



“I am what I am”: a review of the assumptions of anti-self-stigma intervention

Correspondence to:

Izabela Stefaniak
1st Department of Psychiatry
Institute of Psychiatry and Neurology
9 Sobieskiego St.
00-957 Warsaw, Poland
e-mail: istefaniak@ipin.edu.pl

Izabela Stefaniak 

1st Department of Psychiatry, Institute of Psychiatry and Neurology in Warsaw, Poland

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Abstract

Purpose: The aim of this study is to discuss the validity of introducing an intervention based on anti-self-stigma in a group of patients with psychotic disorders. The article describes the assumptions of the proposed intervention and the approximate model of therapeutic work. In this article, the most important concepts in the area of stigmatization and self-stigma are presented and discussed.

Views: Self-stigma is part of a wider social phenomenon known as stigma. The process of stigmatization was first described in the 1960s and consists of ascribing undesirable features to certain social groups, which leads to many negative consequences such as social exclusion and discrimination. While every aspect of the human experience can be stigmatized, recent psychological research has focused mainly on the stigma and self-stigma associated with a diagnosis of mental illness. Self-stigma results in negative self-esteem and a vicious circle of the “why try” effect. Low self-esteem strengthens self-stigma. We predicted that therapy aimed at improving self-esteem may have a positive effect on reducing of self-stigma. Recent studies have shown that therapies targeting low self-esteem are more effective than those targeting self-stigmatizing beliefs.

Conclusions: Self-stigma is an important problem among patients hospitalized due to psychotic disorders. No training aimed at working with this aspect of experience has been introduced in Poland to date. Our observations show that the proposed training can support the healing process of patients and positively affect the ways in which the patient deals with self-stigma. The proposed intervention requires the evaluation of the effectiveness in a clinical trial involving patients diagnosed with psychotic disorders.

Key words: self-stigma, low self-esteem, anti-self-stigma therapy.

INTRODUCTION

Among people with schizophrenia spectrum disorders, the self-stigma associated with diagnosis represents a major barrier to recovery. Across numerous studies, perceived stigma (i.e., the perception that most members of the general public devalue those with mental illnesses) and self-stigma have been shown to undermine self-esteem [1], increase social withdrawal, isolation, and shame, and to deter individuals from seeking mental health treatment [2]. Self-stigma is rarely assessed in clinical practice and few strategies have been designed to face it efficiently. Recognizing and challenging self-stigmatizing beliefs are the first steps of this complex endeavor. Addressing self-stigma beliefs that negatively affect the lives of patients is associated with the recovery process. Personal recovery has been defined as “a deeply personal, unique process of changing one’s attitudes, values,

feelings, goals, skills and/or roles in a way of living a satisfying, hopeful, and contributing life, even with the limitations caused by illness” [3]. Self-stigma is undoubtedly one of the factors burdening patients and hindering their recovery. Despite growing interest among clinicians in the impact of self-stigmatization on patients’ healing process, there is still a lack of interventions designed to counteract self-stigma in Poland. This article presents the assumptions of an intervention to prevent self-stigma, which is based on a literature review and clinical observations of patients’ needs.

STIGMATIZATION

Apart from bearing the hardships associated with the symptoms of the disease, schizophrenia patients often have to cope with the additional burden of stigmatization. Stigmatization is a multi-stage process in which

a person with a mental disorder begins to function outside the social framework, as if on its fringes. Due to feeling ashamed, some people do not reveal their mental problems; others face discrimination when disclosing their difficulties [4-6].

There are three dimensions of stigma: (i) public stigma, which is defined as a negative reaction of the environment towards a stigmatized group based on stereotypes present in a society); (ii) institutional stigma, which is determined by the extent, to which public institutions limit the rights of people from stigmatized groups; and (iii) personal stigma, which is defined as how a person perceives themselves as someone with a mental problem. Stigmatization or treatment in terms of the “other” is a process of differentiation, distancing, and demarcation, according to which people with mental illness are thought of, spoken about, and treated as “other” and strange to the rest of society [7].

Stigmatization as a social process is very complex and consists of several phenomena. One of these is belonging to a group (in-group) and a clear division from an external group (out-group), which makes people more inclined to ascribe positive attributes to members of their own group and negative attributes to members of external groups. Those who are perceived as “different” are usually placed in the external group since, in this way, members of the internal group can try to protect themselves. Another social process that gives rise to stigma is labelling theory, which states that labelling specific social groups and defining them as abnormal facilitates their control. The labelled groups then adopt attributes and roles in line with the label. This forces individuals in the labelled groups to assume new social roles and leads to the internalization of social stigma and self-stigma. An important social consequence of stigmatization is depriving mentally ill persons of subjectivity, thereby taking away their ability to define themselves, and ultimately excluding them [8]. Various studies use a clear terminological distinction between social stigma, in which the general population supports prejudice and discriminates against people with mental illnesses, and personal stigma, which refers to people’s beliefs about the attitudes in the environment towards their condition and their own attitudes towards themselves [9].

Personal stigma can be divided into several components: (i) perceiving stigma, (ii) experiencing stigma, and (iii) feeling self-stigma. Perceiving stigma is related to patients’ beliefs about the attitudes of the general public towards the members of stigmatized groups. The experience of discrimination is an experience of negative, often rejecting, social behavior towards a person with a mental illness. Self-stigma is the loss of some positive beliefs about oneself, low self-esteem, and decreased self-efficacy [10].

SELF-STIGMA

The experience of self-stigma consists of several stages: initially the patient becomes aware of the stigma, then accepts it and adopts to it. The acceptance of stigma is known as internalization. Internalization of stigma may begin with a social stimulus in which the patient notices other, atypical, and previously absent behavior from people in their environment. The patient associates this change with their mental problems, and becomes aware that the prejudice of others has led to changes in their behavior. The patient then begins to believe that the views and attitudes towards people with mental disorders are justified. In the final stage of stigma internalization, patients develop prejudice towards themselves and act in accordance with it. Self-stigma has many negative psychological and social consequences. Previous studies on the psychological consequences of self-stigma have reported influences on mood, anxiety, and some personality components such as low self-esteem or decreased self-efficacy [11-14].

Self-stigma also affects depression. A study by Pellet *et al.* (2019) showed a significant correlation between self-stigma and the severity of depressive symptoms. The more the patient felt discriminated against and the more negative their self-assessment of the condition of their health, the more he or she suffered from depression [15, 16]. The relationship between self-stigma and social anxiety has not received much research attention. Among the few studies that have analyzed this perceived relationship, Lysaker *et al.* (2010) developed a model in which social anxiety develops in patients with schizophrenia as part of a vicious circle. The ongoing experience of discrimination in some patients negatively affects their self-esteem, reinforcing the belief that they are not worthy of other people’s interest. This leads to the expectation of rejection and the experience of shame in social relationships, and thus to avoidance [17]. In addition to these effects, high levels of self-stigma have been found to correlate with decreased hope [18], low self-esteem [19], low self-efficacy [20], and poor quality of life [21].

THE “WHY TRY” EFFECT

Self-stigma is associated with the “why try” effect, in which low self-esteem and self-efficacy are mediators of difficulties in carrying out and achieving objectives. The basic concept of the “why try” effect is the modified theory of labelling, in which labelling does not directly cause mental disorders, but does lead to negative psychological effects. The modified theory of labelling is in opposition to the sociological theory of labelling presented by Scheff in the 1960s, in which mental disorders (secondary deviation) were created on the basis of labelling (primary deviation). As part of belonging to a specific so-

cial group, people learn how other members of the group treat mentally ill persons and create a set of beliefs about them. When they become a person with a psychiatric diagnosis, these beliefs take on new meaning; the more a person believes they will be devalued and discriminated against, the more they feel at risk when interacting with others in their group. As a result, people may keep their condition and treatment a secret, try to educate others about their situation, or withdraw from social contacts that they perceive as rejecting [22]. However, the behavioral consequences of "why try" go much deeper than just simple strategies of avoidance. People who accept stigma and impose it on themselves may feel unworthy or unable to meet the demands of particular life goals. One might think that such beliefs appear because the person is convinced that they do actually lack the basic social skills needed to achieve certain goals. Here, low self-esteem is something more than just negative beliefs, as it is directly related to the use of offensive stereotypes towards their own person. The "why try" model also shows that people who develop a positive identity through interactions with members of their own group can develop more positive self-esteem. As a result, they experience reduced self-esteem and self-efficacy less frequently [23].

ANTI-SELF-STIGMA INTERVENTIONS

For several years now, research has been conducted on therapeutic interventions designed to prevent stigmatization and address self-stigma. Such interventions are based on various theoretical assumptions, vary widely in treatment duration, and are directed at different groups of patients [24, 25]. In the presented descriptions of interventions, no uniformity has been observed as to the definition of the changes that should occur in participating patients. The criteria for improvement usually concern changes in the assessment and severity of self-stigma. A large part of the described research refers to group interventions, but descriptions of individual interventions can also be found [26]. In reviewing the effectiveness of therapeutic programs, one may note their heterogeneity and the wide variation in program duration. The shortest interventions include several sessions (1-3) and are based on the psychoeducational model. Because of the short-term nature of the program, psychoeducational group interventions do not rely on a dynamic model in which the therapist works on the group process. In such a group, the therapist's goal is not to capture the interaction of group members and to guide the group through all stages of that interaction in order to use its dynamics for therapeutic work. In the psychoeducational model, it is important to share knowledge on topics related to the specific nature of the group and to analyze this knowledge in the context of one's own experience. The most frequently discussed issues are:

- 1) effects and consequences of stigmatization [27];
- 2) education on possible changes in the interpretation of the disease experience [28];
- 3) education on self-stigma and its consequences [29].

The interactions between participants in such a group often involve the exchange of knowledge on a given topic. Psychoeducational groups influence participants through the processes of learning, which leads to changes in behavior, attitudes, and in the affective sphere [30]. The anti-self-stigmatizing interventions described in the literature are intended for patients with various diagnoses including schizophrenia, schizoaffective or bipolar disorder, or more generally for people "after experiencing a psychotic crisis" or those with severe mental disorders [31].

An example of a short-term intervention based on psychoeducation is the "anti-stigmatizing project" described by Michaels *et al.* (2014). The effectiveness of this interaction was assessed in a randomized clinical trial involving an experimental group and a control group. The intervention protocol included one three-hour meeting. Before starting the intervention, patients are evaluated, and then, next assessment is carried out after one three-hour-meeting. The trial involved 127 participants, diagnosed with a mental disorder, and 131 participants without a diagnosis of a mental disorder who worked in mental healthcare. After the intervention, participants with mental illness were more aware of stigma, had a lower level of prejudice, and greater hope for recovery. The participants who were professionally engaged in psychiatric care reported greater awareness of stigmatization and a lower level of prejudice [32].

Ivezica *et al.* (2017) proposed a longer program also based on the psychoeducational model. This three-month intervention is based on short-term psychodynamic psychotherapy, during which different topics are discussed, including health and psychoeducation about relapse prevention. The program deepened insight and offered support through more adaptive strategies for coping with stigma and self-stigma. As part of the therapy, patients were encouraged to share their personal experiences associated with their disease and stigma, as well as to discuss effective strategies for coping with stigma and discrimination. The protocol was conducted in accordance with the principles of group therapy and included 12 sessions. Eighty patients diagnosed with schizophrenia with a stable mental condition participated in the study. The intervention took place on an outpatient basis and was planned according to Solomon's four-group plan (an experimental plan consisting of two experimental groups and two control groups). Patients from the experimental group showed improvement on the self-stigma scale. However, patients' scores for the recovery and perceived discrimination scales did not change [33].

Some of the interventions described in the research include cognitive behavioral therapy (CBT) or consist

of elements of therapies belonging to the “third wave of CBT”, containing motivational therapy or therapy based on acceptance and commitment. Studies embracing CBT use techniques to question beliefs associated directly with self-stigma [31] or work with beliefs that are indirectly linked to self-stigma and concern the activation of negative beliefs, such as those associated with low self-esteem [34].

Fung *et al.* (2011) proposed a program that combined psychoeducation with CBT and motivational therapy. The program consisted of 12 group sessions and 4 individual control sessions. The study involved a total of 66 patients diagnosed with schizophrenia. Of these, 34 were in the experimental group and participated in an anti-self-stigma intervention. The remaining 32 participants were in the control group. Evaluation was carried out before and immediately after the intervention, as well as one, two, three, and six months after the intervention. The results indicated that the program improved self-esteem and that patients were more willing to cooperate with the treatment. However, the effects of the intervention were found not to last in the period six months after the end of the program [29].

A very interesting approach was adopted by Roe *et al.* (2014) in the form of anti-self-stigma therapy representing a combination of cognitive-behavioral therapy and some components of narrative therapy (NECT). The inclusion of elements of the latter in anti-stigma training resulted from research on difficulties in creating narratives about one's own life experience [35]. As part of the therapy, participants tell their story, the meaning of which is reflected back to them by the therapist in such a way that patients can see their personal resources in it. The study involved 119 subjects with a diagnosis of severe mental disorders, of which 63 were assigned to the experimental group and 56 to the control group. The therapy program consisted of 20 group sessions. The control patients were treated with standard therapeutic interventions (TAU, treatment as usual). The study found that patients in the experimental group obtained therapeutic benefits in the form of improved self-esteem, increased quality of life, reduced self-stigmatization, and increased hope [36].

DISCUSSION AND JUSTIFICATION OF THE ASSUMPTIONS OF THE “I AM WHAT I AM” ANTI-SELF-STIGMA INTERVENTION

The idea of creating anti-self-stigma training arose from clinical observations of mentally ill patients and from the numerous studies showing the effectiveness of such interventions. The problems of stigma and self-stigmatization among patients with psychiatric disorders – particularly those with schizophrenic conditions

– is increasingly being researched in Poland. However, there is no information on the percentage of patients who are affected by self-stigma. Therefore, we assume that the problem of self-stigma applies to the vast majority of people diagnosed with schizophrenia. A study by Cechnicki *et al.* (2011) asked 202 such patients about their experience of stigmatization. Among those surveyed, 58% anticipated discrimination in the area of interpersonal relationships and 55% in the labor market. The experience of stigma in the form of rejection by others was confirmed by 87% of the respondents, and 50% of respondents experienced a complete breakdown of social contacts due to mental illness [37].

Among the anti-stigma interventions in Poland, the effectiveness of structured training conducted by “experts by experience” and the impact of this intervention on the attitudes of the participants towards people suffering from mental illnesses have recently been described. The intervention took the form of a three-hour workshop led by “experts by experience” [38]. The analysis of the results provides preliminary empirical evidence that the structured anti-stigma intervention can be an effective tool for improving social attitudes towards people with mental illness. Given the absence of Polish interventions aimed at addressing self-stigma, we decided to propose a therapeutic program called “I am what I am”. This is an intervention based on the assumptions of CBT, and its main purpose is the modification of negative convictions related to low self-esteem.

The proposed program includes 10 group therapy meetings, with the assumption that 6 to 8 people will participate at the same time. This will allow the therapist to engage with and involve all patients in the therapeutic tasks. An important and integral element of the therapy is the assignment of personal tasks to patients. Each therapeutic session will last 1 hour 15 minutes.

The therapeutic program consists of several modules:

- 1) psychoeducational module I: related to the discussion of issues in the area of stigma and self-stigma. The development of this part of the program is based on the understanding of the issues of stigma and self-stigma proposed by PW Corrigan (2002, 2004) [39, 40];
- 2) psychoeducational module II: related to the introduction of the principles and assumptions of CBT described by A. Beck (1976) [41];
- 3) module III: related to work with low self-esteem and low effectiveness based on the integrated cognitive stigmatization model of L. Wood (2017) [42] and the cognitive model of low self-esteem of M. Fennell (1997) [43].

The idea of naming the intervention “I am what I am” stems from the emphasis placed on the acceptance of one's current health situation and reframing of the negative beliefs about oneself, which constitute an element of low self-esteem. Self-esteem is an important element of the “why try” model and its improvement increases re-

Table 1. Presentation of the "I am what I am" therapeutic program aimed at coping with self-stigma

Module	Topics of the module	Sessions	Issues raised	Therapeutic goal
I	Psychoeducational – discussion of the nature of stigmatization and self-stigmatization	1, 2	Presentation of the concept of stigma and self-stigma. Education about the nature of stigma. Discussion of experiences related to prejudice and discrimination. Identifying and challenging negative stereotypes. Discussion on ways to deal with stereotypes. Discussion on the importance and impact on the stigma of labelling as a cognitive distortion.	Psychoeducation. Normalization and appeal to the universality of experience. Strengthening resistance to stigma and self-stigma. Support for adaptive coping strategies.
II	Psychoeducational – discussion of the assumptions of PB therapy	3-5	Education in the field of the ABC model. Discussion on the influence of thoughts on emotions, behavior, and physiological reactions. Identifying cognitive distortions. Initial discussion with automatic thoughts.	Psychoeducation. Improving cognitive flexibility. Improving the understanding of experienced emotions.
III	Working with low self-esteem	6-9	Conversation about the emotional and cognitive consequences of obtaining a psychiatric diagnosis. Work on isolating the negative self-scheme that is part of low self-esteem. Creation of a personal history based on the experience of psychiatric diagnosis. Discussion on the negative beliefs about oneself. Discussion on the mechanisms supporting low self-esteem. Discussion: I-NEGATIVE vs. I-POSITIVE. Building a MY-REAL image. Analysis of the negative consequences of low self-esteem.	Improving self-esteem, modifying negative beliefs about oneself.
Summary		10	Summary of previous therapeutic meetings, describing one's strengths and weaknesses. Development of a personal work plan.	

sistance to self-stigma, supports the healing process, and influences the achievement of life goals in patients diagnosed with schizophrenia. The protocol's assumptions are based on the cognitive conceptualization of low self-esteem described by M. Fennell (1997). This model suggests that, based on experiences that most often arise early in life, a person forms beliefs about themselves. When their self-regard is excessively negative (e.g., "I'm worthless" or "I'm not good enough"), the consequence is low self-esteem. In response to their negative beliefs, people develop strategies to cope with their perceived imperfections. Such strategies are defined by Fennell as the "rules of life", and may turn into what A. Beck (1976) specified in his original model of emotional disorders as "dysfunctional conditional assumptions". The purpose of these dysfunctional conditional assumptions is to protect the person from activating a negative self-image. While it is possible to meet the assumed conditions in these rules, negative beliefs are inactive. For example, "If I manage to hide my true self, I will not be rejected" (conditional assumption).

"As long as I limit close contacts, I feel safe and the negative thought 'I am worthless' is not activated". However, the assumptions that develop in response to very negative self-esteem seem to be exaggerated both in content and in their application. The effort to behave according to such rigid and extreme rules is very taxing and there is a high probability that, at some point in a person's life, these rules will not be followed. An imbalance in the ability to meet dysfunctional conditional assumptions can activate negative self-esteem and lead to increased anxiety or depression. The consequences of activating negative beliefs may be several types of behaviors, such as avoiding social situations and withdrawing from activity, which creates a "vicious circle" [43-45].

CONCLUSIONS

The proposed "I am what I am" program is one of the first in Poland aimed at working with self-stigma in patients diagnosed with schizophrenia. During the in-

tervention, patients participate in three modules, including two psychoeducational modules and one module focused on addressing low self-esteem. The work on low self-esteem is based on the assumptions of CBT. Beliefs related to low self-esteem constitute an important element of the “why try” model described by Corrigan *et al.* (2009), in which the mediator of the possibility of achieving a goal is the sense of value and the sense of effectiveness. The proposed protocol was positively received by patients.

In order to fully assess the benefits of the proposed intervention, we plan to conduct a randomized trial in-

volving a sufficiently large group of patients. As part of the study, the number of participants and inclusion criteria will be precisely defined. We plan to describe in detail the intervention that patients will undergo and how patients will be evaluated before and after the intervention. We shall then assess the impact of the intervention on the severity of self-stigma. Self-stigma is a significant problem in the recovery process of patients with psychosis. Despite considerable interest in the problem of self-stigma, no specific interventions aimed at this problem have yet been developed in Poland.

Conflict of interest

Absent.

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