate (2.51-3.00); Severe internalized stigma (3.01-4.00) (**Lysaker, Roe, & Yanos, 2007**).

ISMI _9 was translated into the Arabic language and tested for content validity by five experts in the field of psychiatric nursing and psychiatry. They were accepted as valid. Reliability of tool II (ISMI-9) was tested using the Cronbach's alpha method on 20 adult inpatients with schizophrenia or schizoaffective disorders to test the internal consistency of different items of the scale; that proved to be reliable (Cronbach's alpha =0.772). Additionally, the reliability ISMI-9 was tested by test-retest on the same 20 patients within 10 days interval. Correlation of test–retest between different items was calculated by Weighted Kappa (Kw >0.8) that indicated excellent agreement.

Tool (III): Social Functioning Scale (SFS)

This scale was designed by **Birchwood, Smith, Cochrane, Wetton, and Copestake (1990)**. It is a multidimensional measure of social functioning developed for use with people who have schizophrenia. The scale has been displayed to have strong reliability and validity in studies using both

clinical and non-clinical populations. The SFS is a 79-item that is consisted of the following seven subscales: Social withdrawal (e.g., time spent alone, initiation of conversation), Interpersonal communication (e.g., number of friends, quality of communication), Independence performance (performance of skills necessary for independent living), Independence competence (ability to perform skills necessary for independent living), Recreation (common hobbies such as bicycling, cooking, and shopping), Pro-social activities (e.g., sports, concerts, visiting relatives), and Employment/occupation (engagement in employment or other structured program of daily activity) **(Burns & Patrick, 2007).** The scale is rated on a 5 point likert scale ranging from zero to 5. Thus the total scale score was 223, and subtotal scores for the subscales ranged from 0 up 15, 9, 39, 39, 45, 66, and 10 respectively for the above mentioned subscales. The mid-point for the overall scale and each subscale was calculated, scoring less than mid-point indicate low functioning and scoring at or higher than mid-point indicate high functioning The overall scale has an acceptable internal consistency of 0.80. The Arabic and modified version of SFS has been used in this study that was used by **Atta, Imam, & Mousa (2017)** on Egyptians patients with schizophrenia.

Ethical considerations:

An Ethical approval was received from the Research Ethics Committee of Faculty of Nursing, Mansoura University. An official permission was taken from the Head of Psychiatric Department. Each patient participating in the study gave a verbal consent to participate in the study after explaining aim of the study and guaranteeing privacy for them. The investigator emphasized that participation in the study was voluntary and they can withdraw at any time without any effect on their treatment.

Statistical Analysis

The study data were formulated and analyzed using statistical package for social sciences (SPSS) program version 21.0. Qualitative variables were presented as number and percent. The chi-square ($\chi 2$) test was used for categorical variables to compare between different groups. Pearson coefficient was used to correlate between two normally quantitative variables. P value of ($\leq$ 0.05) was considered statistically significant.

3. Results:

Table (1) reveals that age of the sample ranged from 16 to 53 years with mean and SD 33.99 + 8.015373. 55.5%of the studied patients were between 30 to less than 45 years. Regarding to gender, 77.5 %of the studied patients were male. According to the level education nearly half of studied patients (46%) were of secondary school and diplome certificate while 17% of studied patients were illiterate. almost two thirds of the studied patients (61.5%) were single. Regarding to occupation, 44.5% of the studied patients were manual worker while 31.5% of the studied patients weren't working and 19% were houses wives. About half of the study sample (51.5%) reported insufficient income. The majority of the study (81.5%) diagnosed as schizophrenia and 18.5% have schizoaffective disorders. Regarding family history, nearly one quarter of the patients (27.5%) had family history of mental illness. Concerning duration of illness, 31% of the study sample had illness duration for more than ten years. According to age at 1st attack of illness, 62.5% of the study sample were 1st diagnosed with illness between the age (20-30) years old.

Figure (1) shows that the prevalence of mild stigma among the study sample was 35.5%, while moderate and severe stigma prevailed in 16% & 4% of the study sample respectively.

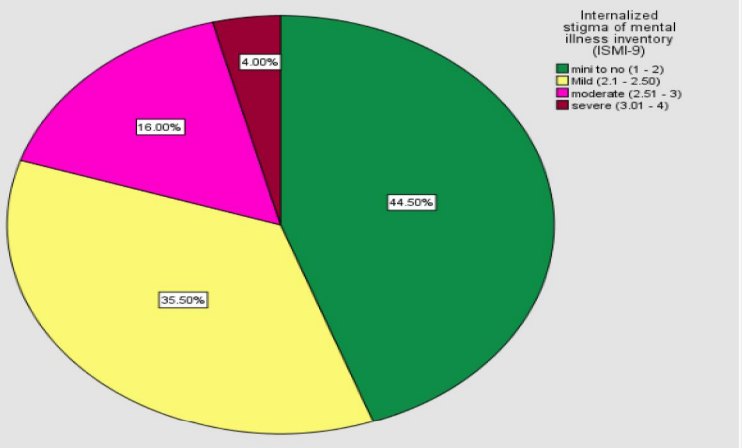

Figure (1): Frequency distribution of the studied subjects according to their level of internalized stigma of mental illness

Table (1) Socio-demographic and clinical characteristics of the studied patients (N= 200)

Socio-demographic characteristics	Number (200)	100%
Age:		
18 – less than 30	68	34%
30 – less than 45	111	55.5%
45 – 59	21	10.5%
Mean±SD =33.99 + 8.015373		
Sex:		
Male	155	77.5%
Female	45	22.5%
Educational level:		
Illiterate	34	17%
Read & write /primary/Preparatory school	53	26.5%
Secondary / Intermediate education/Education above average	92	46%
University education	21	10.5%
Marital status:		
Single	123	61.5%
Married	49	24.5%
Divorced/ separated/ Widow	28	14%
Occupation:		
Not working	62	31%
House wife	38	19%
Manual worker	89	44.5%
Professional worker	11	5.5%
Income satisfaction		
Insufficient	103	51.5%
Sufficient	97	48.5%
Diagnosis		
Schizophrenia	163	81.5%
Schizoaffective	37	18.5%
Duration of mental illness		
1- less 3year	30	15%
3-5 years	53	26.5%
>5 – 10 years	55	27.5%
> 10 and more	62	31 %
Age at 1st attack/ 1st diagnosed		
Less than 20 yrs	39	19.5%
(20-30)yrs	125	62.5%
More than 30 yrs	36	18%
Family history		
Negative	145	72.5%
Positive	55	27.5%
Total	200	100%

Table (2): Quantitative and qualitative presentation of the studied subjects' results according to SFS:

SFS total and subscales scores	Scale Mid-point	Mini-Max.	Mean±SD.	Subjects frequency			
				Low*		High**	
				N	%	N	%
Overall SFS (0-223) **mean±SD** =92.31±24.9	111.5	39-158	92.31±24.9	156	78%	44	22%
Withdrawal Subscale (0-15)	7.5	2-15	10.33±2.6	30	15%	170	85%
Interpersonal Communication (0-9)	4.5	2-9	5.72±1.81	60	30%	140	70%
Independence Performance (0-39)	19.5	2-36	17.47±8.004	123	61.5%	77	38.5%
Independence Competence (0-39)	19.5	6-39	26.91±5.18	10	5%	190	95%
Recreation (0-45)	22.5	2-30	11.06±4.98	194	97%	6	3%
Prosocial activities (0-66)	33	2-37	13.70±7.24	199	99.5%	1	0.5%
Employment/Occupation (0-10)	5	0-10	7.11±3.38	58	29%	142	71%

* Scoring below mid-point represent low,** Scoring at mid-point or higher represent high

Table 3 shows that the majority of the study sample (78%) scored low on social functioning scale with a mean±SD of 92.31±24.9; and reveals that almost all of the studied sample (99.5%) scored low on Pro-social activities subscale, followed by 97% on Recreational activities subscale and 61.5% on Independence performance subscale. On the other hand, most of the studied sample (95%) scored high on Independence competence subscale, followed by 85% on Withdrawal subscale and 71% on Employment subscale.

Table (3) displays that more subjects of younger age (up to 45 years) tend to score less.

(mini/mild) on internalized stigma scale (24% & 46.5%) compared to those who scored moderate/severe on internalized stigma scale (10% & 9% respectively), with a statistically significant difference (X2=6.19, P=0.042).

- The greatest number of the studied subjects (43%) who had mini/mild internalized stigma fell in the group who had sufficient income, while 14.5% who scored moderate/severe internalized stigma were having insufficient income. The difference is statistically significant (X2=8.828, P=0.004).

- The rest of the socio-demographic variables didn't show any statistical significant association with the subjects' scores on internalized stigma scale.

Table (3) Relationship between subjects' socio-demographic characteristics and their level of internalized stigma

Subjects' socio-demographic characteristics	Level of internalized stigma				Significance test Chi Square	
	Mini/ Mild		Moderate/ high			
	N	%	N	%	X2	Sig. (P)
Age:						
18- less than 30	48	24%	20	10%		
30-Less than 45	93	46.5%	18	9%	6.19	0.042*
45-less than 60	19	9.5%	2	1%		
Sex						
Male	125	62.5%	30	15%	0.179	0.833
Female	35	17.5%	10	5%		
Education						
Uneducated	28	14%	6	3%	0.14	0.817
Educated	132	66%	34	17%		
Marital status						
Unmarried	120	60%	31	15.5%	0.108	0.839
Married	40	20%	9	4.5%		
Occupation						
Not working	74	37%	26	13%	4.500	0.051
Working	86	43%	14	7%		
Income						
Insufficient	74	37%	29	14.5%	8.828	0.004**
Sufficient	86	43%	11	5.5%		

Table (4) illustrates that there is a statistically significant negative correlation between internalized stigma and social function (r= -.145, p= 0.014). Additionally, a highly significant negative correlation between internalized stigma and withdrawal, Interpersonal communication and Independence competence subscales of social function was revealed (r= -.350, p=0.000; r= -.191, p=0.007; r= -.229, p=0.001) respectively.

Table (4): Correlation between studied patients' scores on internalized stigma and social function scale

Items	Level of internalized Stigma	
	R	**P**
Social Function	-.145*	.014
Social Withdrawal	-.350**	.000
Interpersonal Behavior	-.191**	.007
Independence Performance	-.087	.219
Independence Competence	-.229**	.001
Recreational activities	-.015	.837
Pro-social Activities	-.035	.618
Employment	-.121	.087

4. Discussion:

In the present study, the characteristics of studied patient revealed that the most common age group ranged between (30- <45) years. This age group represented more than half of the total sample, while 34% of the study sample were between the age group (18- <30) years. This age group represented more than half of the total sample. This was congruent with a study in Nigeria by **Fadipe et al. (2018)** who found that the majority of the studied patients were between the ages of 30 and 44 years.

Present results illustrated that more than two thirds of the studied subjects were male, This may be due to that the prevalence of schizophrenia among males is more frequently than females and typically appears earlier in males. Also it may be due to that families of female schizophrenic patients not seek help because of the stigma of schizophrenia. This result is consistent with a study in Egypt by **Mahmoud & Zaki (2015)** and a study in Ethiobia about schizophrenia by **Assefa, Shibre, Asher, & Fekadu (2012)** which reported highest percent of schizophrenic patients sample were males. In contrast, in Saudi Arabia study the current result was inconsistent with **Hasan (2019)** who showed that the majority of the participants were females.

Results of current study demonstrated that, more than half of the sample were single. This may be attributed to that the most common age group ranged between (30- <45) years and earlier age of onset was a hindrance toward marriage. Also this may be due to that nearly half of the studied sample were manual workers and reported insufficient income. The current result is consistent with **Yılmaz and Okanlı (2015)** who reported that the majority of patients with schizophrenia in turkia were single. This is in contrast to **Mahmoud & Zaki (2015)** who illustrated that the most of the Egyptian sample was married.

With regard to educational level, nearly half of the subjects in the current study had secondary education and diplome certificate and one fifth of sample were illiterate. This may be due to that the majority of the sample had low socioeconomic class and two thirds of the sample were from rural area; additionally, the earlier onset of the illness considered a hindrance for continuing education. This result agrees with Egyptian study by **Dewedar, Harfush & Gemeay (2018)** who reported that (44.2%) had secondary education and (9.2%) of the sample were illiterate.

Schizophrenia may be the most negatively stereotyped, in part due to the unique presentation of symptoms, and because it may also be considered the least likely for recovery **(Wood, Birtel, Alsawy, Pyle, & Morrison, 2014)**.

The present results revealed that one quarter of the studied sample had moderate to severe stigma. This result may be attributed to that in Egypt, psychiatric patients are categorized as unsafe, destructive, uncontrollable, guilty, having several personalities, are punished with this disease, and are influenced by the mischievous spirit **(Shalaby, 2017).** These negative Egyptian societal stereotypes about mental illness which is originated from cultural values compel the patient to internalize the attitudes expressed by the public and experience numerous negative consequences as a result. This result is in agreement with **Sarısoy et al. (2013)** who revealed that levels of internalized stigma were moderate to high in 29.3% of Turkish schizophrenic patient's sample.

This result was incongruent with **Dewedar et al. (2018)** who reported that the most of the patients had

moderate to high levels of internalized stigma. Additionally, in a previous Pan-European study, by contrast high self-stigma was found in around 40% of patients **(Brohan, Gauci, Sartorious & Thornicroft, 2010).**

A significant association between internalized stigma and age group was revealed. Results indicated that Internalized stigma in the younger age group (18- <30 years); (30- <45 years) was found to be higher compared to older age group (>45-60 years). This finding was congruent with Turkish study by **Çapar & Kavak (2019**) who revealed statistical significance between internalized stigma and age. Stigma decreased with increasing age. This may be due to that with increasing age patients were less prone to stigma as they became more used to societal attitudes and they tended to have a more isolated life by withdrawing from society, or may be they got better, one better functioning are less sensitive to others.

But this result was incongruent with Egyptian study by **Hamed, El-Bilsha, El-Atroni & El Gilany (2014)** who revealed that the median of the total stigma scale in the older age group 50 year and above was found to be higher compared to the middle age group (30- 50 year), Their interpretation for this result attributed to co-morbidity of mental illness with physical illness that need much care and much money to overcome it.

The Present results demonstrated that percentage of moderate/severe internalized stigma was significantly higher among patients with insufficient income than those with sufficient income. Because when patients feel that their income is insufficient to meet their basic needs, feel powerlessness and see themselves as a burden on others which results in low self-esteem and thus leads to more feelings of rejection and stigma. This result was consistent with **Çapar & Kavak (2019**) who found that the relation between internalized stigma and income level perception was statistically significant. The level of internalized stigma was found to be lower in those who perceived their income level as sufficient. This also is congruent with **Mosanya et al. (2014)** who found that self-stigma was high among patients who reported insufficient income.

Social functioning impairments are a descriptive feature of schizophrenia, and including decrease in the basic skills required to communicating with others, form and maintain successful interpersonal relationships, and functioning within the community. These deficits have been assessed through individual's performance in these domains and their subjective experience of their social interactions (**Jameset al., 2016).**

Results showed that the majority of the studied sample reported low scores on social functioning scale; this may be attributed to that psychotic symptoms influence perception of reality such as auditory hallucination and delusion. These symptoms significantly affect their interpersonal relationship, and impede their adjustment in various social situations **(Bae et al., 2010),** also due to negative symptoms of schizophrenia as individual with schizophrenia may be less motivated for social interaction and socially withdrawn. This result agrees with **Atta et al. (2017)** who found that most of Egyptian schizophrenic patients have low scores on social functioning scale.

Results illustrated a statistically significant negative correlation between internalized stigma and social function. In other words, individuals who demonstrated higher internalized stigma were found to experience poorer social functioning. It seems that internalized stigmatization has adverse effects on the quality of life due to low self-esteem, and self-efficacy that affect social functioning, also with increasing the symptoms of the illness leads to increased stigma and reducing social functioning. This result is in agreement with **Hofer et al. (2019)** who revealed that higher levels of internalized stigma were associated with poorer social functioning. This result is similar to **Hill & Startup (2013)** who found that higher levels of internalized stigma were positively correlated with higher levels of negative symptoms and poorer social functioning.

Conclusion

From the results of the current study, it can be concluded that that 20% of the subjects experienced moderate/severe level of internalized stigma and most of the patients had low scores on social function scale. In the present results, there was a significant negative correlation between patients′ scores on internalized stigma and their social function. The more internalized stigma patients′ have, the less their social functioning is. These results generate future hypothesis that interventions to reduce patients′ internalized stigma levels may have role in improving their social function.

Recommendations

In the view of the results of this study, the following recommendations are recommended, Planning and implementation of psycho educational programs to increase public awareness about nature of mental illness; replace inaccurate stereotypes and misconceptions of schizophrenia. Increase family social support and acceptance of patients to reduce internalized stigma among their patients through educational programs should be provided for family caregivers covering ways to diminish stigma for patients. Cognitive behavioral therapy may be needed to decrease internalized stigma. Social skill training

programs may be implemented to teach patients socially accepted behaviors and to enhance the patient's social function before their discharge into community. Activation of the role of psychiatric nurses in community mental health services through rehabilitation programs to help patients with schizophrenia to reduce and fight stigma.

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