ARTICLE

The Burden of Mental Illness Beyond Clinical Symptoms: Impact of Stigma on the Onset and Course of Schizophrenia Spectrum Disorders

Gil Dov Hoftman, M.D., Ph.D.

In 2013, 18.5% or 43.8 million American adults suffered from mental illness (1). In the National Survey on Drug Use and Health/Substance Abuse and Mental Health Services Administration (NSDUH-SAMHSA) survey, about one out of every five people aged 18–25 years old—during the years that young adults form critical professional, social, and romantic relationships and transition toward independence—reported mental illness symptoms.

A 2007 survey of roughly 200,000 adults across 35 states focused on attitudes toward mental illness and showed that 57% of people believed that others were caring and sympathetic toward people with mental illness (2). Only 25% of individuals afflicted with an illness themselves believed the above to be true, highlighting the lack of support they feel. Adverse attitudes toward individuals with serious mental illnesses could underlie stigmatization of those individuals.

Prototypical serious mental illnesses affect roughly 10 million U.S. adults and include schizophrenia spectrum disorders, which are characterized by clinical symptoms of hallucinations, delusions, affective dysregulation, and cognitive dysfunction. Current medications that treat delusions and hallucinations often have severe side effects that result in slowed thoughts, slowed or abnormal movements, and significant weight gain. These medications are largely ineffective in treating the affective and cognitive symptoms, leaving individuals still debilitated.

In addition to clinical symptoms, people with schizophrenia spectrum disorders are often targets of negative attitudes and social labels that lead to stigma (3). The stigma associated with schizophrenia can precipitate initial episodes of psychosis, trigger relapses, and promote a more severe course (4). The present review discusses the concept of stigma, its impact on schizophrenia onset and course, and strategies for health care professionals to eradicate stigma.

WHAT IS STIGMA?

In Ancient Greece, stigma was a brand that was cut or burnt into the body to advertise a person's permanent physical or psychological blemish. In modern Western culture, stigma has evolved to indicate some disgraceful attribute such that others see the stigmatized person as an acceptable target for discrimination. Stigma has become a justification for labeling others as inferior and threatening (5).

The concept of stigma has multiple components that include 1) labeling of socially important differences (e.g., hearing voices or having delusions), 2) linking labeled people with negative stereotypes (e.g., people with schizophrenia are violent and unpredictable), 3) categorizing labeled people to facilitate social exclusion (e.g., "psychotic," "schizophrenic"), and 4) status loss for and discrimination toward labeled people (e.g., employment and health care inequalities, incarceration, homelessness, retaliatory violence) (6).

Stigma can be divided into at least three different subtypes (see Table 1). Internalized stigma develops when stigmatized individuals internalize negative stereotypes and view themselves as flawed relative to others, leading to emotions of embarrassment, shame, fear, and alienation (6). Interpersonal stigma results in the social rejection and isolation of a stigmatized person due to emotions of anger, anxiety, pity, or fear elicited in those who are not stigmatized (6). Finally, institutional stigma occurs when institutional practices result in the discrimination of stigmatized groups (6).

IMPACT OF STIGMA ON ONSET AND COURSE OF SCHIZOPHRENIA SPECTRUM DISORDERS

Stigma contributes to the onset and negative clinical course in schizophrenia disorders in multiple ways. Individuals experiencing subclinical psychotic symptoms tend to internalize negative stereotypes about those with mental illness, an example of internalized stigma. One study examined whether the perception of discrimination was associated with symptom onset and found that perceived discrimination predicted incident delusional ideation in a dose-response fashion (7). Internalized stigma also contributes to social isolation in individuals with schizophrenia, which has long been known to increase the risk for poor health outcomes (8). Other consequences of internalized stigma include delayed treatment seeking, perceiving the need for treatment as weak, and decreased treatment adherence (9).

Interpersonal stigma effects on schizophrenia are described by stress-vulnerability models, which postulate that social stressors contribute to the clinical onset of schizophrenia (3, 10). Subtle changes in the behavior of those

TABLE 1. Stigma Types, Definitions, Examples, and Eradication Strategies

Stigma Type	Definition	Examples	Eradication Strategy
Internalized	Negative stereotypes and views of permanent flaws accepted by labeled individuals	Negative self-labeling; low self-esteem; devalued identity; negative self-image	Engaging in a collaborative and empathic relationship focused on patient empowerment
Interpersonal	Labeled individuals socially categorized facilitating discrimination	Social rejection and isolation; bullying or labeling at home, school and/or work	Encouraging regular, informal social contact between labeled and unlabeled individuals
Institutional	Labeled individuals excluded by institutional policies and practices	Decreased opportunities for education, jobs, housing, and health care	Enlisting advocates for policies that protect people with mental illnesses and increase research funding

experiencing subclinical psychosis may give rise to negative social interactions and discrimination, which increases the risk for delusional ideation. For example, the observed risk for schizophrenia in minority groups increases with the level of discrimination endured (11). Another study showed that individuals who were either at high or ultra-high risk that transitioned to schizophrenia reported higher stigma-related harm and that higher perception of harm due to stigma at baseline predicted the transition to schizophrenia (12). Studies also demonstrate that interpersonal stigma can exacerbate schizophrenia symptoms and increase vulnerability to relapse due to increased stress and delayed treatment seeking (4).

Institutional stigma increases negative outcomes in schizophrenia as well. Mental illnesses including schizophrenia receive the least amount of funding per disability-adjusted life-years despite having one of the largest disease burdens worldwide (13). Treatment facilities for schizophrenia tend to be located in isolated, disadvantaged, or otherwise limited-access areas (6). In addition, having a history of mental illness leads to resource-reducing discrimination in employment, wages, mortgages, housing, and education (14).

This combination of internalized, interpersonal, and institutional stigma has a synergistically corrosive effect on mental and physical health that extends far beyond clinical symptoms. Stigmatized individuals often deplete adaptive coping mechanisms while managing a devalued identity and then engage in maladaptive emotional regulation strategies such as rumination and other maladaptive coping behaviors such as smoking and drinking, increasing their risk for other adverse health outcomes (15). Also, the stigmatized fear that publicizing the illness will decrease job opportunities and social status, cause shame, and lead to involuntary hospitalization results in delayed treatment seeking and worse clinical outcomes.

ERADICATING STIGMA

It is crucial to recognize and break down the barriers to reducing stigma. These barriers are manifold (for details, see reference 16), but it is important to note that some stem from the biased attitudes and practices of mental health professionals. Members of the care team, including physicians, psychologists, and care managers, can denigrate individuals with mental illness and hold low expectations for improvement (16). Mental health workers may develop negative attitudes toward the patients they treat because of repeated exposure to derogatory and inaccurate media images of mental illness and of helping professionals (17). Even physicians affected by mental illness suffer from interpersonal stigma due to a deeply rooted view in the medical profession that disclosing mental health issues admits constitutional weakness and invalidates their ability and reputation as physicians (18).

Hinshaw and Stier (16) suggest multiple pathways for overcoming negative attitudes and practices by mental health professionals, including improved training in evidence-based interventions, engaging in a collaborative and empathic relationship focused on patient empowerment, and the provision of psychological support for mental health professionals in response to the daily stresses resulting from working in the mental health field.

A significant barrier to eradicating interpersonal stigma is a paucity of social contact with stigmatized individuals, leading to a lack of empathy (16). Unfortunately, contact with stereotyped representations of people with mental illness—for example, interacting with a homeless individual with profound thought disorganization on the street—appears to reinforce the negative beliefs that the entire group consists of deviant, dangerous individuals (16). In contrast, when majority group members contact stigmatized individuals in

KEY POINTS/CLINICAL PEARLS

- Severe mental illnesses require access to high-quality and affordable care that is evidence-based, respectful, and empathic.
- People with severe mental illnesses like schizophrenia spectrum disorders are often targets of negative attitudes and social labels that lead to stigma.
- Stigma associated with schizophrenia can precipitate initial episodes of psychosis, trigger relapses, and promote a more severe course.
- Mental health professionals can perpetuate stigma in people with mental illness, unless care is taken to provide a collaborative and empathic relationship focused on patient empowerment.

conditions of relatively equal power and status, the interaction is far more likely to generate positive attitudes and chip away at stigma. Regular, informal contact is most likely to eradicate negative perceptions of stigmatized individuals (16). Shared goals and cooperative work toward common ends between people with and without mental illness promote an environment where attitudes are more likely to be positive and contact is likely to continue.

CONCLUSIONS

Stigma is a form of social injustice that contributes to the onset of psychosis in schizophrenia spectrum disorders, delays treatment attainment, promotes social isolation, stress, and maladaptive coping behaviors, and places individuals with schizophrenia at higher risk for a more severe illness course. Reduction and eradication of mental illness stigma will require concerted efforts at the individual (affected person and family unit), interpersonal (schools, workplaces, clinics, hospitals, mental health professionals), and institutional levels (media, advocacy groups, policy changes, new legislation). Mental illnesses are debilitating disorders that require access to high-quality and affordable care that is evidence-based, respectful, and empathic. Effectively integrating these factors can decrease symptom burden while at the same time reducing discrimination, enhancing accurate empathy, and promoting helpful social contact.

Dr. Hoftman is a first-year resident in the Department of Psychiatry, Western Psychiatric Institute and Clinic, University of Pittsburgh Medical Center, Pittsburgh.

REFERENCES

1. Substance Abuse and Mental Health Services Administration: National Survey on Drug Use and Health; Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings. Rockville, Md, Substance Abuse and Mental Health Services Administration, 2014
2. Centers for Disease Control and Prevention; Substance Abuse and Mental Health Services Administration; National Association of County Behavioral Health and Developmental Disability Directors; National Institute of Mental Health; The Carter Center Mental Health Program: Attitudes Toward Mental Illness: Results from the Behavioral Risk Factor Surveillance System. Atlanta, Centers for Disease Control and Prevention, 2012
3. Rüsch N, Angermeyer MC, Corrigan PW: Mental illness stigma: concepts, consequences, and initiatives to reduce stigma. Eur Psychiatry 2005; 20:529–539
4. Van Zelst C: Which environments for G× E? a user perspective on the roles of trauma and structural discrimination in the onset and course of schizophrenia. Schizophr Bull 2008; 34:1106–1110
5. Goffman E: Stigma: Notes on the Management of Spoiled Identity. New York, Simon and Shuster, 1963
6. Link BG, Yang LH, Phelan JC, et al: Measuring mental illness stigma. Schizophr Bull 20014; 30:511–541
7. Janssen I, Hanssen M, Bak M, et al: Discrimination and delusional ideation. Br J Psychiatry 2003; 182:71–76
8. Karidi MV, Vassilopoulou D, Savvidou E, et al: Bipolar disorder and self-stigma: a comparison with schizophrenia. J Affect Disord 2015; 184:209–215
9. Baloush-Kleinman V, Levine SZ, Roe D, et al: Adherence to antipsychotic drug treatment in early-episode schizophrenia: a six-month naturalistic follow-up study. Schizophr Res 2011; 130:176–181
10. Meyer-Lindenberg A, Tost H: Neural mechanisms of social risk for psychiatric disorders. Nat Neurosci 2012; 15:663–668
11. Van Zelst C: Stigmatization as an environmental risk in schizophrenia: a user perspective. Schizophr Bull 2009; 35:293–296
12. Rüsch N, Heekeren K, Theodoridou A, et al: Stigma as a stressor and transition to schizophrenia after one year among young people at risk of psychosis. Schizophr Res 2015; 166:43–48
13. Saxena S, Thornicroft G, Knapp M, et al: Resources for mental health: scarcity, inequity, and inefficiency. Lancet 2007; 370:878–889
14. Corrigan PW, Markowitz FE, Watson AC: Structural levels of mental illness stigma and discrimination. Schizophr Bull 2004; 30:481–491
15. Hatzenbuehler ML, Nolen-Hoeksema S, Dovidio J: How does stigma "get under the skin"? the mediating role of emotion regulation. Psychol Sci 2009; 20:1282–1289
16. Hinshaw SP, Stier A: Stigma as related to mental disorders. Annu Rev Clin Psychol 2008; 4:367–393
17. Gabbard GO, Gabbard K: Cinematic stereotypes contributing to the stigmatization of psychiatrists, in Stigma and Mental Illness. Edited by Fink PJ, Tasman A. Washington, DC, American Psychiatric Publishing, 1992, pp 113–12618. Myers M, Fine C: Suicide in physicians: toward prevention. MedGenMed 2003; 5:11–11