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ORIGINAL ARTICLE

Stigma and self-stigma in patients with anxiety disorders

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Abstract

BACKGROUND: Numerous myths and prejudices about mental disorders are still present in society. Psychiatric patients are stereotypically seen as irrational, dangerous, and hostile which leads to social distance and limited life chances.
METHOD: The literature about stigma and self-stigmatization from 1977 to 2012 was reviewed. Articles were found in Pubmed and PsychInfo when using the key words: anxiety disorder, stigma, self-stigmatization. The topic was also searched in psychiatric textbooks. The aim of review was to find the information about impact of the stigma and self-stigma on the diagnosis, help-seeking, and treatment of patients with anxiety disorders.
RESULTS: The unequal approach negatively affects diagnostics, treatment, and reintegration of patients back into society and leads to a heightened risk of stigma internalization. Although most of the researches has focused on severe mental illneses, such as psychoses or major depression, stigma does not avoid people suffering from minor psychiatric disorders either. Patients with anxiety disorders might be especially prone to negative consequences of self-stigma. They often fear the disapproval from others, have lower self-esteem and self-confidence, and are less hopeful. Such attitudes towards self-concept frequently lead to a treatment delayment and thus to a chronification of anxiety disorders. It seems crucial to identify personality traits contributing to the development of self-stigma and to find the ways to destigmatize psychiatric patients. A possible solution might be putting a greater emphasis on health education of general population.

Introduction

Although there has been an important progress in the diagnostics and treatment of mental disorders during last decades, many prejudices about psychiatric problems still prevail in general population. These distorted ideas contribute to shaping of attitudes that cause a stigma psychiatric patiens are daily exposed to. Psychiatric patients are stereotypically seen as irrational, dangerous, and hostile (Nawkova *et al* 2012) which lead to social distance and limited life chances (Schulze & Angermeyer 2003). We have rather satisfactory knowledge of the stigma process among patients with severe mental illnesses, such as psychoses and major depression (Barney *et al* 2006; Yanos *et al* 2008). However, the mental illness stigma does not avoid minor psychiatric disorders either. Patients with anxiety disorders tend to fear of rejection by others strongly. They use to seek medical help relatively late while they have been suffering from anxiety symptoms for years and their mental problems are chronified. They perceive every diagnosed symptom of an anxiety disorder as a painful stigma which lowers their self-esteem and trust in an improvement of their condition. Such belief has a negative impact on both psychotherapeutic and pharmacotherapeutic care (Prasko 2005).

Stigma and self-stigma

The core of the mental disorder stigma lies in widespread stereotypes that prevail in the Western society. Stereotypes represent rigid and passively accepted ways of valuation of certain groups of people. They are based mainly on tradition and prejudices (Hyhlik & Nakonecny 1977). Stereotypes allow a quick categorization and have a direct influence on expectations and behavior of people. A tendency to stereotype is not just a negative phenomenon but it also contribute to an effective and fast adaptation to the environment. Social psychologists distinguish between *autostereotypes* – ideas and opinions that we hold about ourselves – and *heterostereotypes* that we have about members of other groups, eg. rikshaw drivers. An application of a stereotype on a specific person leads to a concealment of his minor and distinctive attributes. The stereotype of psychiatric patients comes from long-term prejudices and traditional interpretations of mental disorders. A response of the social environment that results in a conclusion *"this person suffers from a mental disorder"* is being called a labeling reaction. Whereas general population tends to use traditional and commonly known labels when describing mental health problems (temper, breakdown, going loony), experts use diagnostic labels. A label can have both corrective and stabilizing effect on an impaired behavior. The corrective effect works through an identification of the disorder and its therapy. Mechanisms of the stabilizing effect can be various:

- A patient changes his or her self-concept and a behavior due to the label or in an effort to get rid of stigma;
- A patient retrospectively interprets his or her behavior in a sense of an impairment (*"I have always been weird"*) which also affects self-concept;
- A diagnosis might serve as a status: it leaves no place for other traits besides the ones that the stereotype include (the individual is reduced to "the schizophrenic/hysteric/hypochondriac" etc.).

People do not judge all individuals suffering from a mental illness in the same way. A dichotomous taxonomy is typical: "a madness" in the true sense on one side, "a nervous breakdown" on the other (Chromy 1990). Labels can also be modified by thoughts about a cause of mental disorders. The laical interpretation of mental disorders causes is crucial for the intensity of a rejection of stigmatized individuals. A general view of the psychiatric disorders causes can be divided into several categories: it can be a matter of a *character* (mental inferiority, weakness, perversion, amorality), *organicity* (hereditary burden, brain disease), or *situational* (breakdown after a traumatic experience, shock, a consequence of highly stressful events, deteriorating socioeconomic status, it might be a consequence of grief or suffering). A presumed cause can modify attitudes towards the patient. *The stress interpretation* that sees various negative events as the cause is more favorable than *the organic interpretation* that highlights the importance of the biological origin of the disorder ("the sick brain"). When preferring an origin in *personality*, the afflicted "should make some effort and change", eventually "should be reeducated". When focusing on the *organic* etiology, the physicians should treat the afflicted (if possible) or isolate him, whereas the preferation of the *situational* cause brings suggestions as "everyone should symphatise with him/her and give a helping hand", eventually "it is time to cheer up, don`t you think?" Thus, although the attitudes differ according to the presumed cause, the resultant behavior is always different from the one that would really help the patient – a responsive and integrative behavior.

The mental disorder stigma significantly reflects the way the patient is being accepted or rejected by others and it also affects the position of psychiatric patients in society. Researches concerned in the subject of the mental disorder stereotypes show that psychiatric patients are commonly seen as irrational, unpredictable, unreliable, dangerous, and hostile (Chromy 1990; Gray 2002; Nawka *et al* 2012; Nawkova *et al* 2012). The stigmatization itself manifests through a *social distance* from the afflicted individual. The shunning behavior can be mainly seen in close interpersonal situations (family relationships, friendships) and work relationships. The motive of the increased rejection can be understood as a maladaptive behavior of the person, a common knowledge of his diagnosis, or knowledge about him undergoing a psychiatric treatment. The rejection that comes from the knowledge of mental health problems also occurs in situations in which the individual behaves absolutely ordinarily. A situation at work and in a family can be quite similar. A patient after a discharge can be excessively monitored, people around him act cautiously, judge his behavior and compare it to the stereotypes they hold. Every unusual behavior, related to the disorder or not, is immediately attributed to the symptoms of the disorder. The created social distance can be diminished only by a long-lasting normal behavior, particularly in the original workplace. Many people fear that they would be socially harmed if they undergo a psychiatric treatment or just an assessment and these concerns seem to be fully justifiable. There is no wonder that a considerable number of people with depressive or anxiety disorders tend to complain of somatic symptoms and look for experts in somatic medicine and refuse to admit that the cause of their suffering lies in their mind.

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Roman is a 35-years old high school graduate. He has not been working for ten years and spent the last 5 years in full disability pension. His life is being completely controlled by a fear of a serious disease – prostate cancer. His problems started after

a divorce. Roman had to sue for a son and his wife`s departure caused him a huge pain. Roman was suffering from an urinary tract infection during the divorce. He was sad, did not enjoy any activities as he had before and he was thinking about suicide. When his wife was leaving, she expressed disdain for his lover's capabilities in an effort to hurt him as much as possible. It happened at the trial, where everyone could hear the mocking speech. Roman established a relationship with another woman half a year later but failed in the intimate area. His attention turned to the underwent urinary tract infection and he began to focus on his urination. One day he got an idea that *"there is something wrong with the prostate."* His sister, a physician, arranged a complete examination for him. All results were negative but Roman was not calm because he was persuaded that *"the doctors might have overlooked something and laboratory results are not always reliable"*. He began to dress warmly and stopped going hiking with friends. He measured the body temperature regularly in the morning and in the evening. His fear of the urinary tract diseases was escalating, he acquired a decent collection of the urological literature and began to visit well-known experts in the field. Their continous assurance of his perfect health calmed him only for a few days. Then again, he started to study the literature and look for new professionals. By chance he learned that a neighbour had prostate cancer. He began to study all of the available literature and found that some of the described symptoms matched his own. While regularly checking his measures, Roman sometimes measured an elevated temperature. It was always just from 37.1 to 37.3 degrees, *"but that's not normal ... The temperature is too high! And higher temperature is typical for cancer!"* He got scared even more and started to ask for a prostate removal. All of that despite the negative findings. When urologists refused, Roman thought that they might not have wanted to operate him because his condition was no longer curable. He stopped to take care of himself, quitted the job, did not go anywhere. He was afraid of any effort and started to have difficulty climbing several steps. The perceived fatigue was attributed to the cancer. Roman was persuaded that his situation was already so bad that he would not get hospitalized. His general practitioner repeatedly suggested him to visit a psychiatrist but Roman was always outraged by the suggestion. In the end, when other doctors refused to pay him any more attention, Roman said he would try to visit a psychiatrist. He got to a psychiatrist care in about 10 years after his problems began.

A patient gets a label through an interaction with the social environment and is strongly influenced by the fact that individual came into contact with psychiatry. It is society and its evaluation of what is normal or abnormal that represents a basis of the stigmatization process. A person who has several features, that are unacceptable in the society, stops being its equal member. Besides the discussed mental disorders, stigma can also be related to a physical abnormity or illness, criminal history, sexual orientation, race, nation etc. (Goffman 1973). Stigma itself divides into three subgroups – social, structural (institutional), and internalized (Livingston & Boyd 2010). The internalized stigma is a three-part process during which a person accepts as his own negative stereotypes held against him by society. The process starts with an individual who notices being rejected by others and becomes aware of the stereotypes that lead to the unequal approach. The stigma internalization continues in the second phase in which the person agrees with the stereotypes. The internalization is completed when the person applies the stereotypes on himself (Corrigan *et al* 2011). Consequences manifest in many levels – there can be present an increase of dyphoric emotions, decrease of self-esteem and overall quality of life, anxious anticipation of the negative actions of the others. The afflicted individual might tend to social withdrawal and phobia, maladaptive behavior, or a change in identity (Livingston & Boyd 2010; Camp *et al* 2002). In case the internalized stigma is related to a mental or somatic disease, it is connected to lower compliance with medical procedures, greater severity of symptomatology, and generally negative prognosis (Padurariu *et al* 2011; Livingston & Boyd 2010).

There exists a satisfactory amount of literature about a relationship between stigmatization and chronic somatic diseases, such as AIDS (Sayles *et al* 2009). There is also extensive work about a connection between internalized stigma and severe mental illnesses like psychoses (Yanos *et al* 2008). It has been shown that people suffering from a mental disorder belong among groups that experience stigmatization especially strongly (Padurariu *et al* 2011) and therefore show a significant risk of its internatization. Although there has been a focus mainly on severe mental illnesses, stigma includes patients with minor psychiatric disorders too (Alonso *et al* 2009). People with anxiety disorders often refuse to accept that their problems have a source in their mind and secretly fear that they "went nuts". This is why they can be prone to the risk of development of the internalized stigma after they are diagnosed with a psychiatric disorder even more than the other groups of psychiatric patients. They can be especially sensitive on the presence of the stereotypes in their social environment and might expect repeated rejection from the others in advance. The patients with anxiety disorders might be too self-critical, feel shame and demoralization, and avoid social contacts. All of these are factors leading to a chronification of anxiety disorders. The negative self-concept can become a main factor of vulnerability, no matter a presence of other co-ocurring life problems. It is typical for social phobia, generalized anxiety disorder, and agoraphobia. A loss of self-confidence and hope is also a part of the negative changes in the self-concept (Prasko 2005).

Stigmatization and medical care

Low self-confidence and self-esteem, which affect compliance and prognosis of disorders, are a consequence of the stigma internalization. Prejudices against psychiatric patients can severely affect diagnostics, treatment, and reintegration back into society. Psychiatric patients

are endangered by misunderstanding and rejection from the others. General attitudes towards mental disorders and their treatment are persistant to a change and do not reflect the progress in the field of psychiatry and possibilities of treatment that psychiatry offers in these days. On the other hand, traditional prejudices, often originating from the past when a mental illness was a sign of a possession by demons, still persist. Embedded prejudices are saturated as well by shocking and frequently completely distorted news in tabloids and other media. These prejudices picture a psychiatric patient as a dangerous or intelectually inferior person who does not belong into society. It is a shameful and humiliating reality for people who struggle with their mental problems. The fact that most of them live an ordinary life, regularly work, and undergo ambulatory care is not interesting for media. Therefore, most people avoid seeking psychiatric care even if they recognize its necessity. Even a well-educated person with an anxiety disorder tends to get incapacity for migraines or stomach disorders rather than would admit the psychological cause of his problems. Labeling does not remain in some airy field of pure theoretizing but it has its tangible consequences. It is well known that untreated anxiety disorders worsen a prognosis and heighten a mortality of patients with cardiac problems and those after a stroke (Moser & Dracup 1996; Januzzi *et al* 2000; Starkstein *et al* 1990). It is not an exaggeration if we state that if a patient is not treated for an anxiety disorder while being in the internal medicine department, it is the same case of a non lege artis procedure as if a patient gets a heart attack while being hospitalized in a department of psychiatry and does not get treatment for it.

Awareness of the existence of the mental disorders stigma affects a phase of help-seeking behavior as well. Identification of self as being a psychiatric patient is particularly difficult. The fear from the stigmatization triggers defense mechanisms of denial and suppression. A person with mental problems looks for other explanations than the psychological ones, mainly in the somatic medicine. But neither the fact that a patient or his relatives successfully identified his problems as psychological in nature does not automatically mean that he will get a proper treatment. Both the person and his family often wait to see if the problems disappear spontaneously. They try if a vacancy, relaxations, or anything other considered to be "natural" helps. Even if these possibilities are not helpful, they delay to visit a psychiatrist. A considerable number of people with agoraphobia, social phobia, and OCD prefer to adjust their own and their families lives to the disorder rather than to seek a mental health professional. The path to a psychiatric care facility might also be hindered by medical professionals themselves. A patient with social phobia might hear from a general practitioner, and sometimes even from a psychiatrist, that his problems are simply a sign of his personality and there is nothing that might be done about it. A number of general practitioners are rather insecure when they should suggest a patient to visit a psychiatrist. While perceiving patient`s problems through the lenses of stigma, practitioners feel anxious to make such a suggestion in a fear the patient might get angry. They prefer to postpone the conversation or try to treat the problems by themselves. The question is how much such treatment remains efficient. These are several reasons why many patients with panic disorder, OCD, and social phobia get into a psychiatric care late, often after 7–15 years of suffering (Johnson & Coles 2012; Wang *et al* 2007).

Labeling by physicians

Although we might be prone to expect that general population shows bigger readiness to stigmatize than health care professionals, it is quite the contrary. It can be explained by an instilled principle that overlooking a symptom of a disease is a grave mistake, while its misdiagnosis is less serious (Chromy 1990). Therefore, there can be a certain justification for a general claim that *"psychiatrist sees loonies everywhere"*. Yet, the issue seems to be far greater for somatic practitioners. According to researches from Canada and USA, they tend to label significantly more than general population and their behavior towards psychiatric patients is often disdainful, despising, or depreciative (Mental Health Foundation 2000; Farmer & Griffiths 1992). Attitudes of many psychiatrists are paradoxically more permissive towards psychotic patients than neurotic ones. These attitudes are largely shaped both by university education, where a greater emphasis is being put on severe mental illnesses, and by first work experience when young graduates typically work in intake departments and meet mainly psychotic patients. They usually diagnose and treat well severe psychotic disorders towards which they hold paternalistic attitudes but might not sufficiently understand neurotic disorders (*"they make it up"*) and can radically despise patients with personality disorders. Young physicians can overestimate a severity of some mental disorders – those with less understandable symptomatology (OCD) – as well as underestimate other (agoraphobia, panic disorder, specific phobias, GAD, social phobia, hypochondriasis, adjustment disorders). The overestimation is connected to the etiology of the disorders based mainly on biological factors (BAP, schizophrenia, OCD, panic disorder), the underestimation is related to the etiology derived from psychological factors (adjustment disorders, GAD, phobias). While overestimating, a psychiatrist might be prone to give up any effort to treat the disorder, thinking that the patient cannot be helped. While underestimating, a physician can trivialize and even disprove the symptoms a patient describes or underestimates treatment. There might be created an implicit double bind when a general practitioner tells a patient with psychiatric symptoms: *"you got it from nerves"* and it seems to him to be less severe (meaning

"you are not going to die from it") but a patient, fearing the stigma, can perceive it as a considerable threat.

A relationship between a psychiatrist and a patient is one of the most significant factors contributing to a successful treatment, both pharmacotherapeutic and psychotherapeutic. Inner attitude of a therapist is the key to his or her commitment. If a therapist starts a therapy with a rigid image of "typical" characteristics of a personality disorder his patient suffers from, it can lead to a persuasion of the incurability and decreasing effort to treat the patient properly. The labeling is particularly common in cases of diagnoses that are stereotypically perceived as hard to treat (hypochondriasis, personality disorders – mainly histrionic, borderline, paranoid, and dissocial). Besides that, people receive more labels if their social status is lower than their therapist`s and they are treated less intensively (Janik 1987). A psychiatrist can put a label of a difficult patient on a person that he does not find likeable, is not able to build a therapeutic alliance with, or is being criticized by. Such psychiatrist often speaks about the patient in terms of pejorative labels (*"stupid hysteric"*, *"hypochondriac jerk"*).

The labeling can also be found among general practitioners. Pejorative labels serve as a defense of a physician who explains by them a failure in a treatment or unwillingness to treat the patient more intensively. It seems that the more a therapist labels patients, the lower is a treatment success and the lower is a scope of patients a therapist is able to help. Paradoxically, professionals who stigmatize most are also the ones who suffer from number of maladaptive neurotic or personality traits. Patients who complain about their insufficient treatment (such as patients with somatoform disorders) have it very difficult. They evoke negative reactions of a physician and often get a label *"grumbler"* or *"chronic complainant"* which discredits them. This creates a vicious circle: the patient complains – gets a label – the physician does not treat the patient properly – the patient complains again.

Family and fear from labeling

The mental disorder stigma also affects families of psychiatric patients. This is why people sometimes discourage their relatives with mental problems to seek professional help. They fear of the possible stigmatization that would spread among the family. As if it would be true that *"everyone who undergoes a psychiatric treatment is a nutter"*. Families might fear of the stigma and "a shame" it would bring. It seems to be unproportional to risk such "disgrace" for couple of issues they do not even perceive as serious (eg. a relative being "just" sad or suffering from a phobia, neurosis). Therefore, families often try to persuade their suffering relative to *"cheer up a bit"* or help him in various ways other than suggesting a psychiatric care (they might take him everywhere by car or otherwise provide relief in situations in which their relative experiences fear etc.). Such kinds of help eventually reinforce symptoms of mental disorders. Families also might not trust psychiatrists. They might not believe that psychiatrists are able to help and can be afraid of being blamed for their relative's mental state. The layman definition of a mental disorder is also narrower than the professional one. The risk that psychiatrists identify mental disorders in their relatives terrifies families.

Self-stigmatization

In spite of strong prejudices against psychiatric patients, not every person suffering from a mental disorder internalizes the perceived stigma. Some individuals remain resilient and fight against the distorted beliefs. They might devote their lives to try to change a general point of view that sees a psychiatric patient as a dangerous, unreliable, or unpredictable person who should be better excluded from society (Camp *et al* 2002). With regards to the harmful potential of the self-stigmatization, there is a noticeable effort to identify personality traits that heighten the risk of the internalization. Cloninger‘s biosocial theory and a psychodiagnostic method developed on its basis – TCI-R (Revised Temperament and Character Inventory) proved to be particularly useful. Personality traits that point to the risk of the development of the self-stigma are higher level of harm avoidance and lower level of self-directedness and persistence (Margetić *et al* 2010). Self-directedness and persistence both resemble Snyder‘s cognitive theory of hope that is based on an assumption that hope flourishes from an ability to identify a goal and realistic pathways to achieve it and to dispose of apropriate amount of willpower to endure possible complications (Snyder 2000). It has been shown that people with the internalized stigma have lower levels of hope compared to the non-affected persons. Such people tend to be hopeless and helpless. They presume in advance that the goal cannot be achieved and it is beyond their abilities to live a satisfactory life (Corrigan *et al* 2009). Such attitude contributes to a non-adherence in treatment and an overall worse prognosis. Patients who develop internalized stigma also prefer emotion-focused coping strategies and tend to avoid interpersonal contacts (Yanos *et al* 2008; Rüsch *et al* 2009).

The avoidant behavior leads to the treatment delaying which elevates a risk of chronification of the disorder. Paradoxically, postponing of treatment or its denial is the most common in disorders which can be cured quite easily. A number of patients with anxiety disorders who never seek out help of a professional is rather extensive – it is approximately 75% individuals suffering from social phobia and 60% suffering from depression or panic disorder. Patients with panic disorder, somatoform diorders, chronic fatigue syndrome, or generalized anxiety disorder often refuse to accept that the core of their problems is psychological. They

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might avoid the label of a psychiatric patient so savagely that they categorically deny (or even suppress) the presence of dysphoric emotions that lie behind their psychosomatic problems and focus solely on the somatic and physiological consequences of the chronic distress (Shape & Wessley 2000).

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Mr. Vlada is 36 years old. He is a successful businessman, accustomed to work for 12–15 hours a day. He constantly lives in a hurry. One day about a year ago, he got a night attack of palpitations. He clutched his chest and felt the tingling in the fingers and the lips. He could not catch his breath, was frightened, and called the ambulance. The doctor in a hospital hesitated a bit when he was reading the ECG record and recorded it again, just to make sure. Then, the physician told him that his heart seemed to be completely healthy, at least according to the ECG, and gave him an injection. Vlada was doing better since then but remained unnerved from the fact that the doctor recorded the ECG twice. Another attack came in about a week later. Vlada woke up in the night sweating, heart pounding like a bell, his chest felt constricted. He could not catch his breath and ran to the window to take a breath of fresh air. His wife took him to the emergency room. Vlada ended up in the emergency room 17 times in a half a year. He completed a number of tests – repeatedly ECGs, blood tests, ultrasound, etc. None abnormality was found and seizures still occurred. Vlada had to be hospitalized in an internal medicine ward, where his former classmate worked. The physician tactfully recommended a psychiatrist, which Vlada refused. He restricted business trips because of a fear of further attacks. The negotiations and purchases of goods throughout Europe had to be handled by the subordinates. He was able to travel by car but only on early mornings and late evenings, when the traffic was better. He had to be hospitalized again, this time on neurology. After a series of tests, a psychiatrist was being recommended to him again. This time Vlada did not refuse...

The treatment of patients with anxiety disorders can be successful if beginning early. The effectiveness declines when the start of the treatment is delayed. Avoiding a label of a psychiatric patient is more common in non-educated people but it can be also found in physicians and nurses. Somatic health care professionals can be even more prone to the stigmatization of psychiatric patients than general population.

Conclusion

Stigmatization of psychiatric patients remains an important topic of a modern psychiatry. It affects the diagnostics, treatment, and reintegration into society. Most studies dealing with a topic of stigma focus on severe mental illnesses. It is also important to identify personality traits and coping strategies that contribute to development of internalized stigma in minor psychiatric disorders, such as anxiety disorders.

Patients suffering from anxiety disorders might be especially prone to fear of disapproval from others. This might lead to a treatment delayment and thus to a chronification of their state. It is crucial to think about possible ways to destigmatize psychiatric patients. An important role in this process might represent health education and specific ways of upbringing the children. General population needs to be more educated about neuroses, anxiety, and somatoform disorders. The insufficient level of information contributes to maintaining the stigma not only in general population, but also among the very patients and health care professionals. Stigmatization itself might rise from a perceived threat by being different. If we compare ourselves to others and put emphasis on the things that divide us and therefore estrange us from them, we might be prone to feel threatened and tempted to eliminate the threat, for example through a process of stigmatization.

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