

Social Stigma and Well-Being in a Sample of Schizophrenia Patients

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Abstract

Objective: The present study analyzes the existing relationship between three variables related to social rejection (perception of overt and subtle discrimination and stigma consciousness) and the psychological and subjective well-being among people with schizophrenia. Likewise, we will analyze the relationship between two possible strategies to cope with stigma (active coping and avoidant coping) and well-being. **Method:** A cross-sectional study was conducted in a sample of 50 people with schizophrenia recruited from the social care network for people with mental illness in the Community of Madrid. **Results:** Results show, as expected, the existence of a negative association between the variables related to social rejection and psychological and subjective well-being. It was also found that avoidant coping is negatively related to well-being, while active coping is positively related, although in the latter case relations do not reach significance. **Conclusions:** In view of the implementation of interventions to improve the well-being of people with schizophrenia, our results suggest implementing strategies to reduce the perception of discrimination (especially subtle or indirect discrimination) and encouraging the use of active strategies to cope with stigma as opposed to avoidant-coping strategies.

Key Words: Schizophrenia, Social Stigma, Subtle Discrimination, Overt Discrimination, Coping, Well-Being

Introduction

People with mental disorders, especially those with schizophrenia and psychoses, are one of the most stigmatized groups in our society (1). According to Crocker, Major and Steele, stigmatization occurs when an individual possesses (or is believed to possess) “some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context” (2). Link and Phelan consider that in order to be able to speak of stigmatization various characteristics must concur, such as labeling or allocation to

a category, the use of negative stereotypes associated with that category, segregation, loss of status and discrimination. These characteristics are often accompanied by a situation of power differential with people from the nonstigmatized group that allows the components of stigma to develop (3). All these circumstances take place in the case of mental illness.

Several studies have found that people with mental disease are perceived as aggressive, dangerous and unpredictable (4). This view of mental disease is transmitted by the media (5), making the integration of this group into society rather difficult (6). Likewise, there are many studies that show that the stigmatization of people with a severe mental disorder, such as schizophrenia, has a negative influence on the success of finding a job, housing, or maintaining friendship or love relationships (7). In this sense, in 1999, the United States Surgeon General’s report identified stigma as the largest barrier to treatment seeking for people with men-

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Clinical Implications

Our study is relevant and innovative because it focuses on how stigma affects the subjective and psychological well-being of people with schizophrenia. Previous literature has focused mainly on the way stigma affects psychiatric symptoms or treatment adherence (13). Furthermore, our data indicate that stigma affects well-being through the way people with schizophrenia perceive their past experiences of discrimination and cope with them, and not only through the internalization of stigma or self-stigma (13). Thus, our results could open the door to new kinds of intervention programs to improve the well-being of people with schizophrenia based on an enhancement of active strategies to cope with stigmatization. These strategies could be both cognitive (looking for a positive reappraisal of the situation), or behavioral, for instance through the association with other people with schizophrenia. In previous research conducted with another highly stigmatized group (people with HIV), we found that in-group identification was positively related with collective action intention that in turn increased feelings of well-being among people with HIV (45).

Besides interventions with schizophrenia patients, we believe that educational programs in the general population are needed in order to change negative attitudes toward this group. Mental health professionals and policy makers would need to coordinate new programs aimed to promote a better image of this type of patient. As our results show, rejection associated with mental illness has a big and negative impact on the lives of individuals with schizophrenia. Thus, making this data public could help to improve the general population's attitude and behavior toward people with schizophrenia.

tal health problems. Studies show that, in addition to direct discrimination, many times people with mental illness also have to face more subtle or indirect discrimination (9). Also, recent work (10) shows that, on many occasions, people with mental disease diagnosis are conscious of their own stigma when they perceive that they are negatively treated by others for suffering a mental disease. As might be expected, the direct and subtle discrimination and stigma awareness experienced by people with schizophrenia adversely affect their quality of life (11, 12).

The stigma of mental illness not only exists in western societies, but rather it is a universal phenomenon (13, 14), although its expression, content, and the forms of discrimination associated with it vary in different cultures (15, 16).

Schizophrenia and Well-Being

In recent years, numerous studies have shown the relationships between the stigmatization of people with mental illness and various psychological and psychosocial variables such as self-esteem, empowerment, self-efficacy, quality of life, symptom severity or treatment adherence (17, 18). Other studies reveal that stigmatization suffered by people with schizophrenia is related to depression (19) or anxiety (20). All these studies prove that stigmatization suffered by people with schizophrenia has a negative impact. However, there are few studies that focus on how it affects other aspects of well-being.

For a long period of time most psychologists focused on the study of pathology, but in recent years a new trend known as positive psychology has developed. According to Sheldon and King (21), positive psychology's purpose is

the scientific study of natural human strengths and virtues and human happiness. There are currently two trends in the study of positive aspects of human beings. On the one hand, the hedonic approach is represented by the concept of subjective well-being (22), which includes and evaluates overall satisfaction with life, positive affect level, and negative affect level. On the other hand, eudaemonism—the tradition started by Aristotle—is reflected by the concept of psychological well-being. From this approach, according to Ryff's model, six core domains for optimal functioning are identified: Self-Acceptance, Environmental Mastery, Positive Relations, Purpose in Life, Personal Growth, and Autonomy (23). This research will address both subjective well-being and psychological well-being of people with schizophrenia.

Stigma and Coping in People with Schizophrenia

It is important to note that even though people with schizophrenia suffer discrimination (24), not all of them react to this situation in the same way (25, 26). There is ample evidence that the same negative situation can affect the well-being of stigmatized people either positively or negatively, depending on the way they cope with it. Carver, Scheier and Weintraub's research study shows that, when facing a potentially stressful situation, active coping (trying to do something to improve the situation) is a better strategy than avoidant coping (avoiding facing the problem), since the latter has a negative correlation with well-being. For example, the stress-vulnerability model of schizophrenia that considers the interplay of personal abilities and environmental factors such as stress in predicting the onset and persistence

of psychotic symptoms, theorizes that environmental and personal resources and deficits interact with everyday experiences (potential stressors of everyday life) and individual responses (coping strategies), and that these responses affect well-being. Thus, course and outcome are thought to be considerably influenced by the modulation of stress, and coping strategies play a critical role in this regard. There is some evidence that in schizophrenia patients some coping strategies may become more effective than others in alleviating symptoms and distress (30).

For this reason, in this research we will analyze to what extent the two possible strategies used by people with schizophrenia to address stigma (active and avoidant coping) are associated with their subjective and psychological well-being.

The Present Research

Although positive psychology is currently receiving considerable attention, no scientific studies have been conducted yet on the psychological and subjective well-being of people with schizophrenia. Further, there are no studies on the relationship between perceived stigma and those aspects of well-being.

The goal of the present study, which is exploratory in nature, is to analyze in a sample of patients with schizophrenia, the relationships that several variables related to stigma (23, 24), such as perceived discrimination (5) or stigma consciousness, have with well-being, measured through affect balance (as a measure of subjective well-being) and self-acceptance (23) (as a measure of psychological well-being). In addition, we will analyze to what extent coping strategies relate to the subjective and psychological well-being of people with schizophrenia. Therefore, on the basis of the reviewed literature we formulate the following hypotheses:

Hypothesis 1: there will be a negative association between the variables related with stigma and discrimination (overt and subtle discrimination and stigma consciousness) and both subjective and psychological well-being of people with schizophrenia.

Hypothesis 2: there will be a negative association between avoidance-based coping strategies and both subjective and psychological well-being of people with schizophrenia.

Hypothesis 3: there will be a positive relation between active-coping strategies and both subjective and psychological well-being of people with schizophrenia.

Furthermore, to examine the predictive ability of the variables related to stigma and coping on well-being variables, two regression analyses will be conducted, taking the variables related to well-being (affect balance and self-acceptance)

as criteria variables, and variables related to stigma and coping as predictors.

This study presents a number of contributions with respect to the previous literature. First, the focus of positive psychology in the study of schizophrenia has not been adopted in the way we have, since previous approaches have mainly been based on generic quality-of-life questionnaires that apply to people suffering from a wide variety of diseases (see for example, the review by Papaioannou [32]). Secondly, we adopt the perspective of the stigmatized group when we refer to subtle and blatant discrimination, a distinction usually applied only when conducting studies based on the perspective of those who exercise discrimination (see, for example, Rodgers [33]). Thirdly, we have focused on relevant variables within Social Psychology, such as perceived discrimination instead of self-stigma; that is, we analyze not the feelings of self-stigma in people with schizophrenia but how they perceive that others stigmatize them. Fourth, and finally, we add the perspective of coping to the field of schizophrenia, not in the sense of how to deal with the daily stress of illness, but in the sense of coping with the stigma associated to this pathology. For all these reasons, we believe that this paper enriches and extends the field of schizophrenia, as it provides a series of approaches that have not been taken into account before.

Method

Participants

The sample consisted of 50 participants (37 men and 13 women) from various centers of the public network of social care for people with mental illness of the Community of Madrid (managed by Intress), all of whom had a diagnosis of schizophrenia or psychosis; 86% of the participants were single, 10% were married and the remaining 4% were divorced.

Regarding the degree of disability, 80% of participants were granted a disability between 46 and 100%, and 64% had a certificate of disability.

Instruments

Multidimensional Perceived Discrimination Scale (36)

This scale consists of ten items that measure, in a 5-point Likert scale, two aspects of perceived discrimination: Overt Discrimination (“People with mental illness face discrimination in the workplace”) and Subtle Discrimination (“People seem to accept people with mental illness, but I think sometimes there is a hidden rejection”). In our study both the Overt Discrimination Scale and the Subtle Discrimina-

tion Scale proved to have a good reliability (a Cronbach's alpha of .83 and .87, respectively).

Pinel's Stigma Consciousness Questionnaire (SCQ) (37)

This scale measures the extent to which members of different social groups expect to be stereotyped by others because of their group membership. A representative item of this scale would be, "When I interact with other people I have the impression that all my behavior is interpreted based on the fact that I have a mental illness." In our study, the reliability of the scale was good (Cronbach's alpha=.79).

The Brief COPE Inventory (38)

To measure coping styles we used the brief version of the COPE questionnaire, composed of fourteen scales of two items each. Based on the interests of this study and the factors obtained in a previous study, we calculated two scores: active-coping strategies and avoidant-coping strategies. The factor "active-coping strategies" is composed of the active coping ("I take some action to improve the situation"), planning ("I try to propose a strategy on what to do"), and positive reappraisal ("I try to find something good in what is happening") subscales, and its reliability in our study was .84. Meanwhile the factor "avoidant coping" corresponded to the mean scores of the subscales of denial ("I refuse to believe that this has happened"), relief ("I express my negative feelings"), substance use ("I drink alcohol or take drugs to help me through"), abandonment or behavioral detachment ("I abandon any attempt to address the problem"), and self-blame ("I blame myself for the things that happen to me"); its reliability in our sample was .65.

Positive and Negative Affect Schedule (PANAS) (39)

This instrument was used to measure emotional balance (subjective well-being). It consists of two subscales of ten items each that assess positive and negative affect. Both subscales showed very high reliability in our study (Cronbach's alpha of .91 in the case of the positive affect scale and an alpha of .91 on the scale of negative affect). To calculate the affect balance score we subtracted negative affect from the positive affect score. A positive score reflects the predominance of positive affect over negative affect.

Ryff's Scales of Psychological Well-Being (40)

Self-acceptance (psychological well-being) was measured by a subscale of four items included in Ryff's Scales of Psychological Well-Being and could be defined as "being aware and accepting one's strengths and limitations." It

is a construct similar to self-esteem (41), which is the best predictor of subjective well-being in individualistic cultures (42). An example item from this scale is: "In general, I am satisfied with my life." In our research, the reliability of this scale was .82.

Procedure

To distribute the questionnaires, we had the collaboration of professionals from different Intress Rehabilitation Centers in the Community of Madrid, who explained the purpose of the study to the people they serve, requested their voluntary cooperation, and handed out the questionnaires, addressing questions that arose in some items.

All the participants gave their informed consent and our protocol was approved by an ethics committee formed by the directors of all the centers involved in the research, and reviewed by the institution's technical director to ensure it was performed in accordance with Helsinki Declaration criteria. All inquiries were performed anonymously.

Results

In Table 1, you can see the descriptive statistics of the variables used in our analyses.

Table 1 Descriptive Statistics

	Mean	Standard Deviation
Affect balance	.93	1.19
Self-acceptance	3.33	.89
Avoidant coping	2.12	.63
Active coping	3.42	.83
Stigma consciousness	3.25	.65
Overt discrimination	2.90	.82
Subtle discrimination	3.19	1.05
N=50		

As seen in Table 1, the average affect balance is tilted toward the positive pole, indicating the predominance of positive over negative emotions. We also see that self-acceptance is around the midpoint of the scale. Among the coping strategies, active coping (above the midpoint of the scale) is more frequently used than avoidant coping (below the midpoint of the scale). The difference between the use of these types of coping is significant ($t=9.87$, $df=49$, $p<.00$).

It is also observed that both stigma consciousness and subtle discrimination are above the theoretical mean of the scale while overt discrimination is below. It should be noted

that the difference between the two types of discrimination is significant ($t=-4.19$, $df=49$, $p<.00$). The intercorrelation between the variables used in the study is shown in Table 2. As shown in this Table, the results confirm hypothesis 1 since the variables related to subjective (emotional balance) and psychological well-being (self-acceptance) are negatively and very significantly associated with psychosocial variables related to perceived stigma and discrimination (stigma consciousness and subtle discrimination). Regarding coping styles, as we predicted in hypothesis 3, avoidant coping was negatively associated with emotional balance and self-acceptance. Hypothesis 2 receives only partial support because, although there are positive relationships between active coping and well-being, their relationship does not reach significance, probably due to sample size. Furthermore, we found that both overt and subtle discrimination experiences are positively and significantly related with stigma consciousness.

Table 2 Correlations

Variables	1	2	3	4	5	6
1. Affect balance						
2. Self-acceptance	.56 [†]					
3. Avoidant coping	-.52 [†]	-.31*				
4. Active coping	.20	.13	.10			
5. Stigma consciousness	-.49 [†]	-.40 [†]	.47 [†]	.02		
6. Overt discrimination	-.35*	-.13	.41 [†]	-.01	.68 [†]	
7. Subtle discrimination	-.52 [†]	-.30	.37 [†]	-.09	.75 [†]	.80 [†]

* $p<.05$; [†] $p<.01$

To examine the predictive ability of the stigma and coping related variables, two regressions were performed by the successive steps method using the well-being variables (affect balance and self-acceptance) as criterion variables and variables related to stigma (perceived discrimination and manifest and subtle stigma consciousness) and coping (active and avoidant) as predictors.

The regression analysis with affect balance as the dependent variable generated two models. The first one had an R^2 of .27 ($F [1,48]=17.63$, $p<.01$) and only one explanatory variable: avoidant coping ($\beta=-.52$). The change in R^2 in the second model increased in a significant way ($\Delta R^2=.12$, $p<.01$), finally reaching a 39% of explained variance ($F [1,48]=15.07$, $p<.01$). The explanatory variables included in the second regression model were, in order of importance: avoidant coping (standardized $\beta=-.38$, $t=-3.11$, $p<.03$) and subtle discrimination (standardized $\beta=-.36$, $t=-3.06$, $p<.04$).

The regression analysis with self-acceptance as the dependent variable generated just one model. This model had an R^2 of .17 ($F [1,48]=9.13$, $p<.01$). The only variable included in the regression model was stigma consciousness (standardized $\beta=-.40$, $t=-3.02$, $p<.04$).

Discussion

Our results show that psychosocial variables related to stigma play a significant role in explaining the well-being of people living with schizophrenia. First, we found that the discrimination suffered by this group (mostly subtle) is negatively related to both subjective (affect balance) and psychological well-being (self-acceptance). We also found that stigma consciousness has a negative relationship with those same variables.

Regression analyses help us to better understand these relationships and show that, when predicting emotional balance (subjective well-being), avoidant-coping style and perceived subtle discrimination are particularly important. That is, the more a person avoids facing stigmatization and the more indirect discrimination he or she perceives, the more likely it is that his or her negative emotions will increase. However, when predicting self-acceptance (psychological well-being) the most important variable is stigma consciousness. That is, the perception of being treated negatively because of prevailing social stereotypes toward one's group has a negative impact on self-acceptance in people with schizophrenia.

These results, therefore, show that in addition to suffering caused by mental illness itself, the social consequences of schizophrenia such as perceived discrimination and social rejection also have very serious implications for the well-being of those affected by this disease, which ultimately may have an impact not only on their psychological state but also on their ability to reintegrate into society.

On the other hand, we have found that among coping strategies considered, not facing problems directly (avoidant coping) has negative consequences for the welfare of people with schizophrenia. The relation of active coping with well-being is positive but—probably due to the small sample size used—it does not reach significance.

Taken as a whole, these results show that when evaluating and promoting the quality of life of people with schizophrenia, one must take into account both the psychosocial variables related to stigma and coping style. To the extent that people with schizophrenia perceive less discrimination, especially subtle or indirect, and stop adopting avoidant-coping strategies, their chances of improvement in their well-being will increase.

The existing differences between subtle and overt dis-

crimination are factors to consider. We believe that this result may be due to the fact that schizophrenia has a social stigma that can be concealed from others (43) and, therefore, people suffering from this mental illness did not reveal their condition to everyone, so there were fewer instances of suffering from direct discrimination for them to report.

On the other hand, it is not so easy to explain why indirect or subtle discrimination is more harmful than overt discrimination. A possible explanation could be that overt discrimination is legally forbidden in many societies and is frowned on by society. Therefore, it occurs to a lesser extent and it is possible to detect and combat its existence. In contrast, subtle discrimination, which is often concealed in “not prejudiced” arguments, is more difficult to detect and creates a feeling of helplessness in the members of the stigmatized group because, for example, they do not know whether they were rejected for a job for “objective” reasons or because of their group membership (44).

For these reasons we think it is important to develop intervention programs to make the existence of subtle or indirect discrimination visible and put an end to it, because it appears to be even more harmful than overt discrimination. It is clear that the ultimate solution would be to reduce the existing prejudice in society toward people with mental illness. However, until this goal is realized, the daily life of people with schizophrenia can improve through training in coping skills, such as actively doing something to improve their situation or trying to see the positive aspects of the situation.

Our study is relevant and innovative because it focuses on how stigma affects the subjective and psychological well-being of people with schizophrenia. Previous literature has focused mainly on the way stigma affects psychiatric symptoms or treatment adherence (13). Furthermore, our data indicate that stigma affects well-being through the way people with schizophrenia perceive their past experiences of discrimination and cope with them, and not only through the internalization of stigma or self-stigma (13). Thus, our results could open the door to new kinds of intervention programs to improve the well-being of people with schizophrenia based on an enhancement of active strategies to cope with stigmatization. These strategies could be both cognitive (looking for a positive reappraisal of the situation), or behavioral, for instance through the association with other people with schizophrenia. In previous research conducted with another highly stigmatized group (people with HIV), we found that in-group identification was positively related with collective action intention that in turn increased

feelings of well-being among people with HIV (45).

Besides interventions with schizophrenia patients, we believe that educational programs in the general population are needed in order to change negative attitudes toward this group. Mental health professionals and policy makers would need to coordinate new programs aimed to promote a better image of this type of patient. As our results show, rejection associated with mental illness has a big and negative impact on the lives of individuals with schizophrenia. Thus, making this data public could help to improve the general population's attitude and behavior toward people with schizophrenia.

Finally, we should mention certain weaknesses of the research. As an exploratory study, the analyses are rather limited. We have only been able to show partial relations between these variables. Future research should expand the sample to be able to perform structural equation models that yield a more global and generalized connection between the variables.

Another limitation is the lack of a comparison group of either physically (other studies have used diabetes patients, for instance [14]) or mentally ill patients, which could help us differentiate between the specific stigma of schizophrenia and the stigma associated with other diseases.

Also, although it has not been the aim of our paper, we believe that the role of family caregivers is very important for patients with schizophrenia. We think the social support that family provides to this type of patient is very relevant and future research should include measures about this topic.

Furthermore, we believe that in addition to correlational approaches to the study of welfare, it would be interesting to run similar experimental studies as shown by the line of work conducted in the field of social exclusion with other groups (see e.g., Baumeister, Twenge, and Nuss [46]). The results of such studies would be very helpful in the development of intervention programs aimed at reducing the impact of social stigma in the well-being of people with schizophrenia.

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