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Perceived discrimination, internalized stigma and well-being in people with mental illness

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INTRODUCCIÓN

Esta tesis trata sobre la influencia de las experiencias de estigmatización y el estigma internalizado en el bienestar de las personas con enfermedad mental. Explora las relaciones de la discriminación percibida, la conciencia de estigma y el estigma internalizado con los distintos componentes del bienestar psicológico y subjetivo. En línea con la tendencia actual en el estudio del estigma social en esta investigación adoptamos la perspectiva del grupo estigmatizado. Más concretamente, esta tesis trata de analizar el impacto de los distintos tipos de discriminación percibida en el bienestar de las personas con enfermedad mental, y de arrojar luz sobre los mecanismos mediante los que se produce este impacto. Proponemos que las experiencias de discriminación producen efectos negativos en el bienestar de las personas con enfermedad mental a través de los procesos de internalización del estigma, es decir, a través de la asunción por parte de las personas con enfermedad mental de los estereotipos negativos que la sociedad tiene sobre ellos. Para alcanzar los objetivos propuestos se realizaron dos estudios empíricos. La metodología empleada en ambos estudios es correlacional, usando en los dos casos diseños transversales y cuestionarios autoaplicados. Los resultados obtenidos son aplicables a la hora de diseñar programas de intervención para la mejora del bienestar de las personas con enfermedad mental.

En el capítulo 1 se analiza el origen del concepto de estigma social, así como algunas definiciones recientes, y su presencia y efectos en las personas con enfermedad mental.

En el capítulo 2 exponemos los resultados del primer estudio (N = 50). En dicho estudio se analizan las relaciones entre la percepción de discriminación sutil y manifiesta, la conciencia de estigma, y algunos indicadores de bienestar psicológico y subjetivo. Se analiza también la relación entre dos posibles estrategias de afrontamiento ante la estigmatización (el afrontamiento activo y el afrontamiento evitativo) y el bienestar. Los resultados muestran la existencia de una asociación negativa entre la discriminación percibida y el bienestar psicológico y subjetivo. También se encuentra que el afrontamiento evitativo se relaciona

negativamente con el bienestar, mientras que las relaciones entre afrontamiento activo y bienestar no son significativas.

Para tratar de esclarecer los mecanismos a través de los cuales la discriminación percibida influye negativamente en el bienestar, en el segundo estudio se introdujo una medida de estigma internalizado. Se esperaba que esta variable actuara como mediadora entre la discriminación y el bienestar. Además, con respecto al estudio 1, se introdujeron nuevas medidas de bienestar psicológico y subjetivo, que aportan una visión más amplia de los mismos. En los capítulos 3, 4 y 5 se muestran, desde diversas perspectivas, los resultados del estudio 2 (N = 213). En el capítulo 3 se analiza el papel mediador del estigma internalizado entre las diferentes facetas de la discriminación percibida y el bienestar.

En el capítulo 4, con objeto de detectar variables que contribuyan a una mejor calidad de vida de las personas con enfermedad mental, se explora el posible papel mediador de diversas variables relacionadas con el bienestar psicológico en la relación entre el estigma internalizado y el bienestar subjetivo. Los resultados son consistentes con la mediación.

La literatura indica que la discriminación individual y la discriminación grupal son constructos diferentes, con efectos distintos sobre el bienestar (Molero, Recio, García-Ael, Fuster y Sanjuán, 2012; Smith y Ortiz, 2002). Además, estudios con otros grupos estigmatizados han encontrado dos vías mutuamente excluyentes para afrontar el estigma: la evitación y la acción colectiva (Molero, Fuster, Jetten y Moriano, 2011). Con la intención de comprobar si estos procesos tienen lugar en el grupo de las personas con enfermedad mental, en el capítulo 5 se propone un modelo de ecuaciones estructurales según el cual la discriminación individual y la discriminación grupal afectarían al bienestar psicológico a través de dos vías distintas: la discriminación individual aumentando la internalización del estigma, y la discriminación grupal incrementando la disposición a participar en acciones colectivas para mejorar la situación del grupo.

Por último, en el capítulo 6, la discusión general, se resumen los resultados de los anteriores capítulos y se discuten en el contexto de la literatura actual. También se discuten

sus implicaciones y aportaciones prácticas. Finalmente, se exponen las limitaciones de la investigación, y se dan algunas recomendaciones para investigaciones futuras.

Esta tesis presenta diversas aportaciones en el estudio de la estigmatización de las personas con enfermedad mental. En primer lugar se analiza el papel de las distintas facetas de la discriminación percibida en la internalización del estigma. En segundo lugar se explora la relación que los distintos componentes del estigma internalizado tienen con el bienestar, tanto psicológico como subjetivo. Al ayudar a comprender las relaciones entre discriminación, internalización del estigma, y bienestar, los resultados expuestos en esta tesis tienen implicaciones relevantes para la construcción teórica sobre el estigma y sus efectos. Estas aportaciones teóricas pueden a su vez ser útiles en el diseño de intervenciones para combatir el estigma y mejorar la calidad de vida de las personas con enfermedad mental.

Capítulo 1: El estigma asociado al trastorno mental

El estigma social

El término “estigma” tiene su origen en la antigua Grecia, y designaba la marca que se realizaba en la piel de los criminales, esclavos o traidores para identificarlos como individuos que debían ser evitados (Goffman, 1963). El principal responsable del empleo de este término y de su estudio en las ciencias sociales es el sociólogo Erving Goffman, quien define el estigma social como el fenómeno por el cual un individuo que posee un atributo profundamente desacreditado por su sociedad es rechazado como resultado de ese atributo. Por lo tanto, el estigma es un proceso mediante el cual la reacción de los demás deteriora la identidad normal del individuo (Goffman, 1963).

Goffman define tres categorías de estigma: las “abominaciones del cuerpo”, que hacen referencia a deformidades, discapacidades y enfermedades físicas; los “defectos del carácter del individuo”, relativos a características psicológicas o morales del individuo, achacables a una voluntad débil, creencias erróneas, o pasiones antinaturales; y por último, los “estigmas tribales”, que hacen referencia a la pertenencia a una raza, nación, o religión diferente de la mayoritaria. (Goffman, 1963).

La mayoría de las definiciones posteriores incluyen dos componentes fundamentales: el reconocimiento de una diferencia y la devaluación de la persona diferente (Bos, Pryor, Reeder, y Stutterheim, 2013). Además, las definiciones actuales enfatizan que el estigma se produce en la interacción social, y que por lo tanto no reside en el individuo, como afirmaba Goffman, sino en el contexto social (Hebl y Dovidio, 2005).

Según Link y Phelan (2001), para poder hablar de estigmatización deben concurrir una serie de elementos tales como: el etiquetado, o asignación del individuo a una categoría, señalándolo como diferente; el empleo de estereotipos negativos asociados a dicha categoría; la división entre “nosotros” (el endogrupo: los no estigmatizados) y “ellos” (el exogrupo: los estigmatizados); la pérdida de estatus, y la discriminación.

Además, para que tenga lugar la estigmatización, todos estos elementos deben darse en una situación de diferencia de poder que permita a los potenciales estigmatizadores hacer que esa etiqueta, esos estereotipos negativos, y esa división entre “ellos y nosotros” sean

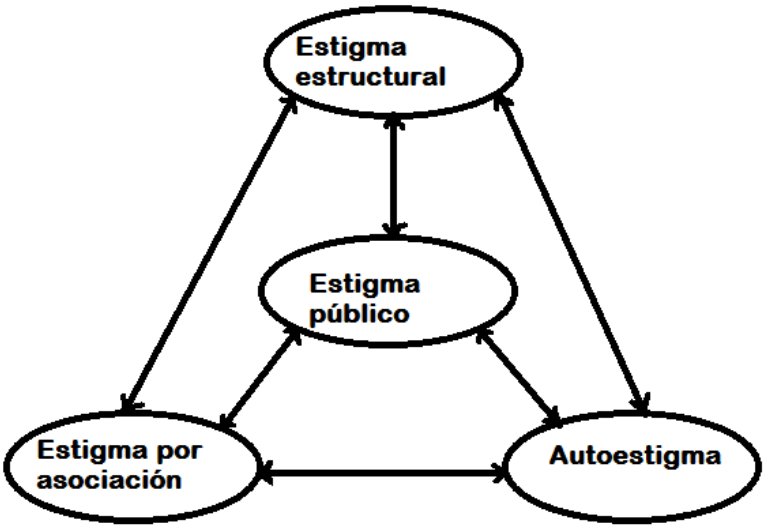
ampliamente reconocidos en su sociedad, y que esas diferencias que ellos han creado tengan consecuencias negativas (pérdida de estatus y discriminación) para aquéllos a quienes se asigna la etiqueta (Link y Phelan, 2001).

Tipos de estigma

Pryor y Reeder (2011) articulan un modelo que muestra las interrelaciones entre cuatro manifestaciones del estigma a distintos niveles.

Figura 1.1: los cuatro tipos de estigma

Fuente: Pryor y Reeder (2011).



El *estigma público* hace referencia a las reacciones psicológicas y sociales de la gente hacia alguien que se percibe como estigmatizado. Se trata, por lo tanto, del conjunto de reacciones cognitivas, afectivas y conductuales de los estigmatizadores hacia los estigmatizados. Dichas reacciones pueden tener lugar tanto a nivel implícito y automático como a nivel explícito y controlado (Bos et al., 2013).

El *autoestigma* es el impacto social y psicológico del estigma público en las personas estigmatizadas. Está compuesto por dos elementos: el *estigma sentido*, es decir, la experiencia o anticipación de discriminación por parte de la persona estigmatizada (Herek, 2007, 2009), y el *estigma internalizado*, que se refiere al acuerdo con los estereotipos sobre el grupo estigmatizado, su aplicación a uno mismo, y las consecuencias de esto (reducción de la

autoestima, malestar psicológico, aislamiento y ocultación)[1] (Corrigan, Watson y Barr, 2006; Ritsher, Otilingam y Grajales, 2003; Ritsher y Phelan, 2004; Yanos, Roe, Markus y Lysaker, 2008).

Tanto el estigma público como el estigma internalizado están compuestos por estereotipos, prejuicio y discriminación. En lo referente al estigma público, los estereotipos se definen como las creencias negativas existentes en una determinada sociedad sobre las personas con enfermedad mental. Los prejuicios hacen referencia al acuerdo por parte de los miembros de la población general con esos estereotipos, así como a la reacción emocional negativa hacia las personas del grupo estigmatizado que se deriva del acuerdo con dichos estereotipos. Las consecuencias conductuales de los prejuicios son lo que entendemos como discriminación.

De la misma manera, en el estigma internalizado, los estereotipos son el conocimiento de estas creencias negativas sobre las personas del grupo estigmatizado extendidas entre la población general. El prejuicio sería el acuerdo con esos estereotipos y su aplicación a uno mismo, y los sentimientos negativos hacia uno mismo derivados de ese acuerdo. Las consecuencias de estos prejuicios son los comportamientos que podríamos definir como "discriminación hacia uno mismo". Ejemplos de este tipo de comportamientos son el

[1] Cabe señalar que no todos los autores utilizan los términos autoestigma y estigma internalizado de la misma forma. Mientras que para Pryor y Reeder el autoestigma es un concepto más amplio que incluye la percepción de estigma y el estigma internalizado, Corrigan no habla de estigma internalizado, sino que usa el término autoestigma para referirse al acuerdo con los estereotipos sobre el propio grupo, su aplicación a uno mismo, y las consecuencias de esto. Esto coincide con lo que Pryor y Reeder llaman estigma internalizado. En esta tesis se emplea este término, puesto que se utiliza la escala de estigma internalizado de enfermedad mental (ISMI) de Ritsher, que usa también el término en el mismo sentido que Pryor y Reeder (es decir, para referirse a lo que Corrigan llama autoestigma).

secretismo y aislamiento para evitar experiencias de rechazo, o (en el caso de la enfermedad mental) lo que algunos autores han denominado el efecto "por qué intentarlo" (*why try*): el evitar perseguir las propias metas por pensar que se es demasiado incompetente para alcanzarlas, debido al descenso en la autoeficacia asociado a la internalización del estigma (Corrigan, Larson y Rüsch, 2009).

Tabla 1.1: Comparación de los componentes del estigma público y el estigma internalizado.

Adaptado de Corrigan y Watson (2002).

	Estigma Público	Estigma internalizado
Estereotipos	Creencias negativas sobre un grupo. Ejemplos: peligrosidad, incompetencia, debilidad de carácter.	Creencias negativas sobre el propio grupo. Ejemplos: debilidad de carácter, incompetencia.
Prejuicio	Acuerdo con las creencias y/o reacción emocional negativa. Ejemplos: ira, miedo, desconfianza.	Acuerdo con las creencias y aplicación a uno mismo. Reacción emocional negativa. Ejemplos: baja autoestima, baja autoeficacia.
Discriminación	Respuesta conductual al prejuicio. Ejemplos: negarse a dar trabajo o alquilar una vivienda a un miembro del grupo estigmatizado, negarle ayuda.	Respuesta conductual al prejuicio. Ejemplos: dejar de buscar oportunidades de trabajo y vivienda, evitar relacionarse con personas sin un trastorno mental.

Por su parte, el *estigma por asociación* se refiere reacciones sociales y psicológicas habitualmente negativas hacia la gente asociada con una persona estigmatizada (normalmente familiares y amigos, aunque también puede producirse cuando la relación es arbitraria, como la

proximidad física; Pryor, Reeder y Monroe, 2012) y la propia reacción de estas personas al ser asociadas con una persona estigmatizada (Bos et al., 2013)

El *estigma estructural* hace referencia a las formas en las que las instituciones e ideologías dominantes de una sociedad legitiman, perpetúan y exacerban un estatus estigmatizado, manteniendo el *statu quo*, las desigualdades, y las diferencias de poder (Bos et al., 2013).

La percepción de discriminación

Otro constructo importante en esta tesis es la percepción de discriminación. Similar a lo que Herek denomina "estigma sentido" (2007; 2009), la discriminación percibida hace referencia a la conciencia de los estereotipos públicos y la discriminación. No se trata, sin embargo, de un constructo unitario. Dentro de ella, podemos diferenciar, por un lado, entre discriminación grupal e individual, y por otro, entre discriminación sutil y manifiesta (Molero, Recio, García-Ael, Fuster y Sanjuán, 2012).

La discriminación grupal percibida se define como la medida en que un individuo cree que su grupo es discriminado, mientras que la discriminación individual percibida se refiere a sus propias experiencias de discriminación. La discriminación sutil hace referencia a la percepción de muestras de desconfianza, trato diferente, o rechazo sutil, mientras que la discriminación manifiesta hace referencia a las muestras abiertas de discriminación y rechazo.

Pese a que los efectos de los distintos tipos de discriminación en las personas con enfermedad mental no han sido puestos a prueba con anterioridad, en esta tesis partimos de la base de que la percepción de discriminación conduce a la internalización del estigma, siendo uno de nuestros objetivos analizar el efecto de los distintos tipos de discriminación percibida. Por otra parte investigaciones realizadas con otros grupos estigmatizados han encontrado que la discriminación grupal suele mostrar puntuaciones más altas que la individual, si bien su relación con el bienestar es menor (Molero et al., 2012). La discriminación sutil, por su parte, ha mostrado efectos al menos tan nocivos para la salud física y mental como la discriminación manifiesta (Jones, Peddie, Gilgrane, King y Gray, 2013).

El trastorno mental

El DSM 5 define el trastorno mental como “un síndrome que se caracteriza por una alteración clínicamente significativa de la cognición, el control emocional o el comportamiento de un individuo, y que refleja una disfunción en los procesos psicológicos, biológicos, o de desarrollo que subyacen al funcionamiento mental.” Añade además que “los trastornos mentales normalmente están asociados con un malestar significativo o una discapacidad en las áreas social y ocupacional y otras actividades importantes” (American Psychiatric Association, 2013, p.20).

Aunque no existen datos sobre la prevalencia de los trastornos mentales en España a nivel estatal, el mayor estudio realizado en población española indica que en torno a un 25% de los españoles había tenido un trastorno mental a lo largo de su vida, y alrededor del 9,6% lo había tenido en los últimos doce meses (Alonso et al., 2004). Si bien en el estudio se emplearon los criterios diagnósticos del DSM-IV, al realizarse entrevistas a domicilio se excluyó de la muestra a colectivos como las personas sin hogar o institucionalizadas y se excluyeron algunos trastornos con prevalencias relativamente pequeñas como los trastornos obsesivo–compulsivos, los trastornos alimentarios, el abuso de drogas, los trastornos infanto–juveniles, o los trastornos psicóticos, por lo que las cifras reales probablemente sean mayores (Alonso et al., 2004).

Entre las personas con trastornos mentales, las más estigmatizadas son las que tienen trastornos mentales graves (Frances, 2014; Hinshaw,2007). “Enfermedad mental severa y persistente” es el término empleado por los profesionales de la salud para referirse a aquellas enfermedades mentales que requieren un tratamiento continuado, a menudo combinando distintos tipos de medicación y terapia (UNC Center for Excellence in Community Mental Health, 2014). Esta definición se ha operativizado de distintas formas, en algunos casos equiparándose con el diagnóstico de psicosis, y en otros centrándose en el grado de disfunción y la duración del tratamiento, con independencia del tipo de diagnóstico (New York State Office of Mental Health, 2012; Ruggeri, Leese, Thornicroft, Bisoffi y Tansella, 2000).

Se calcula que en la actualidad aproximadamente un 1% de la población española tiene un trastorno mental grave, y la mayoría de esas personas, unas 400.000, están diagnosticadas de esquizofrenia (Centro de Investigación Biomédica En Red de Salud Mental, 2011). .

El estigma de la enfermedad mental

A un nivel teórico, el estigma asociado a la enfermedad mental se enmarca en la categoría que Goffman denominó "defectos del carácter del individuo", y de hecho es uno de los ejemplos que el sociólogo menciona al referirse a este tipo de estigmas, junto a otros como el alcoholismo o la homosexualidad (Goffman, 1963).

El estigma asociado a la enfermedad mental ha existido a lo largo de toda la historia. Si bien la explicación mágico-religiosa de la enfermedad mental no siempre supuso un trato cruel hacia quienes la padecían, se cree que a partir del siglo XV, y hasta principios del XIX, muchas personas con enfermedad mental fueron perseguidas y quemadas por hechicería o posesión demoníaca. La concepción científico-racional de la enfermedad mental, presente ya entre los médicos de la antigüedad, como el propio Hipócrates, fue ganando predominancia a partir del siglo XVII, a medida que el modelo mágico-religioso se debilitaba. Desafortunadamente, pese a que el concepto científico-racional ha permitido una mejor comprensión de los trastornos mentales y un innegable desarrollo terapéutico, su preminencia no supuso ni mucho menos el fin del estigma y la discriminación hacia las personas con enfermedad mental. De hecho, en algunos momentos históricos, sirvió para justificar diferentes tipos de trato cruel y estigma estructural, tales como el encierro manicomial, la lobotomía, e incluso políticas de eugenesia (Stucchi-Portocarrero, 2014).

A día de hoy, el estigma social sigue siendo uno de los problemas más importantes a los que tienen que hacer frente las personas que padecen trastornos mentales (Comisión Europea: Dirección General de Salud y Consumidores, 2005; Muñoz, Guillén y Pérez-Santos, 2013; Organización Mundial de la Salud, 2005). El estigma provoca la exclusión y

discriminación de las personas con enfermedad mental en áreas como la vivienda, el empleo, las relaciones interpersonales, la salud y los medios de comunicación, sumándose en muchos casos a las dificultades que las propias enfermedades pueden provocar en estas áreas (Corrigan y Watson, 2002; Magallares, 2011; Michaels, López, Rüsch y Corrigan, 2012; Sampietro, 2010).

En los últimos años se han llevado a cabo numerosos estudios que ponen de manifiesto las relaciones negativas existentes entre la estigmatización de las personas con enfermedad mental y diversas variables psicológicas y psicosociales, como la autoestima, el empoderamiento, la autoeficacia, la calidad de vida, o la adherencia al tratamiento (Drapalski et al., 2013; Livingston y Boyd, 2010; Muñoz, Sanz, Pérez-Santos y Quiroga, 2011). Otros trabajos ponen de manifiesto que la estigmatización que sufren las personas con enfermedad mental se relaciona con la depresión (Markowitz, 1998), la ansiedad (Lysaker, Yanos, Outcalt, & Roe, 2010), o la gravedad de los síntomas (Drapalski et al., 2013).

Además, el estigma asociado al trastorno mental tiene consecuencias negativas para la búsqueda y el acceso a la atención sanitaria. El estigma afecta a la búsqueda de ayuda y al acceso a la misma a través de tres niveles distintos. A nivel personal, las personas pueden evitar acudir a los servicios de salud mental para evitar la etiqueta asociada a la enfermedad mental, o simplemente pensar que no servirá de nada debido al efecto "¿por qué intentarlo?" asociado con el estigma internalizado (Corrigan, Druss y Perlick, 2014; Corrigan et al., 2009). La voluntad de la familia de evitar la etiqueta y el consiguiente estigma por asociación también puede ser un obstáculo para la búsqueda de atención sanitaria. A nivel de los profesionales sanitarios, hay estudios que sugieren que algunos psiquiatras son reticentes a compartir toda la información sobre el diagnóstico y tratamiento de la esquizofrenia con sus pacientes (Üçok, Polat, Sartorius,Erkoç y Atakli, 2004), y el estigma parece contribuir al peor trato dispensado por los profesionales de atención primaria a las personas con enfermedad mental (Thornicroft, 2013). A un nivel macro, el estigma estructural provoca una distribución desigual de los recursos que supone que los destinados a los servicios de salud mental sean insuficientes (Corrigan et al., 2014).

El estigma también parece ser una de las causas de la elevada incidencia del suicidio y la ideación suicida entre las personas con enfermedad mental (entre el 18% y el 55% de las personas con enfermedad mental afirman haber tenido algún intento de suicidio, frente a sólo el 0,5% de la población general) (Corrigan et al., 2014). El estigma no sólo expone indirectamente a las personas con enfermedad mental a un mayor riesgo de suicidio al actuar como barrera para la búsqueda y el acceso al tratamiento, sino que además puede hacer que el suicidio parezca la mejor solución para quienes lo padecen (Pompili, Mancinelli, y Tatarelli, 2003).

En el campo de la enfermedad mental se ha estudiado mucho el estigma internalizado y sus efectos. El estigma internalizado ha sido asociado con un descenso en los niveles de autoestima y autoeficacia (Corrigan, Watson yBarr, 2006; Ritsher et al., 2003; Ritsher y Phelan, 2004; Yanos, Roe, Markus y Lysaker, 2008), un incremento en la sintomatología depresiva y negativa (Ritsher & Phelan, 2004; Yanos et al., 2008), menores puntuaciones de esperanza y un mayor uso del afrontamiento evitativo (Yanos et al., 2008) y un menor empoderamiento y orientación a la recuperación (Ritsher et al., 2003). Además, diversos autores consideran que tiene un efecto más directo sobre el bienestar de las personas con enfermedad mental que el estigma o la discriminación percibidos (Lysaker, Roe y Yanos, 2007; Muñoz et al., 2011; Ritsher et al., 2003; Watson et al., 2007).

Chapter 2: Social Rejection and Subjective Well-being in a Sample of Schizophrenia Patients

The research described in this chapter has been accepted for publication (and published online) in a similar form as:

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Abstract

Objective: The present study analyzes the existing relationship between three variables related to social rejection (perception of blatant 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 (specially 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, blatant discrimination, coping, well-being.

People with mental disorders, especially those with schizophrenia and psychoses, are one of the most stigmatized groups in our society (Domenici, 1993). 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" (Crocker, Major, & Steele, 1998). Link and Phelan consider that in order to be able to speak of stigmatization various characteristics must concur, such as labelling 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 non-stigmatized group that allows the components of stigma to develop (Link & Phelan, 2001). 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 (Byrne, 2001). This view of mental disease is transmitted by the media (Annabel Ferriman, 2000), making the integration of this group in society rather difficult (Vezzoli et al., 2001). 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 (Penn & Martin, 1998). In this sense, in 1999, the United States Surgeon General’s report identified stigma as the largest barrier to treatment seeking for people with mental health problems (Satcher, 2000). Studies show that in addition to direct discrimination many times people with mental illness also have to face more subtle or indirect discrimination (Kapungwe et al., 2010). Also, recent work (Cavelti, Kvrgic, Beck, Rüsch, & Vauth, 2012) 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 (Barber, Palmese, Reutenauer, Grilo, & Tek, 2011; Uçok et al., 2012).

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 (Livingston & Boyd, 2010; Muñoz, Sanz, Pérez-Santos, & Quiroga, 2011). Other studies reveal that stigmatization suffered by people with schizophrenia is related to depression (Reavley & Jorm, 2011) or anxiety (Lysaker, Yanos, Outcalt, & Roe, 2010). 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 (Sheldon & King, 2001) 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 (Diener, 1984) 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 (Ryff & Keyes, 1995). 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 (Cañas, 2010) not all of them react to this situation in the same way (Folkman & Lazarus, 1980; Rüsch et al., 2009). There is ample evidence that the same negative situationcan affect the well-being of the stigmatized people either positively or negatively,

depending on the way they cope with it. Carver et al.'s (C. S. Carver, Scheier, & Weintraub, 1989) 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 to face 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 competencies and environmental factors such as stress in predicting the onset and persistence of psychotic symptoms, theorize that environmental and personal resources and deficits interact with everyday experiences (potencial stressors of the every day life) and individual responses (coping strategies), and that these responses affect well-being (Yanos & Moos, 2007). Thus, course and outcome are thought to be considerably influenced by the modulation of stress (Rudnick, 2001), and coping strategies play a critical role in this regard. There is some evidence that in schizofrenia patients, some coping strategies may become more effective than others in alleviating symptoms and distress (Cohen, Hassamal, & Begum, 2011; Tseng, Chiou, Yen, Su, & Hsiao, 2012).

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 as yet been conducted 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 has an exploratory nature, is to analyze, in a sample of patients with schizophrenia, the relationships that several variables related to stigma, such as perceived and subtle discrimination (Annabel Ferriman, 2000) or stigma consciousnes have with well-being, measured through affect balance (as a measure of subjective well-being) and self-acceptance (Ryff & Keyes, 1995) (as a measure of psychological well-being). Besides, we will analyze to what extent coping strategies relate to

the subjective and psychological well-being of people with schizophrenia. Therefore, from the reviewed literature, we formulate the following hypotheses:

Hypothesis 1: There will be a negative association between the variables related with stigma and discrimination (blatant 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 (Papaioannou, Brazier, & Parry, 2011). 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 (Rodgers, 2003). Thirdly, we have focused on relevant variables within Social Psychology, such as perceived discrimination instead of self-stigma (Tang & Wu, 2012) 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 (Zappia et al., 2012) but in the sense of coping with the stigma associated to this pathology. For all these reasons, we believe that this article 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 (Molero, Recio, García-Ael, Fuster, & Sanjuán, 2012). This scale consists of 10 items that measure, in a 5-point Likert scale, two aspects of perceived discrimination: Blatant 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 Blatant Discrimination Scale and the Subtle Discrimination Scale proved to have a good reliability (a Cronbach's alpha of .83 and .87, respectively).

Pinel’s *Stigma Consciousness Questionnaire* (SCQ) (Pinel, 1999). 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).

COPE. To measure coping styles we used the brief version of the *COPE* questionnaire (Carver, 1997), composed of fourteen scales of two items each. Based on the interests of the 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") scales, 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"), and its reliability in our sample was .65.

Positive and Negative Affect Schedule (PANAS) (Watson, Clark, & Tellegen, 1988). This instrument was used to measure the emotional balance (subjective wellbeing). 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 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 the negative.

Self-acceptance (psychological well-being) was measured by a subscale of four items included in Ryff's *Scales of Psychological Well-Being* (Ryff, 1989) and could be defined as "being aware and accepting one's strengths and limitations." It is a construct similar to self-esteem (Chamberlain & Haaga, 2001), which is the best predictor of subjective well-being in individualistic cultures (Heine et al., 2001). 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 to the participants the purpose of the study, requested their voluntary cooperation, and handed out the questionnaires, solving doubts that arose in some items.

Results

As seen in Table 1, the average affect balance is tilted towards 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) are more frecuently used than Avoidant Coping (below the midpoint of the scale). The difference between the use of these types of coping is significant ($t = 9.87$, $df = 49$, $p < .00$).

Table 1

Descriptive statistics of the main variables in the study

	Mean	Standard deviation
Affect balance$_1$	.93	1.19
Self-acceptance$_2$	3.33	.89
Avoidant coping$_2$	2.12	.63
Active coping$_2$	3.42	.83
Stigma consciousness$_2$	3.25	.65
Blatant discrimination$_2$	2.90	.82
Subtle discrimination$_2$	3.19	1.05

Note. $N = 50$. $_1$: Range = -4 ─ 4. $_2$: Range = 1 ─ 5.

It is also observed that both stigma consciousness and subtle discrimination are above the theoretical mean of the scale while blatant 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, probably due to sample size, does not reach significance. Furthermore, we found that experiences of discrimination, both blatant and subtle, are positively and significantly related with stigma consciousness.

Table 2

Bivariate 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 Blatant discrimination	-.35*	-.13	.41**	-.01	.68**	
7 Subtle discrimination	-.52**	-.30	.37**	-.09	.75**	.80**

Note. * $p < .05$. ** $p < .01$.

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 manifest subtle stigma consciousness) and coping (active and avoidant) as predictors.

The regression analysis with affect balance as DV generated two models. The first one had a R2 of .27 [F (1,48) = 17.63, p < .01], and only one explanatory variable: avoidant

coping (β = -.52) The change in R2 in the second model increased in a significant way [DR2 = .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 β = -.38, t = -3.11, p < .03) and subtle discrimination (standardized β = -.36, t = -3.06, p < .04).

The regression analysis with self-acceptance as DV generated just one model. The model had a R2 of .17 [F (1,48) = 9.13, p < .01]. The only variable included in the regression model was stigma consciousness (standardized β = -.40, t = -3.02, p < .04).

Discussion

In line with our results we can conclude 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 awareness also 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 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 towards 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 wellbeing 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 avoidance coping strategies, their chances of improvement to their wellbeing will increase.

The existing differences between subtle and blatant discrimination are a factor to consider. We believe that this result may be due to the fact that schizophrenia is a social stigma that can be concealed from others (Wheat, Brohan, Henderson, & Thornicroft, 2010) and therefore people suffering from this mental illness did not reveal their condition to everyone, so there are fewer opportunities for them to suffer direct discrimination. On the other hand, it is not so easy to explain why indirect or subtle discrimination is more harmful than direct discrimination. A possible explanation could be that direct discrimination is legally forbidden in many societies and is frowned on by society, so it occurs to a lesser extent and, in any case, 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 it 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 (Crocker, Voelkl, Testa, & Major, 1991).

For these reasons we think it is important to make the existence of subtle or indirect discrimination visible to put an end to it, because evidently subtle discrimination is not less harmful than direct discrimination, but rather the opposite. It is clear that the ultimate solution would be to reduce the existing prejudice in society towards people with mental illness, however, while 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 subjective and psychological well-being of people with schizophrenia. Previous literature has focused mainly in the way stigma affects psychiatric symptoms or treatment adherence (Livingston & Boyd, 2010). Furthermore, our data indicate that stigma affects wellbeing 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 (Livingston & Boyd, 2010). 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. Furthermore, we believe that in addition to correlational approaches to the study of welfare, it would be interesting to run some kind of experimental studies, as shown by the line of work conducted in the field of social exclusion with other groups (Baumeister, Twenge, & Nuss, 2002).

Chapter 3: Perceived Discrimination, Internalized Stigma and Psychological Well-Being of People with Mental Illness

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Abstract

Objective: The present study examines the relationships between perceived discrimination, internalized stigma, and well-being in a sample of people with mental illness. **Method:** We conducted a cross-sectional study with 213 outpatients from the Spanish public network of social care. **Results:** Perceived discrimination was positively and significantly correlated with internalized stigma. Blatant individual discrimination, subtle individual discrimination, and internalized stigma were negatively correlated with life satisfaction, affect balance, and psychological well-being. Regression and mediation analyses indicate that subtle individual discrimination is the kind of discrimination most negatively associated to the well-being measures, and that this association is mediated by internalized stigma. **Conclusions:** Future research should confirm these findings in a longitudinal or experimental model. In light of our findings, we suggest the development and implementation of intervention programs that target subtle discrimination, and point at the importance of implementing programs to reduce internalized stigma.

Key words: mental illness, discrimination, internalized stigma, psychological well-being, subjective well-weing.

Social stigma has been identified as one of the most important problems for people with mental illness (PWMI) (World Health Organization, 2005). Social stigma towards PWMI causes them to be excluded and discriminated in areas such as housing, employment, interpersonal relationships, healthcare and media, adding to the impairments that some of the mental illnesses themselves can cause in these areas (Corrigan & Watson, 2002). In addition, stigmatizing experiences are also related to a lower life satisfaction, reduced psychological well-being, and a lower probability to seek mental healthcare (Corrigan, 2004; Link, Struening, Neese-Todd, Asmussen & Phelan, 2001; Markowitz, 1998). According to Ritsher, Otilingam, and Grajales (2003), the subjective perception of devaluation and marginalization directly affects self-esteem and level of distress of a stigmatized individual. This subjective perception has been called internalized stigma (Bos, Pryor, Reeder, &

Stutterheim, 2013; Livingston & Boyd, 2010; Ritsher et al., 2003). In a recent review, Bos et al. (2013) state that being aware of the existence of stigma in the community can result in self-stigma.

Perceived discrimination

Perceived discrimination has been defined as the awareness of public stereotypes and discrimination. It is not a unitary construct. Within it, we can differentiate between perceived group and individual discrimination, on one hand, and perceived subtle and blatant discrimination, on the other hand (Molero, Recio, García-Ael, Fuster, & Sanjuán, 2012).

Perceived group discrimination is defined as the extent to which an individual believes his or her group is discriminated, while perceived individual discrimination is the extent to which a person believes he or she has been personally discriminated. Group discrimination shows significantly higher scores (but lower relations to well-being) than individual discrimination in groups such as ethnic and sexual minorities, and people with HIV (Molero et al., 2012). The relationship between perceived group discrimination and perceived individual discrimination, on the one hand, and mental health outcomes on the other hand has not been examined before among PWMI.

Perceived subtle discrimination refers to the perception of distrust and subtle rejection, while blatant discrimination refers to open discrimination and rejection. Blatant discrimination can be identified with traditional prejudice; subtle discrimination relates to the "modern" forms of prejudice (Anderson, 2010). Most of the research comparing the effects of both types of discrimination has been conducted on women and racial minorities. A meta-analysis by Jones, Peddie, Gilrane, King and Gray (2013) supported the notion that subtle discrimination is at least as damaging for both psychological and physical health as blatant discrimination. Subtle discrimination has only been measured once before in PWMI, and it showed a bigger impact on well-being than blatant discrimination (Magallares et al., 2013).

The combination of these two dimensions gives us four different types of discrimination: blatant group discrimination, subtle group discrimination, blatant individual

discrimination, and subtle individual discrimination. The effects of these four types of discrimination have never been compared before in PWMI. However, among the different forms of perceived discrimination, subtle discrimination can be expected to be more harmful for three reasons (Jones et al., 2013). First, because it is more difficult to identify and assess than blatant discrimination, people who face subtle discrimination are less likely to attribute negative feedback to prejudice, which protects well-being (Cihangir, 2008; Operario & Fiske, 2001). Second, because subtle discrimination is more difficult to detect, targets may not have as many options for reporting or remedying this kind of discrimination. Third, because it is more pervasive than blatant discrimination (which is widely considered as socially unacceptable or even illegal nowadays), it might have chronic effects. Furthermore, it seems legitimate to assume that personally experienced discrimination will have a greater impact in an individual than discrimination towards his or her group (Molero et al., 2012), and a recent meta-analysis (Schmitt, Branscombe, Postmes, & Garcia, 2014) points that indeed individual discrimination has a stronger negative relation with well-being than group discrimination. Consistently with these findings, individual subtle discrimination has displayed the highest negative association with psychological well-being in members of different immigrant collectives and sexual minorities (Molero et al., 2012). However, its relationship with well-being in PWMI has not been tested yet.

Internalized stigma

Internalized stigma refers to the endorsement of negative stereotypes about PWMI, their application to oneself, and the resulting reduction of self-worth, psychological distress, withdrawal, and secrecy (Bos et al., 2013; Livingston & Boyd, 2010; Ritsher et al., 2003). Its negative effects on the well-being of PWMI are well documented. Higher scores in internalized stigma are associated with lower self-esteem and self-efficacy (Corrigan, Watson, & Barr, 2006; Ritsher, 2003; Ritsher & Phelan, 2004; Yanos, Roe, Markus, & Lysaker, 2008); higher depressive and negative symptoms (Ritsher & Phelan, 2004; Yanos et al., 2008); lower hope, and more avoidant coping (Yanos et al., 2008); and lower empowerment and recovery orientation (Ritsher et al., 2003).

Well-being in people with mental illness

Life satisfaction

Subjective well-being is defined as 'a person's cognitive and affective evaluations of his or her life' (Diener, Oishi & Lucas, 2002). This cognitive evaluation of one's life is what we call *life satisfaction*, and it can be measured as a global judgment or as the satisfaction with specific life domains (Baker & Intagliata, 1982). Furthermore, a meta-analysis by Livingston and Boyd (2010) shows that life satisfaction in PWMI is negatively associated with different measures of stigma.

Affect balance

The affective evaluation of one's life can be measured through the levels of positive and negative moods, emotions and feelings (Diener et al., 2002). Although positive and negative affect are two relatively independent dimensions, their scores can be summarized by *affect balance*, which indicates the predominance of positive moods, emotions and feelings, or vice versa (Bradburn, 1969). A previous study by Magallares et al. (2013) showed that affect balance was negatively associated with stigma in PWMI.

Psychological well-being

Ryff argued that asking people about their life satisfaction or affects is not enough to assess their wellness. Well-being is more than just happiness, and most people, regardless of their actual life conditions, report themselves to be happy. Therefore, she proposed a model of psychological well-being comprised by a set of features of positive psychological functioning. (Ryff & Keyes, 1995).

Traditionally, the well-being measures used in stigma in PWMI have been self-esteem, self-efficacy, life satisfaction, and symptoms of anxiety and depression, all of which have been found to be significantly related to stigma (Markowitz, 1998; Link et al, 2001). To our knowledge, only one study about stigma in PWMI (Magallares et al., 2013) has used affect balance and one of the well-being subscales (self-acceptance) of Ryff's measure. It found self-acceptance to be negatively related to stigma consciousness, and affect balance

to be negatively related to both stigma consciousness and perceived discrimination (Magallares et al., 2013).

The present research

According to Corrigan (Corrigan & Rao, 2012; Watson, Corrigan, Larson & Sells, 2007), stigma awareness does not directly harm well-being: it is the internalization of stigma that harms self-esteem and self-efficacy. In a previous study in Spanish PWMI, Muñoz, Sanz, Pérez-Santos, and Quiroga (2011) found support for a structural equation model in which internalized stigma acted as a mediator between stigma and discrimination experiences, and psychosocial functioning. Thus, their results indicate that it is not only stereotype awareness that leads to internalized stigma, but also personal discrimination experiences. Therefore, we would like to explore the relationship between all four perceived discrimination scales and internalized stigma, as group discrimination refers to beliefs about general discrimination (stigma awareness), and individual discrimination refers to personal discrimination experiences. The relationship of these four types of perceived discrimination with internalized stigma has never been tested before in PWMI.

The present study examines perceived discrimination, internalized stigma and well-being in PWMI. In particular, we investigate to what extent internalized stigma mediates the relationship between perceived discrimination and various measures of psychological and subjective well-being. In order to explore which type of discrimination is more strongly related to the internalization of stigma, we will assess the effects of the different types of perceived discrimination separately. As for the hypotheses, first, we expect perceived discrimination (especially subtle individual discrimination) to be positively related to internalized stigma.

Second, for the reasons discussed above, we expect both perceived discrimination (again, we expect subtle individual discrimination to have the highest association) and internalized stigma to be negatively associated with the psychological well-being scales, life satisfaction and affect balance.

Third, we expect internalized stigma to mediate the relationship between perceived discrimination and well-being among PWMI.

Method

Participants

The sample consisted of 213 clients from 19 different centers from the public network of social care for people with mental illness of the communities of Madrid (*N* = 170), Catalonia (*N* = 35) and the Balearic Islands (*N* = 8), of whom 126 were men and 85 were women (the remaining two respondents did not indicate their gender). All of our respondents were over 18 years old, their mean age being 43.04 years old (*SD* = 10.65). All of them were Spaniards of Spanish ethnicity, which compose the vast majority of the clients of these centers. Main diagnosis was registered by the professionals in the centers, taken from the participant's medical history. 64.8 % were said to have "schizophrenia, schizotypal disorders or delusional disorders", 11.7% were reported to have "mood disorders", another 11.7% had "personality disorders", 2.8% had "neurotic disorders", 1.4% were marked as having "other" disorders. There is no data about the diagnosis of the remaining 7.5% participants (both socio-demographical and clinical variables were filled out by the proffesionals from the different centers, based on information from the patients' files, all of whom had been diagnosed in the public health care system).

Measures

Multidimensional Perceived Discrimination Scale (Molero, Recio, García-Ael, Fuster, and Sanjuán, 2012). This scale consists of 12 items that measure, in a five-point Likert scale, the respondent's perception of four different types of discrimination: Blatant Group Discrimination (e.g., "In Spanish society there is a strong rejection towards people with mental illness"), Subtle Group Discrimination (e.g., "People seem to accept people with mental illness, but I think sometimes there is a hidden rejection"), Blatant Individual Discrimination (e.g.,"I have felt rejected for being a person with mental illness"), and Subtle Individual Discrimination (e.g., "I feel people do not trust me for being a person with mental

illness"). The original scale, which was designed to be used in a wide variety of stigmatized groups (Molero et al., 2012), was comprised of 20 items. However, in order to make the scale shorter, the last five items in each of the two Blatant Discrimination subscales, concerning discrimination in employment, health, legal, social relationships and private institution areas, were replaced for a more general item about discrimination "in various social and work settings". All the subscales showed a good consistency in the present study (Blatant Group Discrimination had an alpha of .86; Subtle Group Discrimination had an alpha of .73; Blatant Individual Discrimination had an alpha of .92, and Subtle Individual Discrimination had an alpha of .84).

Internalized Stigma of Mental Illness Scale (Ritsher et al., 2003) is a 29-item questionnaire which consists of five subscales, each assessing a different aspect of internalized stigma: Alienation, Stereotype Endorsement, Discrimination Experience, Social Withdrawal and Stigma Resistance. However, we decided to drop the Stigma Resistance subscale, as the original authors of the scale suggest, because of its low reliability coefficients and the fact that some of its items also weighted in other factors. We used Muñoz et al's (2011) Spanish translation of the questionnaire. Respondents had to answer how much they agreed with each statement in a five-point likert scale. The scale as a whole showed a high internal consistency ($\alpha = .93$).

Baker and Intagliata's *Satisfaction with Life Domains Scale* (SLDS) (1982) is a 15-item questionnaire in which participants are asked about their satisfaction with 15 different areas related to their life quality: housing, neighborhood, food, clothing, health, cohabitants, friends, family relationships, relationships with others, occupation/work, free time, leisure environment, neighborhood services, economic situation, and hospital/community. In this study, we used the Spanish translation validated by Carlson et al. (2009). Responses were given in a five-point scale. This scale had a high internal consistency in our study ($\alpha = .92$).

Positive and Negative Affect Schedule (PANAS) (Watson, Clark, & Tellegen, 1988) was used to measure Affect Balance. It consists of two 10-item subscales which asses positive and negative affect in a five-point scale. To calculate affect balance we simply

subtracted the negative affect score from the positive affect score. A positive score indicates the predominance of positive over negative affect. This instrument measures two internally consistent and largely uncorrelated factors: Positive Affect and Negative Affect, both of which showed a high alpha in our sample (.90 and .89, respectively). We used Sandín et al.'s Spanish translation (1999).

Ryff's Psychological Well-Being Scales (Ryff & Keyes, 1995) is an instrument that measures six aspects of psychological well-being: self-acceptance (positive attitudes towards oneself), positive relations with others (ability to love and maintain stable and positive personal relationships), autonomy (ability to maintain independence and personal authority in different social contexts), environmental mastery (the ability to choose or create enabling environments to meet one's own needs and desires), purpose in life (personal goals and objectives that give life a meaning), and personal growth (efforts to develop one's own potential and grow as a person) (Díaz et al., 2006). In the present study we used the general scale, which other researchers have also used in the past**.** We used Díaz's 29-item Spanish adaptation (Díaz et al., 2006). Responses were given in a five-point likert scale. The general scale showed a high internal consistency (α = .91).

Procedure

To distribute the questionnaires, we had the collaboration of the workers from the different Intress Rehabilitation Centers. These professionals explained the purpose of the study to their clients and requested their voluntary cooperation. After volunteers had read and signed an informed consent form, professionals handed out the questionnaires, solving doubts that arose in some items. The research's goals, instruments and procedure had been previously approved by Intress' ethics committee.

Results

Table 1 shows the descriptive statistics and partial correlations (controlling for the effect of diagnosis and gender) for the variables we used in our analyses. It should be noted that both blatant and subtle group discrimination scores are significantly higher ($p < .001$)

than the individual discrimination scores. The two group discrimination scores are not significantly different from each other, and neither are both individual discrimination scores. As for these variables' correlations, as we can see, the four perceived discrimination scales are highly correlated with internalized stigma, and both forms of subtle discrimination show the highest correlations with internalized stigma (especially subtle individual discrimination). We can also see that both perceived discrimination and internalized stigma are negatively and significantly correlated with psychological well-being, life satisfaction, and affect balance, and that those correlations are higher for internalized stigma. Both individual discrimination scores have significant correlations with all three well-being variables, while the correlations are lower for group discrimination (and only significant for subtle group discrimination and psychological well-being).

To test for the possible mediation of internalized stigma between perceived discrimination and well-being, we ran a multiple regression analysis[2] for each of our three well-being measures (psychological well-being, affect balance and life satisfaction). We used the four types of perceived discrimination as predictors in the first step, and added internalized stigma in the second. Subtle individual discrimination appears as the only form of discrimination that significantly predicts psychological well-being (see Table 2). For affect balance and life satisfaction, however, its effects are only marginally significant when controlled for the other forms of perceived discrimination. When internalized stigma is included in the model, the direct effect of subtle discrimination is reduced to non-significance for all three outcome variables.

[2]We used Preacher and Hayes's (2008), bootstrapping method, which generates confidence intervals for total and indirect effects of one variable on another through one or more mediating variables

Table 1
Means, standard deviations and partial correlations of the main variables in this study

	M	*SD*	1	2	3	4	5	6
1 Blatant group discrimination[a]	3.78	.98	-	.78**	.53**	.52**	.83**	.32**
2 Subtle group discrimination[a]	3.83	.80	.78**	-	.45**	.49**	.78**	.28**
3 Blatant individual discrimination[a]	3.32	1.19	.53**	.45**	-	.74**	.85**	.49**
4 Subtle individual discrimination[a]	3.41	1.05	.52**	.49**	.74**	-	.85**	.53**
5 Perceived discrimination (general score)[a]	3.59	.84	.83**	.78**	.85**	.85**	-	.50**
6 Internalized stigma (general score)[a]	2.57	.72	.32**	.28**	.49**	.53**	.50**	-
7 Life satisfaction[a]	3.40	.70	-.10	-.12†	-.19**	-.22**	-.20**	-.42**
8 Affect balance[b]	.74	1.27	-.09	-.13†	-.14*	-.18**	-.16**	-.49**
9 Psychological well-being (general score)[a]	3.25	.59	-.10	-.14†	-.22**	-.26**	-.22**	-.56**

Note. N=208. [a] rated on scale of 1 to 5 with higher scores indicating greater agreement; [b] rated on a scale of -4 to 4 with higher scores indicating predominance of positive affect over negative affect. Partial correlations controlling for the effect of gender and diagnosis.
* $p < .05$; ** $p < .01$; † $p < .10$

Table 2

Predictors of Subjective and Psychological Well-Being

	Life satisfaction		Affect Balance		Psychological Well-Being	
	Model 1 *B*	Model 2 *B*	Model 1 *B*	Model 2 *B*	Model 1 *B*	Model 2 *B*
Blatant group discrimination	.08	.09	-.03	-.02	.14	.15
Subtle group discrimination	-.06	-.07	.015	.01	-.10	-.11
Blatant individual discrimination	-.07	.01	.022	.13	-.10	-.02
Subtle individual discrimination	-.18†	-.02	-.19†	-.02	-.21*	-.01
Internalized stigma	-	-.42**	-	-.54**	-	-.59**
R^2 (Adjusted)	.03	.16	.06	.26	.07	.32
F Change	2.81	29.80	1.77	56.85	4.16	74.09
df	(4,198)	(1,197)	(4, 198)	(1, 197)	(4, 198)	(1, 197)

Note .Table reports standardized regression coefficients for each variable, controlling for the effect of diagnosis. *df* = degrees of freedom.
† $p < .10$; * $p < .05$; ** $p < .001$

In order to confirm that internalized stigma behaved as a mediator between individual discrimination and the three measures of well-being, we ran mediation analyses. Subtle individual discrimination was the only type of discrimination which was a significant predictor in our regression analyses. Therefore, we only report mediation analyses with subtle individual discrimination as a predictor variable[3]. As we can see in Figure 1, the results of the analyses are consistent with full mediation for all three variables, as the total effect (*c* path) is significant for all of them and the direct effect (*c'*) is not significant for any of them.

[3] Mediation analyses with other perceived discrimination subscales showed there was also a full mediation effect of blatant individual discrimination on all three outcome variables, and of subtle group discrimination on psychological well-being.

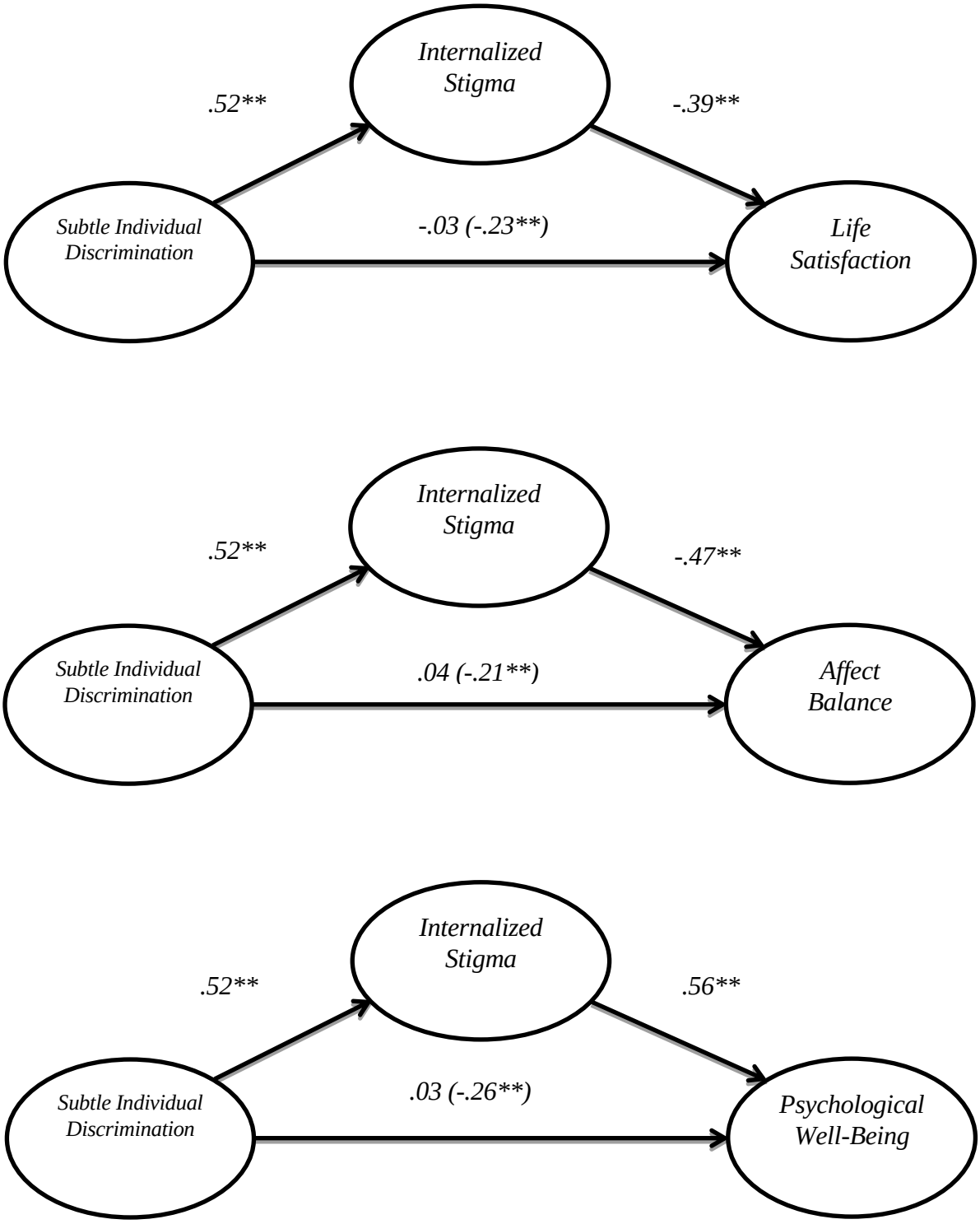

Figure 1. Mediation models for Psychological Well-Being, Affect Balance and Life Satisfaction (tested on the basis of Preacher and Hayes, 2008). Standardized regression coefficients. Total effect (*c* path) in parentheses. * $p < .01$; ** $p < .001$

Discussion

The present study examined the relations between perceived discrimination, internalized stigma, psychological well-being, affect balance, and life satisfaction. Based on previous research and theory (Corrigan & Rao, 2012; Livingston & Boyd, 2010; Magallares et al., 2013; Muñoz, 2011; Ritsher et al., 2003), we expected perceived discrimination and internalized stigma to be signicantly related to each other and our three well-being measures, and internalized stigma to explain the associations between perceived discrimination and well-being.

Our first hypothesis was that perceived discrimination would be positively related to internalized stigma, and that the individual subtle discrimination score would have the strongest relation. In line with our hypothesis, perceived discrimination and internalized stigma were indeed positively and significantly correlated. In fact, even though all types of perceived discrimination are significantly correlated with internalized stigma, individual discrimination shows the strongest correlations, especially subtle individual discrimination, as we predicted. This suggests that subtle individual discrimination might play the most important role in the internalization of stigma. This is consistent with Cihangir's finding that, in an experimental setting, women in the subtle discrimination condition experienced more self-directed negative emotions and less other-directed negative emotions than their peers in the blatant discrimination condition (Cihangir, 2008). As Operario and Fiske (2001) stated, when faced with ambiguous rejection experiences, attributing negative interactions to prejudice can help members of minorities avoid the debilitating effect of internalizing rejection and discrimination. Together with these previous findings, our results suggest that when discrimination is subtle it is harder for people who suffer it to attribute negative interaction or outcomes to social stigma, and thus they are more likely to internalize stigma.

Our second hypothesis was that perceived discrimination and internalized stigma would be significantly associated with psychological well-being, life satisfaction, and affect balance. We also expected subtle individual discrimination to be the type of discrimination with the strongest relation to well-being. Our second hypothesis was partially supported by the data, as only both forms of individual discrimination were significantly associated with all three well-being measures. As we predicted, subtle individual discrimination had the strongest relation with all of them. Although this finding is consistent with previous literature (Molero et al, 2012; Schmitt et al., 2014), it had never been tested before in PWMI. Internalized stigma is also significantly associated with all the well-being variables. In fact, it has a stronger association with well-being than any of the perceived discrimination scales or the general score for perceived discrimination, which is consistent with the idea that internalized stigma might have a more direct effect on well-being than perceived discrimination (Corrigan & Rao, 2012; Rithser, 2003).

Based on Corrigan and Ritsher's idea (Corrigan & Rao, 2012; Rithser et al., 2003) that discrimination does not harm well-being directly, but through internalization, our third hypothesis predicted that the magnitude of the associations between perceived discrimination and the three measures of well-being would be reduced to non-significance when the scores for the internalized stigma were included in the regression model. We found support for this hypothesis, even though when we performed our regression analyses including all the types of perceived discrimination, the only one which significantly predicted psychological well-being was subtle individual discrimination, and it only had a marginally significant effect on life satisfaction and affect balance. Internalized stigma, however, did significantly predict all three, and its inclusion in the model made the effects of subtle individual discrimination become non-significant. Moreover, while the regression models with

all four perceived discrimination measures significantly predict well-being[4], they only explain a very small fraction of the variance. The inclusion of internalized stigma makes the proportion of explained variance increase substantially. Mediation analyses confirm that our results are consistent with full mediation for the three outcome variables, as subtle individual discrimination has a significantly negative total effect on all of them, but a non-significant direct effect.

Together, these findings suggest that subtle discrimination plays an important role in the internalization of stigma, and that internalized stigma has an important negative effect on well-being (especially on psychological well-being). This is consistent with previous literature about stigma in PWMI. Muñoz found support for a structural equation model in which internalized stigma acted as a mediator between stigma and discrimination experiences, as predictor variables, and psychosocial functioning, as an outcome (Muñoz et al., 2011), while Watson and Corrigan found support for the mediating effect of self-concurrence between group identification and perceived legitimacy of discrimination, as predictors, and self-efficacy, as an outcome (Watson et al., 2007). However, this is the first time that internalized stigma is tested as a mediator between perceived discrimination and well-being. Furthermore, the finding that subtle individual discrimination seems to have the greatest effect on the internalization of stigma is completely new.

The present study has several strengths: In the first place, this study explores for the first time the possible mediating role of internalized stigma between perceived discrimination and well-being outcomes. Second, it assesses how the perception of different kinds of discrimination (blatant group discrimination, subtle group discrimination, blatant individual discrimination and subtle individual discrimination) relates to the internalization of stigma. The relation of these four different types of perceived discrimination with internalized stigma

[4] *Model 1 significantly predicts psychological well-being and life satisfaction (*p = *.002 and* p = *.023, respectively). In the case of affect balance, Model 1 is only marginally significant (*p = *.058).*

had never been studied before in PWMI. Finally, this study addresses the effects of social stigma from a positive psychology perspective, focusing not on the impact of perceived discrimination and internalized stigma on negative mental health outcomes such as depression or anxiety symptoms (Lysaker, Yanos, Outcalt & Roe, 2010), or behavioral outcomes such as psychosocial functioning or treatment adherence (Livingston & Boyd, 2010), but on life satisfaction, affect balance, and psychological well-being.

Limitations of our study also need to be considered. First, because our data are cross-sectional, causality cannot be determined. There are theoretical reasons in previous literature to think that it is perceived discrimination that causes internalized stigma, and not the other way around (Corrigan & Rao, 2012). Furthermore, a recent study showed that perceptions of public stigma predicted self-stigma over a three-month span in a sample of college students, although both measures only assessed stigma related to seeking and receiving psychological help (Vogel, Bitman, Hammer, & Wade, 2013). The role of internalized stigma as a predictor of well-being variables is also supported by previous research (Ritsher & Phelan, 2004). Therefore, the pathway we propose in the present paper is supported by previous research. However, to be able to establish causal relationships with certainty, longitudinal studies with PWMI should be conducted. The relationship between discrimination and internalized stigma could also be tested experimentally, manipulating the type of discrimination participants are exposed to, in a similar fashion to what Cihangir did (2008), and measuring internalized stigma.

Second, we only use self-report measures of internalized stigma. Rüsch found that implicit internalized stigma is a measurable construct which independently predicts quality of life (Rüsch, Corrigan, Todd, & Bodenhausen, 2010). It would be relevant to test the relationship of implicit internalized stigma with perceived discrimination, and its effect on other well-being outcomes.

Third, previous research on PWMI suggests that disclosure can be a protective factor against the negative effects of internalized stigma on quality of life and well-being (Corrigan,

Kosyluk, & Rüsch, 2013). Future research should assess the role of disclosure in the mediation we propose in this paper.

The finding that subtle individual discrimination seems to have the greatest impact on internalized stigma and well-being, points at the need to make subtle discrimination and its deleterious effects visible. Intervention programs to make this kind of discrimination visible for PWMI, professionals and members of the general population, are needed in order to be able to fight it. In a recent review, Corrigan et al. (2013) distinguished three different strategies to reduce public stigma: *protest* strategies, which point at the injustice of stigma; *educational* approaches, which try to change stereotypical thoughts by providing factual information about mental illness, and *contact* strategies, which use interpersonal contact with PWMI as a way to change targets' attitudes. These three approaches can be used in media-based interventions or *in vivo* interventions. The latter type of intervention has proved to be more effective for all three strategies (Corrigan & Kosyluk, 2013). Moreover, research shows that the most effective in vivo interventions are those targeted at a specific population (e.g. landlords and employers), developed to meet local needs, and in which the contact is credible and continuous (Corrigan & Kosyluk, 2013). As it is public stigma that causes self-stigma (that is, both perceived discrimination and internalized stigma), reducing the former will also have the effect of reducing the latter. Therefore, we think that developing intervention programs aimed at reducing subtle discrimination that adhere to these principles is in PWMI's best interest.

Finally, our results suggest that perceived discrimination affects well-being through internalized stigma. Needless to say, the roots of the problem of stigma towards PWMI are external to them. However, we think that interventions aimed at reducing internalized stigma will undoubtedly also have a positive effect on PWMI's well-being. A recent review identified two approaches for reducing internalized stigma: interventions aimed at changing stigmatizing beliefs and attitudes about mental illness, and interventions that do not challenge stereotypes but rather improve stigma-coping skills by enhancing self-esteem, empowerment, and help-seeking behavior (Mittal, Sullivan, Chekuri, Allee, & Corrigan,

2012). Even though tackling stigmatizing beliefs might seem a more direct and logical way to reduce internalized stigma, an important number of stigma experts seem to favor the coping training approach (Mittal et al., 2012). Future research should explore if such reduction has, in turn, a positive effect on well-being, as our results suggest.

Chapter 4: Internalized Stigma and Subjective Well-Being: The Mediating Role of Psychological Well-Being

This chapter has been published in a similar form as:

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Abstract

Objective: This study examines the relationships between internalized stigma, psychological well-being, and subjective well-being in a sample of people with mental illness. **Method:** We conducted a cross-sectional study with 213 outpatients from the Spanish public social care network. **Results:** The results showed that a) internalized stigma was significantly negatively correlated with psychological well-being and subjective well-being (affect balance and life satisfaction) (all correlations are significant with at least $p < 0.05$; most with $p < 0.001$), b) the two types of well-being were significantly positively correlated and regressions models were significant and (all correlations are at least $p < 0.01$, and regression models are also significant), c) the effect of internalized stigma on affect balance and life satisfaction was mediated by psychological well-being. The component of internalized stigma most consistently associated with both types of well-being was alienation (life satisfaction: $B = -0.35$, $p = 0.001$; affect balance: $B = -0.38$, $p = 0.001$). **Conclusions:** These findings should be confirmed in future longitudinal or experimental research. On the basis of these results we recommend that interventions to combat self-stigma aim to reduce feelings of alienation and improve self-acceptance and other aspects of positive psychological functioning.

Keywords: stigma, internalized stigma, psychological well-being, subjective well-being

The stigma of mental illness

Social stigma is one of the most important difficulties faced by people with mental illness (PWMI) (European Commission Health & Consumer Protection Directorate-General, 2005; World Health Organization, 2005; Muñoz et al., 2013). Stigma leads to exclusion and discrimination which affect access to housing, healthcare, employment and social activities for PWMI, adding to the problems that people with severe and persistent mental illness often have in these areas (Corrigan and Watson, 2002; Magallares, 2011). Stigma also affects the well-being and behavior of PWMI. Stigmatizing experiences have been associated with lower psychological well-being, lower life satisfaction and a lower probability of seeking help from mental health services (Markowitz, 1998; Link et al., 2001; Corrigan, 2004).

Experiencing stigma can also lead to internalization of stigma. This is the process of endorsing negative stereotypes of PWMI and applying them to themselves, and the resulting psychological distress, social withdrawal, secrecy and reduction in sense of self-worth (Ritsher et al., 2003; Livingston and Boyd, 2010; Bos et al., 2013). There is evidence that internalized stigma has numerous negative effects on the well-being of PWMI. It has been associated with low self-esteem and low self-efficacy (Ritsher et al., 2003; Ritsher and Phelan, 2004; Corrigan et al., 2006; Yanos et al., 2008; Bos et al., 2009), depressive symptoms and negative symptoms (Ritsher and Phelan, 2004; Yanos et al., 2008; Lysaker et al, 2009), lack of hope and greater use of avoidant coping strategies (Yanos et al., 2008), poor social functioning (Muñoz et al., 2011); and low scores on measures of empowerment and recovery orientation (Ritsher et al., 2003).

Subjective well-being and psychological well-being

Since the emergence of positive psychology well-being has received increasing attention in psychological research (Sheldon and King, 2001). Ryan and Deci (2001) argued that there are two aspects to well-being: hedonic or subjective well-being and eudemonic or psychological well-being. Hedonic well-being relates primarily to happiness, which is based on a person's affective and cognitive evaluations of his or her own life (Diener et al., 2003). The affective evaluation is comprised by two measures: the presence of positive mood and

absence of negative mood, which can be summarized as 'affect balance' (Bradburn, 1969). The cognitive evaluation represents what we call life satisfaction and can be measured as a global variable (Diener et al., 1985) or in terms of satisfaction with specific life domains (Baker and Intagliata, 1982). Eudemonic psychologists argue, however, that it does not follow that someone who claims to be happy – as most people do – is psychologically well (Ryff, 1989). The eudemonic approach to well-being emphasizes meaning and self-realization; defining well-being in terms of effective psychological functioning (Ryan and Deci, 2001). Ryff's multidimensional model of psychological well-being is one of the most integrative eudemonic models; it includes six aspects of psychological actualization: self-acceptance, relations with others, autonomy, environmental mastery, personal growth and purpose in life (Ryff, 1989; Ryff and Keyes, 1995).

The distinction between subjective well-being and psychological well-being is empirical as well as theoretical. Keyes, Shmotkin and Ryff (2002) found that, although both types of well-being were highly correlated, their constituent components loaded on two different factors. This finding was later replicated in China (Biaobin et al., 2004), and in the UK (Linley et al., 2009).

Some authors have suggested that subjective well-being might be a consequence of living well (Ryan et al., 2006; Sanjuán, 2011). Sanjuán (2011) suggested that experiencing autonomy and personal growth and having positive relationships with others and a purpose in life could increase positive feelings and improve satisfaction with life.

As stated above there is evidence that internalized stigma is related to various measures of psychological well-being. Ritsher and Phelan (2004) found that in a sample of psychiatric outpatients internalized stigma score predicted depressive symptoms at a four-year follow-up and that alienation also negatively predicted self-esteem. Associations between internalized stigma and depressive symptoms and low self-esteem were also found in a cross-sectional study which also found a negative association between internalized stigmas and self-efficacy (Corrigan, Watson, and Barr, 2006). A meta-analysis found that internalized stigma was associated with a low life satisfaction, low perceived social support

and low scores on measures of empowerment and hope (Livingston and Boyd, 2010). Although the relationship of positive and negative moods with internalized stigma has not previously been tested, affect balance was shown to be negatively associated with social experience of stigma and perceived discrimination (Kahng and Mowbray, 2004; Magallares et al., 2013; Pérez-Garín et al., in press).

In short, internalized stigma has been shown to have a generally detrimental effect on well-being, and psychological well-being appears to be causally related to subjective well-being (affect balance and life satisfaction). On this basis we hypothesized that psychological well-being mediated the relationship between the internalization of stigma and subjective well-being. Drawing on previous empirical findings on well-being and internalized stigma we propose a pathway in which internalized stigma has a negative impact on psychological well-being which, in turn, has a negative impact on affect balance and life satisfaction.

We formulated the following specific hypotheses, Hypothesis 1: the various components of internalized stigma are negatively associated with subjective well-being (affect balance and life satisfaction); Hypothesis 2: internalized stigma is negatively associated with psychological well-being; Hypothesis 3: psychological well-being is positively associated with subjective well-being and Hypothesis 4: psychological well-being mediates the relationship between internalized stigma and subjective well-being.

A longitudinal study demonstrated that the various aspects of stigma have different effects on depressive symptoms and self-esteem (Ritsher and Phelan, 2004). In this study the more 'internal' components of self-stigma (particularly alienation) were the strongest predictors of self-esteem and depressive symptoms, whereas discrimination experiences were not predictors of either. The authors argued that this was consistent with the notion that internalization is the most psychologically harmful aspect of stigma (Ritsher and Phelan, 2004). We expected to find similar relationships between the components of self-stigma and psychological well-being and subjective well-being. In order to provide more information and guide future interventions to combat stigma we decided to analyze the various facets of internalized stigma and psychological well-being separately. On the basis of Ritsher and

Phelan's (2004) results, we predicted negative associations between both psychological and subjective well-being and alienation (Hypothesis 5), stereotype endorsement (Hypothesis 6), and social withdrawal (Hypothesis 7).

Feeling inferior, different and thus set apart from others seems to play an important role in the stigmatization process. The finding that alienation reduces self-esteem and increases depressive symptoms hints at the existence of a vicious cycle involving alienation and psychological distress (Ritsher and Phelan, 2004). Ritsher and Phelan (2004) found that the factor most consistently associated with negative psychological outcomes was alienation so we expected that alienation would be strongly negatively associated with both types of well-being.

Method

Participants

The sample comprised 213 users of Spanish public social care services for PWMI. Participants were recruited from 19 centers located in Madrid (*n* = 170), Catalonia (*n* = 35) and the Balearic Islands (*n* = 8). It was an incidental sample, as, in order to make it as representative as possible of the population of PWMI, we tried to balance the number of female and male participants (the majority clients in these centers are men), and the number of participants in each of three age groups (20-35 years; 36-50 years; 51-65 years). We also tried to ensure that least 10 participants were recruited from each center. Most of the participants were men (*n* = 126); 85 were women and 2 participants did not report their gender. All participants were over 18 years old (*M* age = 43.04 years, *SD* = 10.65). Over half the sample (64.8%) had a main diagnosis of 'schizophrenia, schizotypal disorders or delusional disorder', 11.7% were reported to have 'mood disorders', another 11.7% had 'personality disorders', 2.8% had 'neurotic disorders', 1.4% were marked as having 'other' disorders. The main diagnosis for the remaining 7.5% of participants was not reported (socio-demographic and clinical data were provided by workers in the centers on the basis of information in the patients' files; all the participants had been diagnosed by a psychiatrist from the public health care system).

Measures

The *Internalized Stigma of Mental Illness scale* (ISMI; Ritsher et al., 2003) is one of the most commonly used measures of internalized stigma (Livingston and Boyd, 2010). It is a 29-item instrument that measures five different aspects of internalized stigma. The *Alienation* subscale assesses the extent to which the respondent feels that he or she is not a full member of society because of his or her mental illness. In our sample the Alienation subscale had good internal consistency (α = 0.83) The *Stereotype Endorsement* subscale (α = 0.76 in our sample) measures agreement with common stereotypes of PWMI. *Discrimination Experience* (α = 0.84 in our study) is intended to capture the respondent's perception of how others interact with him or her. *Social Withdrawal* (α = 0.86) assesses the extent to which the respondent avoids close relationships with others, especially those with no mental illness. *Stigma Resistance* is intended to capture the extent to which the respondent is unaffected by internalized stigma (Ritsher et al., 2003). We used Muñoz et al's (2011) Spanish translation of the questionnaire but – in accordance with the authors' recommendations - dropped the Stigma Resistance scale, which has low reliability coefficients and some the items of which also load on other factors.

The *Psychological Well-Being Scales* (Ryff and Keyes, 1995) measure six aspects of psychological well-being: *self-acceptance* (positive attitudes towards oneself; α = 0.79 in our study), *positive relations with others* (the ability to love and to maintain stable, positive personal relationships; α = 0.59), *autonomy* (the ability to remain independent and assert personal authority in various social contexts; α = 0.66), *environmental mastery* (the ability to choose or create environments which meet one's own needs and desires; α = 0.45), *purpose in life* (having personal goals and objectives that give life a meaning α = 0.77), and *personal growth* (efforts to fulfill one's potential and grow as a person; α = 0.63) (Ryff and Keyes, 1995; Díaz et al., 2006). We used a 29-item Spanish adaptation of the scales (Díaz et al., 2006) which was based on Van Dierendonck's (2004) 39-item version. Some of the subscales did not have high internal consistency in our sample; however Schmitt (1998) has

argued that when a scale has other desirable properties, such as meaningful content coverage, a relatively low alpha coefficient is not necessarily an impediment to its use.

The *Satisfaction with Life Domains Scale* (SLDS; Baker and Intagliata,1982) is a 15-item questionnaire in which participants must rate their satisfaction with different areas of their lives: housing, neighborhood, food, clothing, health, cohabitants, friends, family relationships, relationships with others, occupation or work, free time, leisure environment, neighborhood services, economic situation and hospital or community. We averaged scores for all items to obtain and overall life satisfaction score. We used the Spanish version of SLDS validated by Carlson et al. (2009). The scale had high internal consistency in our sample (α = .92)

The *Positive and Negative Affect Schedule* (PANAS; Watson et al., 1988) consists of two 10-item subscales which assess positive and negative affect. This instrument measures two internally consistent and largely uncorrelated factors (positive affect and negative affect) and affect balance can be calculated by subtracting the negative affect score from the positive affect score. We used a Spanish translation of the original scale (Sandín et al., 1999). Both factors had high internal consistency (positive affect α = .90; negative affect α = .89).

Responses to all the items in the battery were made on a five-point Likert scale.

Procedure

Questionnaires were distributed by the workers from the rehabilitation centers. The questionnaire was self-administered so workers received no particular training for their role in the study, although they were advised to read the booklet for participants as well as their own (which was used to collect clinical and socio-demographical information about participants). The workers explained the goals of the study to their clients and asked if they would be willing to take part. After participants had read and signed an informed consent form, they filled out the questionnaires in presence of a worker who answered any questions they had about items in the questionnaire. The goals of the research and the instruments and procedure used were approved by the Intress' ethics committee.

Results

Table 1 displays descriptive statistics for the variables used in the analyses, as well as the correlations between them. All four internalized stigma subscales were negatively correlated with the six psychological well-being scales. All the components of internalized stigma and psychological well-being were also correlated with life satisfaction and affect balance.

Table 2 shows the results of multiple regression analyses with life satisfaction or affect balance as outcome variables; these were used totest for the possible mediation of the components of psychological well-being.

Alienation was the only aspect of internalized stigma which predicted life satisfaction. When psychological well-being scores were added to the model the effect of alienation became non-significant, and self-acceptance, positive relations with others, autonomy and environmental mastery all predicted life satisfaction. This second model explained 44% of the variance in life satisfaction.

Alienation and social withdrawal both predicted affect balance, but once again they lost their predictive significance when psychological well-being scores were added to the model. The only psychological well-being factors which predicted affect balance were personal growth and purpose in life. The second model explained 50% of the variance in affect balance.

We ran mediation analyses to confirm that our data were consistent with the hypothesis that the relationship between internalized stigma and both indices of subjective well-being (affect balance; life satisfaction) was mediated by psychological well-being. We used Hayes's (2013) PROCESS macro for SPSS, which uses bootstrapping to generate confidence intervals for the total and indirect effects of one variable on another through one or more mediator variables. We generated 10,000 resamples, twice the minimum recommended by Preacher and Hayes (2008) for final reporting. Because alienation

Table 1.
Means, standard deviations and correlations for the main variables in this study

			Self-acceptance		Positive relations		Autonomy		Environmental mastery		Personal growth		Purpose in life		Life satisfaction		Affect balance	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
			3.23	1.00	3.20	0.76	3.14	0.73	3.13	0.69	3.59	0.80	3.26	0.93	3.40	0.71	0.74	1.27
Alienation [a]	2.81	0.92	-0.48***		-0.49***		-0.40***		-0.39***		-0.30***		-0.38***		-0.42***		-0.47***	
Stereotype endorsement [a]	2.20	0.69	-0.24***		-0.30***		-0.25***		-0.30***		-0.24***		-0.26***		-0.27***		-0.30***	
Discrimination experience [a]	2.75	0.97	-0.29***		-0.41***		-0.28***		-0.42***		-0.15*		-0.19**		-0.28***		-0.29***	
Social withdrawal [a]	2.59	0.94	-0.34***		-0.51***		-0.35***		-0.36***		-0.28***		-0.28***		-0.36***		-0.42***	
Life satisfaction [a]	3.40	0.71	0.60***		0.43***		0.22**		0.46***		0.41***		0.53***		-		0.57***	
Affect balance [b]	0.74	1.27	0.62***		0.40***		0.42***		0.46***		0.54***		0.61***		0.57***		-	

Notes. [a] Rated on scale of 1 to 5 with higher scores indicating greater agreement; [b] rated on a scale of -4 to 4 with higher scores indicating predominance of positive affect.
*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$

Table 2
Multiple regression analyses

	Life satisfaction		Affect Balance	
	Model 1	Model 2	Model 1	Model 2
Alienation	-0.35***	-0.09	-0.38***	-0.11
Stereotype endorsement	-0.01	-0.03	0.00	0.03
Discrimination experience	0.03	0.06	0.07	0.04
Social withdrawal	-0.14	-0.02	-0.21*	-0.11
Self-acceptance	-	0.40***	-	0.16
Positive relations	-	0.23**	-	0.07
Autonomy	-	-0.17**	-	0.09
Environmental Mastery	-	0.15*	-	0.08
Personal growth	-	0.04	-	0.21**
Purpose in life	-	0.07	-	0.21*
R^2 (Adjusted)	0.18	0.44	0.23	0.50
F Change	12.03	16.97	16.69	19.37
df	(4,203)	(6,197)	(4,203)	(6,197)

Note. Table reports standardized regression coefficients for each variable.
*p < 0.05; **p < 0.01; ***p < 0.001

was the only aspect of internalized stigma that predicted subjective well-being in our regression analyses, we only report mediation analyses with alienation as a predictor variable.

The relationship between alienation and life satisfaction (Figure 1) appeared to be mediated by self-acceptance, relations with others, autonomy and environmental mastery; the mediation model had R^2 = 0.47. The results met the criteria for full mediation; the total effect of alienation on life satisfaction (c path) was significant, but the direct effect (c') was not. It should be noted, however, that experts have recently argued against the use of terms such as 'full' or 'partial' mediation as, paradoxically, these criteria are easier to meet with a smaller sample size and a smaller initial direct effect (Preacher and Kelley, 2011; Rucker et al., 2011).

The relationship between alienation and affect balance (Figure 2) appeared to be mediated instead by personal growth and purpose in life. The results were

consistent with partial mediation; the direct effect of alienation on affect balance was significant ($p < 0.05$) after the effect of the mediators was taken into account. The model had $R^2 = 0.46$.

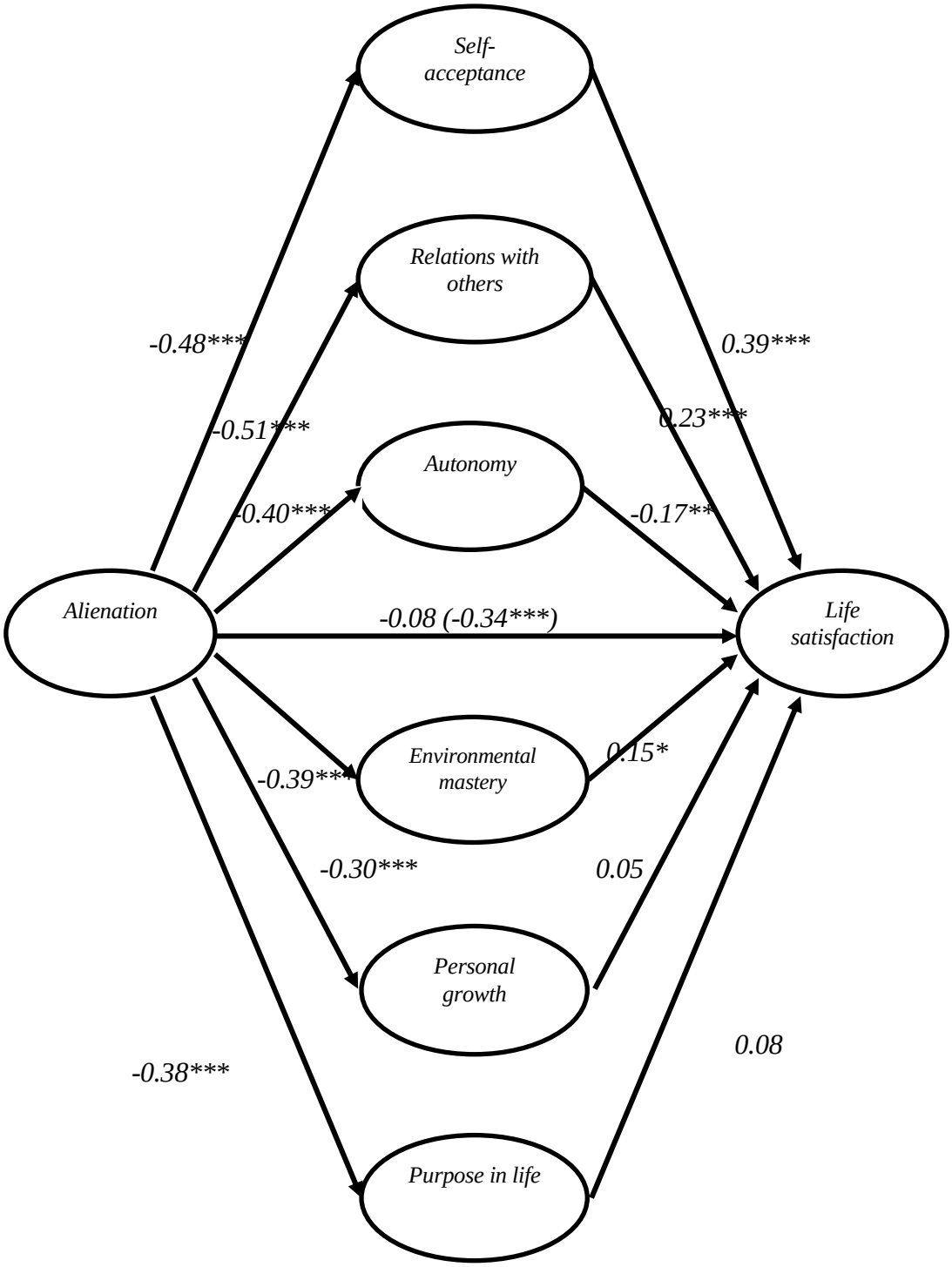


Figure 1. *Mediation model for life satisfaction (constructed using the method described by Preacher and Hayes, 2008). Data are standardized regression coefficients. Total effect (c path) is given in parentheses. †p < 0.10; *p < 0.05; **p < 0.01; ***p < 0.001*

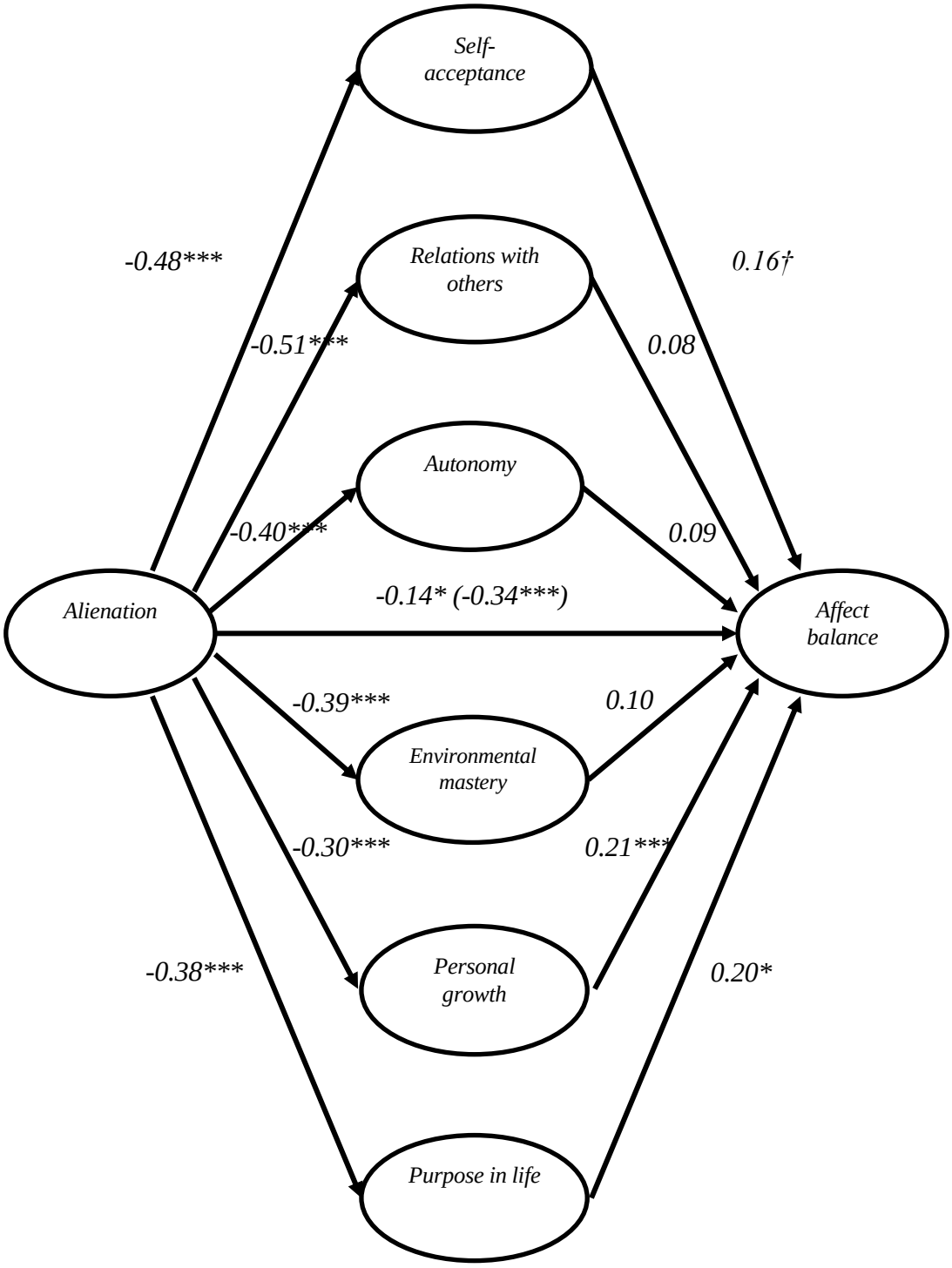


Figure 2. *Mediation model for affect balance (constructed using the method described by Preacher and Hayes, 2008). Data are standardized regression coefficients. Total effect (c path) is given in parentheses. †p < 0.10; *p < 0.05; **p < 0.01; ***p < 0.001*

Discussion

On the basis of previous research we predicted that internalized stigma, psychological well-being and subjective well-being would be related to each other, and that psychological well-being would mediate the relationship between internalized stigma and subjective well-being. Although our division of internalized stigma was based on the structure of the ISMI, it is interesting to note that alienation was the facet of internalized stigma most consistently correlated with psychological well-being scores. This is consistent with a previous longitudinal study (Ritsher and Phelan, 2004) which reported that alienation was the only facet of stigma which predicted self-esteem. The alienation subscale measures 'the subjective experience of being less than a full member of society, or having a 'spoiled identity'', and it contains items such as 'People without mental illness could not possibly understand me' and 'I feel inferior to others who don't have a mental illness' (Ritsher et al., 2003). Ritsher and Phelan (2004) argued that thoughts and feelings of difference and inferiority seem to play an important role in stigmatization and our results corroborate this idea.

Our first hypothesis was that internalized stigma would be negatively related to subjective well-being. This hypothesis was supported by our data; scores for all facets of internalized stigma were negatively correlated with life satisfaction and affect balance. This is consistent with previous research showing that subjective well-being is associated with perceived discrimination and various measures of stigma (Livingston and Boyd, 2010; Magallares et al., 2013).

Our second hypothesis was that internalized stigma would be negatively associated with psychological well-being. In line with our hypothesis all facets of internalized stigma were negatively related to all the psychological well-being factors. This is consistent with previous research demonstrating negative associations between internalized stigma and factors closely related to psychological well-being, such as self-

esteem, self-efficacy (Ritsher et al., 2003; Ritsher and Phelan, 2004; Corrigan, Watson, and Barr, 2006; Yanos et al., 2008) and social functioning (Muñoz et al., 2011).

Our third hypothesis was also confirmed; both measures of subjective well-being (life satisfaction and affect balance) were positively correlated with all the psychological well-being factors. This is consistent with the notion that subjective well-being is a consequence of positive psychological functioning (Ryan et al., 2006; Sanjuán, 2011).

Our fourth hypothesis was that psychological well-being would mediate the relationship between internalized stigma and subjective well-being (affect balance and life satisfaction). We therefore expected that the associations between internalized stigma and psychological well-being would become non-significant when psychological well-being scores were included in the model. Regression analyses confirmed this prediction. Mediation analyses confirmed that our results were consistent with a model in which the relationship between life satisfaction and internalized stigma was fully mediated by psychological well-being as there was no direct association between alienation and life satisfaction; however the relationship between affect balance and internalized stigmas was only partially mediated by psychological well-being as alienation remained directly associated with affect balance when psychological well-being was included in the model. Our fourth hypothesis thus received only partial support.

We had also predicted negative associations between well-being and alienation (H5), stereotype endorsement (H6) and social withdrawal (H7). All three variables were correlated with both psychological and subjective well-being; however, only alienation predicted both life satisfaction and affect balance. Social withdrawal only predicted affect balance and stereotype endorsement predicted neither aspect of subjective well-being. Our fifth hypothesis was supported, but our sixth and seventh hypotheses were only partially supported.

Although the effect of internalized stigma on well-being has been documented before, our study improves understanding of this effect because we assessed the relationship in the light of relatively recent proposals about the structure and functioning of well-being taken from positive psychology (Ryan et al., 2006; Sanjuán, 2011).

This research makes two important contributions to the study of the effect of stigma on PWMI. First, it provides the first assessment of the role of psychological well-being as a mediator of the relationship between internalized stigma and subjective well-being. Second, it explored relationships among the various facets of internalized stigma (alienation, stereotype endorsement, discrimination experience and social withdrawal), psychological well-being (self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth) and subjective well-being (life satisfaction and affect balance).

It is also important to consider the limitations of this study. First, because our data are cross-sectional they cannot be used to determine causality. The most we can conclude is that our results are consistent with the possibility that psychological well-being mediates the relationship between internalized stigma and subjective well-being. There are theoretical arguments and empirical data suggesting that internalized stigma predicts a reduction in the well-being of PWMI (Ritsher and Phelan, 2004) and that subjective well-being may be a consequence of psychological well-being (Ryan et al., 2006; Sanjuán, 2011); however longitudinal or even experimental studies should be carried out to provide evidence on causality.

Second, internalized stigma was indexed using only self-report measures. It has been demonstrated that implicit internalized stigma is a measurable construct which independently predicts quality of life (Rüsch et al., 2010). It would be interesting to explore the relationships between implicit internalized stigma and various facets of psychological well-being and subjective well-being. There are several reasons why self-report data may lack including social desirability bias and bias related to the respondent's current mood. Future studies should also include third-party (mental

health service workers) reports of participants' internalized stigma and well-being. This would enable us to estimate the convergent validity of both kinds of report.

Our results and those of Ritsher and Phelan (2004) suggest that alienation is the aspect of internalized stigma with the greatest impact on well-being. Together with the finding that all aspects of psychological well-being (particularly self-acceptance) are highly correlated with life satisfaction and affect balance, this suggests that intervention programs designed to reduce internalized stigma should focus on improving the self-directed feelings and attitudes of PWMI. This is consistent with the recommendations of experts on stigma, who favor interventions that seek to improve participants' ability to cope with stigma by enhancing their self-esteem, empowering them and increasing help-seeking behaviors, rather than by trying to change stigmatizing beliefs and attitudes about mental illness (Mittal et al., 2012). Another piece of evidence which hints at the importance of alienation in internalization of stigma is that three out of six programs reported to be successful in reducing self-stigma in a recent review (Yanos et al., 2014) focused on self-esteem and empowerment.

Our data suggest that reducing feelings of alienation and improving self-acceptance and other aspects of positive psychological functioning would have a positive effect on life satisfaction and affect balance; however further research is needed to confirm this.

Although our results show that the feeling or experience of being stereotyped and rejected by society affects the well-being of PWMI results in internalization of stigma, we must not forget that the root cause of stigmatization is the attitudes and behavior of the general population. This means that if we really want to tackle the problem of stigma we need to reduce public stigmatization of mental illness and people who experience it. Research has shown that the most effective approaches to reducing public stigma are targeted (aimed at key social groups), local (tailored to the local context), credible (for example, it is helpful if the message is delivered by someone who is similar to the target audience in terms of role and status), continuous (the

message is delivered on multiple occasions, via different people, in different venues and several forms) and make use of *in vivo* contact (Corrigan and Kosyluk, 2013). The goal of promoting positive contact with PWMI is to reduce negative emotional reactions (e.g. fear, anger, disgust) and increase positive emotional reactions, especially empathy, as this would be expected to reduce the perception of 'difference' and hence discrimination.

In conclusion, although this study provides information which could be used to develop interventions to reduce internalized stigma, it is only by fighting both public and internalized stigma that we can reduce the stigma attached to mental health problems and the impact this has on the lives of PWMI.

Chapter 5: The effect of individual and group discrimination on the well-being of people with mental illness: the role of internalized stigma and collective action intention

This chapter has been submitted for publication in a similar form as:

Pérez-Garín, D., Molero, F., & Bos, A. E. R. (2015). *The effect of personal and group discrimination on the well-being of people with mental illness: the role of internalized stigma and collective action intention.* Manuscript submitted for publication.

Abstract

The goal of this study is to test a model in which individual discrimination predicts internalized stigma, while group discrimination predicts a greater willingness to engage in collective action. Internalized stigma and collective action, in turn, are associated to positive and negative affect. A cross-sectional study with 213 PWMI was conducted. The model was tested using path analysis. Although the data supported the model, its fit was not sufficiently good. A respecified model, in which a direct path from collective action to internalized stigma was added, showed a good fit. Personal and group discrimination appear to impact subjective well-being through two different paths: the internalization of stigma and collective action intentions, respectively. These two paths, however, are not completely independent, as collective action predicts a lower internalization of stigma. Thus, collective action appears as an important tool to reduce internalized stigma and improve subjective well-being. Future interventions to reduce the impact of stigma should fight the internalization of stigma and promote collective action are suggested.

Keywords: *mental illness, discrimination, internalized stigma, collective action, affects, structural equation modelling*

As numerous studies have shown, the perception of being discriminated (perceived discrimination) has a negative impact on the well-being of the members of all kinds of disadvantaged groups (see Schmitt, Branscombe, Postmes & García, 2014 for a meta-analysis).

Some studies have found that the perception of being personally discriminated because of one's group membership –individual discrimination- and the perception that the ingroup as a whole is discriminated –group discrimination- are two distinct constructs. Moreover, members of stigmatized groups often report lower rates of individual discrimination than group discrimination, and both have different, and even opposite effects on well-being (Smith & Ortiz, 2002; Molero et al., 2012). When controlling for the effect of individual discrimination, studies on latino/a adolescents in the U.S. (Armenta & Hunt, 2008), and both African immigrants and women in Belgium (Bourguignon, Seron, Yzerbyt. & Herman, 2006) have found that group discrimination is positively related to personal self-esteem. Bourguignon et al. argued that perceiving group discrimination might alleviate the negative effects of being personally discriminated, because people feel they are not alone in their plight. Consistently with the Rejection-Identification model (Branscombe, Schmitt, & Harvey, 1999), the positive effect of group discrimination on self-esteem appeared to be mediated by ingroup identification.

Molero, Fuster, Jetten, and Moriano (2011) found that people with HIV had two ways of coping with discrimination: hiding their stigmatized identity or increasing their identification with the stigmatized group and engaging in collective action to improve its position.

Based on these findings, we propose a model in which individual discrimination predicts a greater internalization of stigma in people with mental illness (PWMI), while group discrimination predicts a greater willingness to engage in collective action. Internalized stigma and collective action should, in turn, have different associations

with subjective well-being, which we measure in the form of positive and negative affect. The model is represented schematically in Figure 1.

Individual discrimination refers to personal experiences of rejection, so it is very relevant to the self. Thus, we expect it to be positively associated with internalized stigma (hypothesis 1), which authors define as the endorsement of negative stereotypes about PWMI, their application to oneself, and the resulting reduction of self-worth, psychological distress, withdrawal, and secrecy (Bos, Pryor, Reeder, & Stutterheim, 2013; Livingston & Boyd, 2010; Ritsher, Otilingam, and Grajales, 2003).

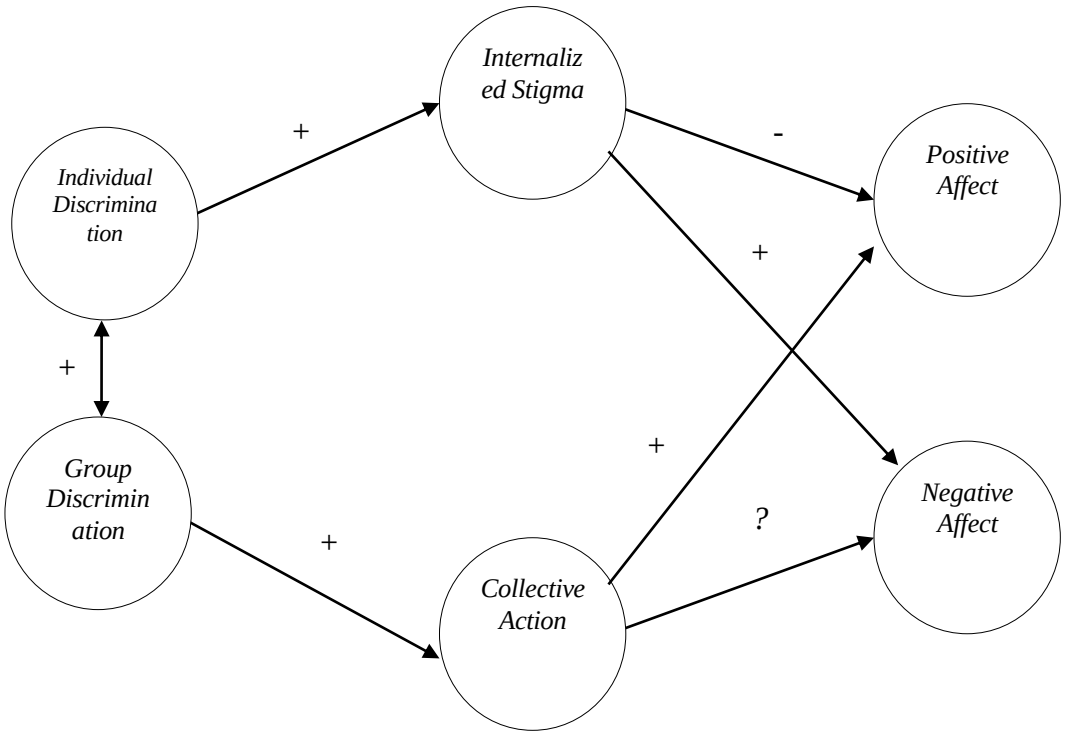


Figure 1. Hypothesized model.

Because internalized stigma is negatively associated with several measures of well-being (Corrigan, Watson, & Barr, 2006; Ritsher et al., 2003; Ritsher & Phelan, 2004; Yanos, Roe, Markus, & Lysaker, 2008), we also expect it to predict lower levels of positive affect (hypothesis 2) and higher levels of negative affect (hypothesis 3).

A meta-analysis by Van Zomeren, Postmes, and Spears (2008) showed that perceptions of unjust treatment towards the in-group (including group discrimination)

were positively related with attitudinal and behavioral measures of collective action. Thus, it is also reasonable to assume that a greater perception of group discrimination will predict a greater willingness to participate in collective action (hypothesis 4).Molero et al. (2011) found that collective action intention significantly predicted a general measure of well-being. We expect to find a positive association with positive affect (hypothesis 5). Although we also expect to find a significant association with negative affect (hypothesis 6), we are not sure of the direction of that relationship. Perhaps believing in the need to engage in collective action and in its effectiveness might decrease negative affects, but this kind of involvement and self-responsibility might also increase negative affect. Or perhaps negative affects motivate collective action.

Thus, the purpose of this study, is to test the proposed model, in which individual discrimination affects well-being through the internalization of stigma, and group discrimination affects it through the willingness no engage in collective action.

Method

Participants

The sample comprised 213 clients from 19 different centers of the public network of social care services for PWMI of the communities of Madrid (*N* = 170), Catalonia (*N* = 35) and the Balearic Islands (*N* = 8), of whom 126 were men and 85 were women (the remaining two participants did not report their gender). All of our respondents were over 18 years old, their mean age being 43.04 years (*SD* = 10.65). All of them were Spaniards of Spanish ethnicity, which compose the vast majority of the clients of these centers.

Procedure

Questionnaires were distributed with collaboration from the workers in the rehabilitation centers. The research's goals, instruments and procedure had been previously approved by Intress' ethics committee.

Measures

Multidimensional Perceived Discrimination Scale (Molero, Recio, García-Ael, Fuster, & Sanjuán, 2012). This is a 12-item scale that measures the perception of four different types of discrimination: blatant group discrimination, subtle group discrimination, blatant individual discrimination, and subtle individual discrimination. However, because confirmatory and exploratory data analysis show that a two-factor model has a better fit, we grouped the four factors into two, which also served the purpose of this study better: group discrimination and individual discrimination. Perceived group discrimination measures the extent to which the respondent believes his or her group is discriminated, while perceived individual discrimination is the extent to which the respondent believes he or she has been personally discriminated. Both subscales showed a good internal consistency: group discrimination had an alpha of .89, and individual discrimination had an alpha of .92.

Internalized Stigma of Mental Illness scale (ISMI) (Ritsher et al.,2003) is a specific scale that measures internalized stigma in PWMI. It is composed of 29 items divided in five subscales: alienation, stereotype endorsement, discrimination experience, social withdrawal and stigma resistance (Ritsher et al., 2003).

We used Muñoz, Sanz, Pérez-Santos, and Quiroga's Spanish translation of the scale (2009). However, we decided to drop the stigma resistance subscale, as the original authors suggest (Ritsher et al., 2003), because it shows a low reliability and a poor correlation with the rest of the subscales and the Internalized Stigma construct itself. The scale as a whole showed a high internal consistency (α = .93).

Collective Action Intention was measured with four items assessing the perceived effectiveness of collective action, and intention to engage in it. Sample items are "Collective action is a good way to defend the rights of people with mental illness" and "I am willing to participate in collective actions to support the rights of people with mental illness". The four items were averaged, with higher scores indicating that the

respondent believed that collective action was useful and was willing to participate in it (α = .82).

Positive and Negative Affect Schedule (PANAS) (Watson, Clark, & Tellegen, 1988) consists of two 10-item subscales which assess the extent to which the respondent experiences positive and negative moods. Positive and negative affect are two consistent and largely uncorrelated factors, and both subscales showed high alphas (positive affect: α = .90; negative affect: α = .89). We used Sandín et al.'s Spanish translation (1999).

Responses to all the items in the battery were made on a five-point Likert scale.

Results

Preliminary analyses show that sex did not correlate with any of the reported main dependent variables. However, age was positively correlated with internalized stigma (r = .27; p < .01) and negatively correlated with positive affect (r = -.28; p < .01), and main diagnosis also had a significant effect on negative affect (p < .01). Therefore, we controlled for age and main diagnosis in the subsequent analyses.

Table 1 displays descriptive statistics for the variables of the model, as well as the correlations between them. As we can see, our participants perceive moderately high levels of personal (M = 3.36, SD = 1.05) and group discrimination (M = 3.81, SD = 0.84), and are generally willing to engage in collective actions (M = 4.00, SD = 0.70).

Model testing

We used path analysis to simultaneously assess the relationships between the variables in our model. Path analysis is considered as a special case of structural equation modelling (SEM) used to confirm potential causal dependencies between endogenous and exogenous variables in which only the s*tructural model* is included (leaving out the *measurement model*, which shows the relations between latent variables and their indicators).

We specified individual discrimination and group discrimination as the exogenous predictor variables, internalized stigma and collective action as the

mediators, and positive affect and negative affect as the outcome variables. Each latent variable was defined by the mean of the corresponding scale. The measurement errors of the model were eliminated, and, in order to enhance intelligibility, the regression errors are not shown in the figures.

Table 1.

Means, standard deviations and partial correlations of the main variables in this study

	M	*SD*	1	2	3	4	5	6
1. Individual discrimination	3.36	1.05	-	.56**	.52**	.27**	.05	.28**
2. Group discrimination	3.81	0.84	.56**	-	.32**	.32**	.01	.30**
3. ISMI	2.57	0.73	.52**	.32**	-	.01	-.24**	.41**
4. Collective action	4.00	0.70	.27**	.32**	.01	-	.25**	.18*
5. Positive affect	2.78	0.87	.05	.01	-.24**	.25**	-	-.19**
6. Negative affect	2.05	0.77	.28**	.30**	.41**	.18*	-.19**	-

Note. $N = 207$. Partial correlations controlling for the effect of age and diagnosis.
* $p < .05$; ** $p < .01$

Table 2 shows the standardized parameter estimates, the goodness-of-fit statistics, and the coefficients of determination of the hypothesized model. Most of the fit indexes meet acceptable levels (Hu & Bentler, 1999). The three incremental fit indexes (comparative fit index [CFI], incremental fit index [IFI], and goodness-of-fit index [GFI]) are above the .95 threshold. Both root mean square residual [RMR] and root mean square error of approximation [RMSEA] are below .08, which is considered

acceptable (Browne and Cudeck, 1993). Chi-square, however, is significant, which does not indicate a good fit ($\chi^2 = 16.04$, df = 8, $p < .05$).

Table 2

	Hypothesized model	Adjusted model
Goodnes-of-fit statistics		
χ^2 (df)	16.04 (8)	10.99 (7)
CFI	.97	.98
IFI	.97	.99
GFI	.98	.98
RMR	.03	.03
RMSEA	.07	.05
Squared multiple correlations (R^2)		
Internalized stigma	.28	.31
Collective action	.12	.12
Positive affect	.14	.15
Negative affect	.19	.18

Fit Indexes and Squared Multiple Correlations for Tested Models

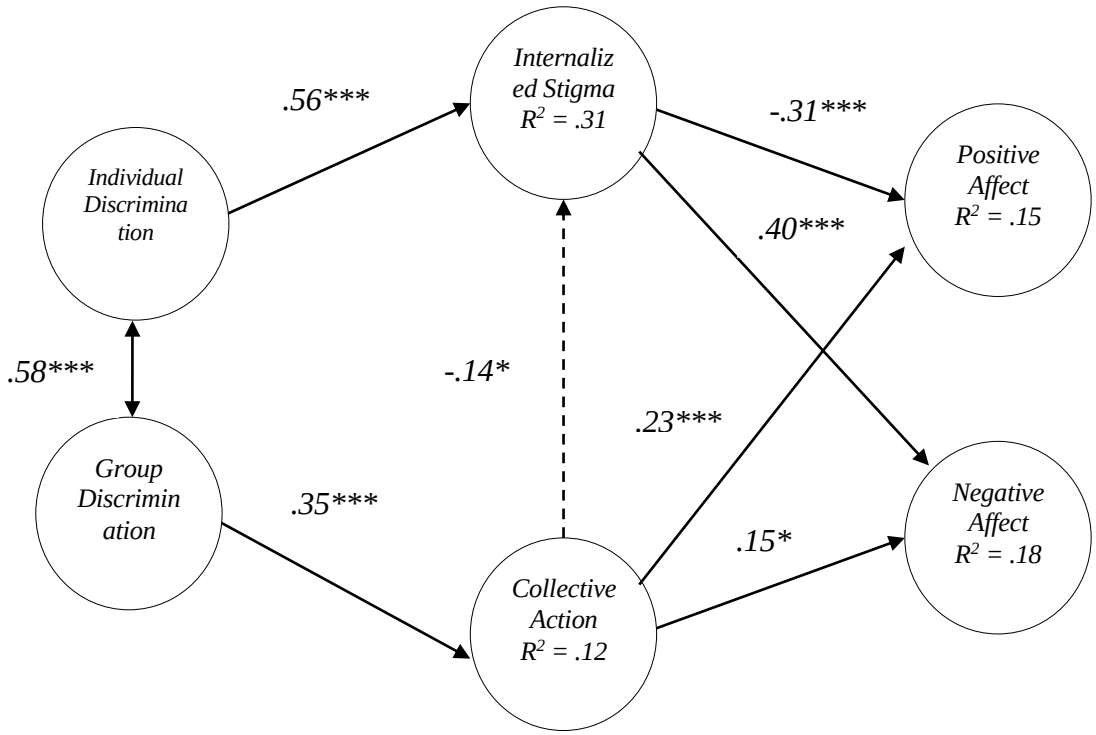
Note. CFI = comparative fit index; IFI = incremental fit index; GFI = goodness-of-fit index; RMR = root mean square residual; RMSEA = root mean square error of approximation.

The model was respecified based on modification indexes (Arbuckle, 2003), adding an additional direct path from collective action to internalized stigma. Chi-square becomes non-significant ($\chi^2 = 10.99$, df = 7; $p = .14$), and all the other fit indexes are equally good or better than they are for the hypothesized model.

Discussion

In this paper, we test the possibility that personal experiences of discrimination and the perception of discrimination towards the ingroup affect subjective well-being through two separate paths. We propose that individual discrimination influences

positive and negative affects through an individual route, leading to the internalization of stigma, which would in turn lower positive affect and increase negative affect. Group discrimination, on the other hand, would act through a more collective route, enhancing collective action intentions, which in turn increase both positive and negative affect.



*p < .05. ***p < .001

Figure 2. Respecified model

We found support for both paths, but the model fit was improved when the model was respecified allowing for a direct path from collective action to internalized stigma. This added path appears logical and can be justified theoretically. Collective action intention has been found to predict higher levels of empowerment (Drury, Cocking, Beale, Hanson, & Rapley, 2005), and low levels of empowerment have been associated with internalized stigma (Ritsher et al., 2003). Thus, it is not surprising that engaging in collective action appears to reduce internalized stigma.

Because all of our hypotheses referred to the relationships of the variables included in the model, they were all confirmed. However, our sixth hypothesis was

bilateral, as we did not predict whether collective action would be positively or negatively associated to negative affect. According to our results, collective action is positively associated with both positive and negative affect. Because engaging in collective action is associated with a greater sense of empowerment (Ritsher et al., 2003), and usually with a positive group identity (Ellemers, 2001) and stronger group ties, it is easy to understand how it could be related with higher scores for positive affect. Why it also predicts higher negative affect scores is less evident. It should be noted that collective action always has a cost for the individuals who engage in it. In the best case scenario, it requires effort and concern for the group's well-being. In the case of groups with a concealable stigma, such as people with HIV or a mental illness, collective action requires disclosing one's stigmatized identity, which usually has negative consequences. Although this finding is new in the case of PWMI, it is consistent with previous research on different contexts, which had found that collective action could have both positive and negative psychological outcomes (Drury & Reicher, 2005).

These explanations, however, are tentative, and future research should assess the relationships between collective action, group identity, empowerment, disclosure, and mood. In order to be able to assert causality, these relationships should be tested in a longitudinal design, as should the respecified model.

Although our results should be confirmed in future research, they are of practical importance and have the potential to inform the design of future interventions aimed at enhancing well-being among PWMI. Our results suggest that individual discrimination affects subjective well-being through the internalization of stigma. Therefore, intervention programs aimed at reducing the impact of discrimination on well-being should fight the internalization of stigma. Collective action intention might not only predict higher levels of positive affect (and also, to a lesser extent, higher levels of negative affect), but it also seems to reduce the internalization of stigma and thus the negative impact of personal experiences of discrimination on well-being. Thus, it seems

that collective action is not only important at a societal level (as a mean to improve the situation of the group), but has also an important effect on the individuals who engage in it.

Capítulo 6: Discusión general

El estigma social es uno de los problemas más importantes a los que tienen que hacer frente las personas con trastornos mentales (Comisión Europea: Dirección General de Salud y Consumidores, 2005; Muñoz, Guillén y Pérez-Santos, 2013; Organización Mundial de la Salud, 2005). El estigma provoca la exclusión y discriminación de las personas con enfermedad mental en áreas como la vivienda, el empleo, las relaciones interpersonales, la salud y los medios de comunicación (Corrigan y Watson, 2002; Magallares, 2011; Michaels, López, Rüsch y Corrigan, 2012; Sampietro, 2010).

Además, como cabe suponer, la estigmatización es negativa para el bienestar psicológico y subjetivo de las personas con enfermedad mental, habiéndose demostrado su influencia en áreas como la autoestima, el empoderamiento, la autoeficacia, la calidad de vida, la gravedad de los síntomas o la adherencia al tratamiento (Drapalski et al., 2013; Livingston y Boyd, 2010; Muñoz, Sanz, Pérez-Santos y Quiroga, 2011). Esta influencia es aún mayor cuando el estigma se internaliza, puesto que en ese caso la relación con el bienestar es más directa (Ritsher et al., 2003; Watson et al., 2007).

En este contexto, el objetivo de este trabajo era analizar la influencia del estigma sobre el bienestar psicológico y subjetivo de las personas con enfermedad mental. En el estudio expuesto en el capítulo 2 se analizó la relación de los distintos tipos de discriminación percibida y la conciencia de estigma con el bienestar. Se encontró que la discriminación sutil y la conciencia de estigma predecían niveles más bajos de autoaceptación y balance afectivo, respectivamente. También se encontró que emplear un estilo de afrontamiento evitativo frente a la estigmatización estaba asociado con niveles más bajos de bienestar subjetivo.

Los resultados expuestos en el capítulo 3 indican que la discriminación individual sutil predice una mayor internalización del estigma, y ésta a su vez predice un menor bienestar psicológico y subjetivo. Tal y como se expone en el capítulo 4, los datos también son coherentes con la existencia de mediación del bienestar psicológico

en la relación entre el estigma internalizado y el bienestar subjetivo. No obstante, al analizar los efectos de los distintos componentes del estigma internalizado por separado, se observó que la alienación era el único que predecía significativamente ambos tipos de bienestar.

Los datos también son consistentes con el modelo propuesto en el capítulo 5, según el cual la discriminación individual aumenta la internalización del estigma, mientras que la discriminación grupal aumenta la intención de tomar parte en acciones colectivas para mejorar la situación de las personas con enfermedad mental, y ambas variables influyen a su vez en la frecuencia y la intensidad con las que se experimentan emociones negativas y positivas.

Esta tesis presenta varias aportaciones al estudio del estigma en la enfermedad mental y sus consecuencias. Una de las principales novedades de las investigaciones recogidas en esta tesis es el estudio de las diversas facetas de la discriminación percibida, y su relación con el estigma internalizado y el bienestar, tanto psicológico como subjetivo de las personas con enfermedad mental. Básicamente podemos decir que la discriminación percibida ejerce sus efectos negativos sobre el bienestar de las personas con enfermedad mental, no tanto de forma directa, sino aumentando la internalización del estigma. Hasta donde sabemos, las distintas facetas de la discriminación percibida sólo se habían estudiado con anterioridad en otros grupos estigmatizados, como inmigrantes, personas con VIH, gays y lesbianas (Molero et al., 2012). Los resultados de las personas con enfermedad mental son similares a los de otros grupos en varios sentidos. Al igual que las personas de otros grupos estigmatizados, nuestros participantes perciben más discriminación hacia el colectivo de personas con enfermedad mental que hacia sí mismos, y más discriminación sutil que manifiesta. Por lo tanto, encontramos las mayores puntuaciones para la discriminación grupal sutil, y las menores para la discriminación individual manifiesta. Por otro lado, la discriminación individual sutil es la que más se relaciona con un menor bienestar psicológico y subjetivo, así como con una mayor internalización del

estigma. Esto podría deberse, por un lado, a que las experiencias personales de discriminación tienen un mayor impacto en el individuo que la discriminación que percibe hacia el grupo en su conjunto (Schmitt, Branscombe, Postmes, y Garcia, 2014), y por otro, a que la discriminación sutil, además de ser más frecuente, es más difícil de combatir, y, al ser más ambigua, hace más difícil atribuir los resultados o interacciones negativos al prejuicio (Cihangir, 2008; Operario y Fiske, 2001).

La conciencia de estigma, por su parte, muestra una correlación positiva con la discriminación percibida, como en el estudio de Pinel (1999), pero además resultó ser la variable que mejor predecía la autoaceptación. Es decir, que las expectativas que las personas tienen de ser estereotipadas y discriminadas en la interacción con los demás es lo que mejor predice la medida en que aceptan sus propias fortalezas y limitaciones.

En cuanto al estigma internalizado, nuestra investigación es la primera en analizar su relación con los distintos tipos de discriminación percibida. Como decíamos más arriba, la discriminación individual sutil es la que más se relaciona con la internalización del estigma. Además, al analizar por separado la relación de los distintos componentes del estigma internalizado con el bienestar psicológico y subjetivo, encontramos que la alienación es el único que predice significativamente ambos tipos de bienestar. Si bien no tenemos noticia de que se haya analizado antes la relación de los distintos componentes del estigma internalizado con el bienestar psicológico, la satisfacción con la vida, y el balance afectivo, nuestros resultados son consistentes con los del estudio longitudinal Ritsher y Phelan (2004), que encontraron que la alienación era el único componente que predecía significativamente un descenso en la autoestima.

Otra importante aportación del segundo estudio es que mide el bienestar teniendo en cuenta tanto los aspectos eudaimónicos (bienestar psicológico) como los hedónicos (bienestar subjetivo). Además de poner ambos tipos de bienestar en relación con la discriminación percibida y el estigma internalizado, en el capítulo 4

proponemos la mediación del bienestar psicológico entre el estigma internalizado y el bienestar subjetivo. Pese a que la direccionalidad de las relaciones entre estas variables debe ser confirmada mediante el uso de metodología longitudinal, es consistente con la idea defendida por varios autores de que el bienestar subjetivo es una consecuencia del funcionamiento psicológico positivo (Ryan et al, 2006; Sanjuán, 2011). Lo que proponemos es que la internalización del estigma, y más concretamente la experiencia de alienación (el sentimiento de valer menos que el resto por tener una enfermedad mental), hace que empeoren una serie de indicadores de funcionamiento psicológico positivo (la autoaceptación, las relaciones con otros, la autonomía, el dominio del entorno, el crecimiento personal, y el propósito en la vida), y como consecuencia de esto, empeora la valoración cognitiva sobre la propia vida (satisfacción con la vida) y disminuye la proporción de emociones positivas experimentadas frente a las negativas (desciende el balance afectivo). Si el bienestar subjetivo (la evaluación cognitiva y emocional de la propia vida) es consecuencia de este funcionamiento psicológico positivo (el bienestar psicológico), la internalización del estigma hace que las personas con enfermedad mental vivan peor, y como consecuencia estén menos satisfechas con su vida y experimenten menos emociones positivas y más negativas.

Por otro lado, el modelo expuesto en el capítulo cinco es novedoso por proponer por primera vez que la percepción de discriminación hacia uno mismo o hacia el grupo de personas con enfermedad mental podrían tener efectos distintos en el bienestar subjetivo, a través de la internalización del estigma en un caso, y de un aumento en la predisposición a la acción colectiva, en el otro. El que la discriminación individual prediga una mayor internalización del estigma es consistente con los resultados de un meta-análisis reciente, que indica que la discriminación individual predice niveles más bajos de bienestar que la discriminación grupal (Schmitt et al., 2014). Además, el que la discriminación grupal prediga una mayor predisposición a la acción colectiva, es coherente con el modelo de rechazo-identificación de

Branscombe, Schmitt, y Harvey (1999). Es razonable suponer que este incremento en la predisposición a luchar por los intereses del colectivo va acompañado de un aumento de la identificación con el grupo, que se produce al percibir que todo el grupo es discriminado.

Limitaciones y recomendaciones para investigaciones futuras

Si bien esta tesis ha contribuido a la comprensión teórica del efecto del estigma y la discriminación en las personas con enfermedad mental, futuras investigaciones deberían confirmar las relaciones propuestas aquí. En primer lugar, para descartar el llamado sesgo de método común, es decir, el aumento de la relación entre las variables debido al empleo del mismo método para su medición (Podsakoff et al., 2003), estudios futuros podrían incluir (además de los autoinformes) informes llevados a cabo por terceras personas (como los profesionales de los centros de rehabilitación o los familiares) sobre el estigma internalizado y el bienestar de los participantes. Además, estos informes de terceras personas ayudarían a descartar el efecto de sesgos de respuesta tales como la deseabilidad social.

Para poder confirmar que las relaciones entre variables que se proponen en esta tesis son de causalidad, deberían ponerse a prueba los modelos utilizando diseños longitudinales o incluso experimentales. En algunos casos, por motivos prácticos y éticos, sería difícil emplear un diseño experimental (por ejemplo, para estudiar la internalización del estigma, un proceso que cabe suponer que ocurre a lo largo del tiempo). En otros, sin embargo, sí podría usarse la metodología experimental. Por ejemplo, para confirmar que las experiencias de discriminación sutil afectan más al estado de ánimo que las de discriminación manifiesta, y si esta diferencia tiene que ver con una atribución interna de la experiencia negativa.

Además de confirmar las relaciones entre discriminación, estigma internalizado y bienestar empleando otros diseños, la investigación futura debería explorar el papel que juegan en dichas relaciones otros constructos relevantes, como la revelación u ocultación de la enfermedad mental (Corrigan, Kosyluk y Rüsch, 2013), el estigma

internalizado implícito (Rüsch, Corrigan, Todd y Bodenhausen, 2010), o incluso el estigma por asociación experimentado por personas cercanas (Pryor, Reeder y Monroe, 2012.

Implicaciones prácticas y reflexiones finales

Los resultados expuestos en esta tesis apuntan una serie de cuestiones importantes a tener en cuenta a la hora de desarrollar y llevar a cabo intervenciones para reducir el impacto del estigma en las vidas de las personas con enfermedad mental. En los capítulos 2 y 3 se pone de manifiesto que la discriminación sutil es la que más se relaciona con un menor bienestar y con la internalización del estigma. Como se discute en el capítulo 3, esto pone de manifiesto que a la hora de elaborar programas para combatir el estigma entre la población general es importante visibilizar y concienciar contra comportamientos como las muestras de desconfianza o el rechazo sutil.

En cuanto a los programas orientados a reducir el estigma internalizado y mejorar el bienestar de las personas con enfermedad mental, de esta tesis también se extraen varias recomendaciones. En este sentido, quizá la aportación más relevante es la importante relación negativa entre el estigma internalizado y el bienestar tanto psicológico como subjetivo que se encuentra en el segundo estudio. Nuestros resultados parecen indicar que la internalización del estigma, y más concretamente la alienación (el que la persona sienta que vale menos que los demás por tener una enfermedad mental) daña el funcionamiento psicológico positivo, reduce la satisfacción con la vida, y aumenta la proporción de emociones negativas experimentadas. Al mismo tiempo, el tener en cuenta la internalización del estigma reduce la significación del efecto de la discriminación percibida sobre el bienestar, siendo los datos también coherentes con el papel mediador del estigma internalizado. Todo ello sugiere que el estigma internalizado, y más concretamente la alienación, deberían ser factores clave sobre los que trabajar en cualquier programa cuyo objetivo sea reducir el impacto del estigma en las personas con enfermedad mental. Es cierto que la causa del estigma

internalizado es el estigma público. Sin embargo, parece poco probable erradicar completamente este último. Por lo tanto, luchar contra la internalización y legitimación de las creencias, actitudes y comportamientos negativos hacia las personas con enfermedad mental probablemente sea la forma más inmediata y efectiva de combatir el daño que el estigma puede producir a quienes lo padecen.

Además de esto, los resultados de esta tesis también indican que promover ciertos comportamientos para afrontar el estigma y evitar otros también puede mejorar el bienestar de las personas con enfermedad mental. En concreto, en el primer estudio se encuentra una relación negativa entre el uso de estrategias de afrontamiento pasivo y el bienestar, tanto subjetivo como psicológico. Por otra parte, los resultados del segundo estudio indican que la predisposición a la acción colectiva se relaciona con mayores niveles de afecto positivo. La acción colectiva tiene también la ventaja de que permite mejorar la situación del grupo en su conjunto, y puede dirigirse, por ejemplo, a reducir el estigma público o institucional. Por todo ello, teniendo en cuenta nuestros resultados, recomendamos que los programas de intervención con personas con enfermedad mental traten de reducir el uso de estrategias de afrontamiento perjudiciales, como la negación, la auto culpa, o el abuso de sustancias, y al mismo tiempo promover la implicación en acciones colectivas para mejorar la situación del colectivo y combatir el estigma.

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